Harvard Pilgrim Health Care

Benefit Handbook

POS 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 POS provider network. Plan Providers may be found in the states of Maine, Massachusetts, New Hampshire, Vermont, Rhode Island, and Connecticut. 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: 01/01/2023
FORM #2857

INTRODUCTION

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

The Plan is designed to comply with the requirements of the Internal Revenue Service for a "High Deductible Health Plan." Persons covered under a High Deductible Health Plan may be entitled to contribute to a Health Savings Account, often called an "HSA." Depending on your personal circumstances, an HSA may be used to pay for Member Cost Sharing associated with Covered Benefits in addition to some health care services that are not covered by the Plan. An HSA may also provide you with generous tax advantages. It is important that you consult a qualified tax advisor for advice on whether you are eligible to contribute to an HSA and how an HSA may be used.

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

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 changes to your premium 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.

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

In-Network Benefits

Your "In-Network" benefits provide coverage at a lower out of pocket cost. With very limited exceptions, you must receive care from "Plan Providers" to obtain In-Network benefits. Plan Providers are medical providers under contract to care for HPHC members. They include Primary Care Providers (PCPs), specialists, Hospitals and many other types of providers. You can locate Plan Providers by using the Plan's Provider Directory described in this Benefit Handbook. You may also call Member Services at **1–877–907–4742**.

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

Out-of-Network Benefits

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

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

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

You may also call the Member Services Department at **1–877–907–4742** if you have any questions. Member Services staff are available to help you with questions about the following:

- Selecting a PCP
- Your Benefit Handbook
- Your In-Network and Out-of-Network benefits
- Your enrollment
- Your claims
- Pharmacy management procedures
- Provider information
- Requesting a Provider Directory
- Requesting a Member Kit
- Requesting ID cards
- Registering a complaint

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

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

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

Harvard Pilgrim Health Care
Member Services Department
1 Wellness Way
Canton, MA 02021
1-877-907-4742
www.harvardpilgrim.org

Medical Necessity Guidelines

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our Medical Necessity Guidelines applicable to a service or procedure for which coverage is requested. Medical Necessity Guidelines may be obtained by calling **1-877-907-4742** or going to **www.harvardpilgrim.org**.

Exclusions or Limitations for Preexisting Conditions. The Plan does not impose any restrictions, limitations or exclusions related to preexisting conditions on your Covered Benefits.

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, sex, sexual orientation, or gender identity. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or 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, sex, sexual orientation, or 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.

TABLE OF CONTENTS

Benefit Handbook

I. How the Plan Works

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

A. HOW TO USE THIS BENEFIT HANDBOOK

1. Why This Benefit Handbook Is Important

This Benefit Handbook, the Schedule of Benefits, the Prescription Drug Brochure and any applicable riders and amendments (collectively referred to as the Evidence of Coverage) make up the legal agreement stating the terms of the Plan.

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

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

You can view your Benefit Handbook, Schedule of Benefits, Prescription Drug Brochure and any applicable riders and amendments 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 is a description of some of the important sections of the Handbook.

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

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

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

B. HOW TO USE YOUR PROVIDER DIRECTORY

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

The Provider Directory lists the Plan's Providers you may use to obtain In-Network coverage. You may view the Provider Directory online at our website, **www.harvardpilgrim.org**. Please select "POS" from the list of "standard plans". You can also get a paper copy of the Provider Directory, free of charge, by calling the Member Services Department at **1–877–907–4742.**

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

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

C. MEMBER OBLIGATIONS

1. Choose a Primary Care Provider (PCP)

If you live in the Plan's Service Area, you must select a PCP for yourself and each covered member of your family. You may choose a different PCP for each family member. If you do not choose a PCP when you enroll, or if the PCP you select is not available, we will assign a PCP to you. The Plan Service Area is the states of Massachusetts, New Hampshire, Maine, Rhode Island, Connecticut and Vermont.

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

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

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

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

2. Obtain Referrals to In-Network Specialists

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

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

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

3. Show Your Identification Card

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

4. Share Costs

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

- Copayments
- Coinsurance
- Deductibles

Your Plan also has an Out-of-Pocket Maximum that limits the amount of Member Cost Sharing you will be required to pay. Your specific Member Cost Sharing responsibilities are listed in your Schedule of Benefits. See section *I.E. MEMBER COST SHARING* for more information on Copayments, Coinsurance, Deductibles and Out-of-Pocket Maximums.

5. Obtain Prior Approval

You are required to obtain Prior Approval before receiving certain Covered Benefits. Please see section *I.F. PRIOR APPROVAL* for more information on these requirements.

6. Be Aware that your Plan Does Not Pay for All Health Services

There may be health products or services you need that are not covered by the Plan. Please review section *IV. Exclusions* for more information. In addition, some services that are covered by the Plan are limited. Such limitations are needed to maintain reasonable premium rates for all Members. Please see your Schedule of Benefits for any specific limits that apply to your Plan.

D. HOW TO OBTAIN CARE

IMPORTANT POINTS TO REMEMBER

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

In-Network and Out-of-Network Coverage

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

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

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

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

You coverage is described further below.

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

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

1. How Your In-Network Coverage Works

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

- The service must be provided by your PCP;
- The service must be provided by a Plan Provider upon Referral from your PCP;
- The service must be one of the special services that do not require a Referral listed in section *I.D.8. Services That Do Not Require a Referral*, and be received from a Plan Provider;
- In the case of mental health and substance use disorder treatment, the service must be provided by a Plan Provider upon Referral from the Behavioral Health Access Center.
- The service must be provided in a Medical Emergency. In a Medical Emergency, including an emergency mental health condition, the Plan provides In-Network coverage for ambulance and Hospital emergency room services. You do not need to use a Plan Provider and you do not need a Referral from your PCP.

To obtain In-Network coverage outside the Service Area, you must receive Covered Benefits through the Plan's national provider network. To find a Plan Provider, see the Provider Directory. The Provider Directory is available online at **www.harvardpilgrim.org** or by calling our Member Services Department at **1–877-907–4742**.

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

Please Note: In Massachusetts, Maine, Connecticut, Rhode Island, 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.

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

2. Your PCP Manages Your Health Care

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

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

- Care in a Medical Emergency.
- Mental health care, which may be arranged by calling the Behavioral Health Access Center at **1–888–777–4742.** The telephone number for the Behavioral Health Access Center is also listed on your ID card. Please see section *III. Covered Benefits*, *Mental Health and Substance Use Disorder Treatment* for information on this benefit.
- Special services that do not require a Referral that are listed in section *I.D.8. Services That Do Not Require a Referral*, below.

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

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

3. Referrals for Hospital and Specialty Care

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

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

If the services you need are not available through your PCP's Referral network, your PCP may refer you to any Plan Provider. If you or your PCP has difficulty finding a Plan Provider who can provide the services you need, we will assist you. For help finding a medical provider, please call **1–877–907–4742**. For help finding a mental health care provider, please call **1–888–777–4742**. If no Plan Provider has the expertise needed to meet your medical needs, we will assist you in finding an appropriate Non-Plan Provider.

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

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

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

Certain specialty services may be obtained without involving your PCP. For more information please see section *I.D.8. Services That Do Not Require a Referral*.

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

4. Centers of Excellence

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

Centers of Excellence are selected by us based on the findings of recognized specialty organizations or government agencies such as Medicare. Centers of Excellence are located in Massachusetts, Maine, Connecticut, Rhode Island and New Hampshire.

The following specialized service should be obtained through a designated Center of Excellence:

- Weight loss surgery (bariatric surgery)

A list of Centers of Excellence may be found in the Provider Directory. The Provider Directory is available online at **www.harvardpilgrim.org** or by calling our Member Services Department at **1–877–907–4742**.

We may revise the list of services that must be received from a Center of Excellence upon 30 days' notice to Members. Services or procedures may be added to the list when we identify services in which significant improvements in the quality of care may be obtained through the use of selected providers. Services or procedures may be removed from the list if we determine that significant advantages in quality of care will no longer be obtained through the use of a specialized panel of providers.

To receive In-Network benefits for the service listed above in Massachusetts, Maine, Connecticut, 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 Massachusetts, Maine, Connecticut, Rhode Island or New Hampshire for the above service 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 service listed above outside of Massachusetts, Maine, Connecticut, Rhode Island or New Hampshire, you must obtain care at a Hospital that is listed as a Plan Provider. Please check 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. Using Plan Providers

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

1. The service was received in a Medical Emergency from an emergency room or for ambulance transport. (Please see section *I.D.6. Medical Emergency Services* for information on your coverage in a Medical Emergency.)
2. No Plan Provider has the professional expertise needed to provide the required service. In this case, services by a Non-Plan Provider must be authorized in advance by us, unless one of the exceptions above applies.
3. Your Physician is disenrolled as a Plan Provider or you are a new Member of the Plan, and one of the exceptions stated in section *I.G. SERVICES PROVIDED BY A DISENROLLED OR NON-PLAN PROVIDER* applies. Please refer to that section for the details of these exceptions.

To find out if a provider is in the Plan network, see the Provider Directory. The Provider Directory is available online at **www.harvardpilgrim.org** or by calling our Member Services Department at **1–877–907–4742**.

6. Medical Emergency Services

In a Medical Emergency, including an emergency mental health condition, you should go to the nearest emergency facility or call 911 or other local emergency number. Your emergency room Member Cost Sharing is listed in your Schedule of Benefits. Please remember that if you are hospitalized, you must call the Plan at **1-877-907-4742** within 48 hours or as soon as you can. This telephone number can also be found on your ID card.

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

See the *Glossary* for additional information on Medical Emergency Services.

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

In-Network Coverage

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

If you need mental health and substance use disorder treatment outside of the Service Area, simply contact the Plan's Behavioral Health Access Center at **1-888-777-4742**.

As is the case within the Service Area, you do not need to use a Plan Provider to obtain care in a Medical Emergency, including an emergency mental health condition. You also do not need to obtain a referral from your PCP. In a medical emergency, the Plan

provides In-Network coverage for ambulance and Hospital emergency room services.

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

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

i. Family Planning Services:

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

ii. Outpatient Maternity Services

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

iii. Gynecological Services

- Annual gynecological exam, including routine pelvic and clinical breast exam
- Cervical cryosurgery
- Colposcopy with biopsy
- Excision of labial lesions
- Follow-up care provided by an obstetrician or gynecologist for obstetrical or gynecological conditions identified during maternity care or annual gynecological visit
- Laser cone vaporization of the cervix
- Loop electrosurgical excisions of the cervix (LEEP)
- Treatment of amenorrhea
- Treatment of condyloma

iv. Dental Services:

- Emergency Dental Care
- Extraction of teeth impacted in bone

v. Other Services:

- Acupuncture treatment for injury or illness
- Chiropractic care
- Nutritional counseling
- Routine eye examination
- Urgent eye care
- Urgent Care services

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

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

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

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

Payments to Plan Providers are usually based on a contracted rate between us and the Plan Provider. Since we have no contract with Non-Plan Providers, there is no limit on what such providers can charge. You are responsible for any amount charged by a Non-Plan Provider in excess of the Allowed Amount for the service, unless it is a Surprise Bill. See section *V. Reimbursement and Claims Procedures* for additional information.

E. MEMBER COST SHARING

Below are descriptions of Member Cost Sharing that may apply when using Plan or Non-Plan Providers. Member Cost Sharing under your Plan may apply to services received In-Network, Out-of-Network or both. See your Schedule of Benefits for Member Cost

Sharing details that are specific 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." Member Cost Sharing may include Copayments, Coinsurance, or Deductible amounts, as described throughout this section.

When using Plan Providers, you are only responsible for your Member Cost Sharing. Plan Providers are prohibited from balance billing 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. For more information about Copayments under your Plan, including your specific Copayment requirements, please refer to your Schedule of Benefits.

2. Deductible

A Deductible is 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. Deductible amounts are incurred on the date of service. You may have different Deductibles that apply to different Covered Benefits under your Plan. Your Deductible is listed in your Schedule of Benefits.

Your Plan Deductible may or may not apply to a list of preventive care services covered by the Plan. If the Deductible does not apply to the listed preventive care services, the Plan will cover those services even if you have not yet met the Deductible that applies to the other services covered by the Plan.

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 amount, you will have no additional Deductible Member Cost Sharing for Covered Benefits for the remainder of the Calendar Year. An individual Deductible may also apply if you have Family Coverage that includes a family Deductible with an embedded individual Deductible. Please see additional information on Family Coverage Deductibles below.

Family Deductible. A Family Deductible will apply when you have Family Coverage. If you have Family Coverage, the Deductible may be met by all Members of the family combined. For example, a family of four would meet a $4,000 family Deductible if one covered family Member incurs $3,000 in covered medical expenses and another covered family Member incurs $1,000 in covered medical expenses during the Calendar Year. At that point, the family Deductible would also be met for the entire family for that Calendar Year.

Family Deductibles with embedded individual Deductibles Family Deductibles with embedded individual Deductibles may apply when you have Family Coverage. If your Family Coverage includes a family Deductible with an embedded individual Deductible, the Deductible can be satisfied in one of two ways:

a. If a Member of a covered family meets an individual Deductible, then that Member has no additional Deductible Member Cost Sharing for Covered Benefits for the remainder of the Calendar Year.

b. If any number of Members in a covered family collectively meet the family Deductible, then all Members of the covered family have no additional Deductible Member Cost Sharing for Covered Benefits for the remainder 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 Deductible applies to your Plan. Once a Deductible is met, coverage by the Plan is subject to any other Member Cost Sharing that may apply.

If a Member changes to Family Coverage from Individual Coverage or to Individual Coverage from Family Coverage within a Calendar Year, expenses that Member incurred for Covered Benefits toward the Deductible under the prior coverage will apply toward the Deductible under his/her new coverage. If the previously incurred Deductible amount is greater than the new Deductible limit, the Member or family will only be responsible for applicable Copayment or Coinsurance amounts listed in his/her Schedule of Benefits.

3. Coinsurance

After the appropriate Deductible amount is met, you may be responsible for paying a Coinsurance amount, which is a percentage of the Allowed Amount, or the Recognized Amount, if applicable. When using Plan Providers, the Allowed Amount is based on the contracted rate between HPHC. and the Provider. When using 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 general higher Coinsurance amounts will apply to Out-of-Network services. Coinsurance amounts are listed in your Schedule of Benefits.

4. Out-of-Pocket Maximum

Your coverage includes an Out-of-Pocket Maximum. An Out-of-Pocket Maximum is the total amount of Copayments, Deductibles or Coinsurance payments for which a Member or a family is responsible in a Calendar Year. Once the Out-of-Pocket Maximum has been reached, no further Copayment, Deductibles or Coinsurance amounts will be payable by the Member and HPHC will pay 100% of the Allowed Amount for the remainder of the Calendar Year. Once a family Out-of-Pocket Maximum has been met in a Calendar Year, the Out-of-Pocket Maximum is deemed to have been met by all Members in a family for the remainder of the Calendar Year.

Certain expenses 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.

All Plans have one or more individual Out-of-Pocket Maximums or family Out-of-Pocket Maximums.

Individual Out-of-Pocket Maximums. An Individual Out-of-Pocket Maximum will apply when you have Individual Coverage. Once you have you met the individual Out-of-Pocket Maximum amount, you will have no additional Member Cost Sharing for Covered Benefits for the remainder of the Calendar Year. An individual Out-of-Pocket Maximum may also apply if you have Family Coverage that includes a family Out-of-Pocket Maximum with an embedded individual Out-of-Pocket Maximum. Please see additional information on Family Coverage Out-of-Pocket Maximums below.

Family Out-of Pocket Maximums. Family Out-of-Pocket Maximums will apply when you have Family Coverage. If you have Family Coverage, the Out-of-Pocket Maximum can be met by all Members of the family combined. For example, a family of four would meet a $10,000 family Out-of-Pocket Maximum if one covered family Member pays $5,000 in Member Cost Sharing, another family Member pays $3,000 in Member Cost Sharing and yet another covered family Member pays $2,000 in Member Cost Sharing during the Calendar Year. At that point, the family Out-of-Pocket Maximum would be met for the entire family for that Calendar Year.

Family Out-of-Pocket Maximums with embedded individual Out-of-Pocket Maximums Family Out-of-Pocket Maximums with embedded individual Out-of-Pocket Maximums may apply when you have Family Coverage. If your Family Coverage includes a family Out-of-Pocket Maximum with an embedded individual Out-of-Pocket Maximum, the Out-of-Pocket Maximum can be satisfied in one of two ways:

a. If a Member of a covered family meets an individual Out-of-Pocket Maximum, then that Member has no additional Member Cost Sharing for the remainder of the Calendar Year.

b. If any number of Members in a covered family collectively meet the family Out-of-Pocket Maximum, then all Members of the covered family have no additional Member Cost Sharing for the remainder of the Calendar Year. 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.

If a Member changes to Family Coverage from Individual Coverage or to Individual Coverage from Family Coverage within a Calendar Year, expenses that Member incurred for Covered Benefits toward the Out-of-Pocket Maximum under the prior coverage will apply toward the Out-of-Pocket Maximum limit under the Member's new coverage. If the incurred Out-of-Pocket Maximum amount is greater than the new Out-of-Pocket Maximum limit, the Member will have no additional 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 amounts in excess of the Allowed Amount. In those instances, you will be financially responsible for the difference between what the Provider charges and the Allowed Amount payable by the Plan. This means that you will be responsible for paying the full amount above the Allowed Amount, unless it is a Surprise Bill. Amounts charged by a Non-Plan Provider in excess of the Allowed Amount do not count toward

the Out-of-Pocket Maximum. You may contact the Member Services Department at **1–877–907–4742** or call **711** for TTY service if you have questions about the maximum Allowed Amount that may be permitted by HPHC for a service. See section *V. Reimbursement and Claims Procedures* for additional information.

6. Penalty

A Member is responsible to pay a Penalty for certain Out-of-Network services when Prior Approval has not been received before obtaining the services. The Penalty charge is in addition to any Member Cost Sharing amounts. The Penalty charge will be no more than $500. Penalty charges do not count towards any Out-of-Pocket Maximum. Please 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 when obtaining care. When this occurs, your entitlement to In-Network or Out-of-Network coverage always depends upon the participation status of the individual service Provider and whether you chose to receive services from a Non-Plan Provider. For example, you may receive treatment in a Plan Provider's office but choose to receive associated blood work from a non-plan laboratory. In this example, the Plan Provider would be paid at the In-Network coverage level and the laboratory would be paid at the Out-of-Network coverage level because the laboratory is a Non-Plan Provider and you chose to receive those services from a Non-Plan Provider. However, if a Plan Provider directs you to a Non-Plan Provider and you did not choose that Non-Plan Provider to provide such services, you would be entitled to In-Network coverage for those services from the Non-Plan Provider.

The benefit payment level that is applied to a Hospital admission depends on the participation status of both the admitting Physician and the Hospital. If a Plan Provider admits you to a participating Hospital, both the Hospital and Physician are paid at the In-Network coverage level. If an Out-of-Network Physician admits you to a participating Hospital, the Hospital's charges are paid at the In-Network coverage level but the Physician's charges are paid at the Out-of-Network coverage level. Likewise, if a Plan Provider admits you to a non-plan Hospital, the Hospital's charges are paid at the Out-of-Network coverage level but the Physician's charges are paid at the In-Network coverage level. All Out-of-Network payments 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 from a Non-Plan Provider or Plan Provider outside the Service Area. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. This section explains when Prior Approval is required and the procedures to follow 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, please contact Member Services at **1–877–907–4742**.

Please Note: Your doctor or Hospital can seek Prior Approval on your behalf. Also, 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 any of the services listed below.

a) **For Mental Health and Substance Use Disorder Treatment from a Non-Plan Provider**

Prior Approval must be obtained before receiving certain mental health and substance use disorder treatment from a Non-Plan Provider. To obtain Prior Approval for the mental health and substance use disorder treatment listed below, you should call the Behavioral Health Access Center at **1-888-777-4742**.

The following services require Prior Approval when obtained from a Non-Plan Provider:

- **Inpatient services**
- **Partial Hospitalization Programs (PHPs) and day treatment Programs**
- **Residential treatment**
- **Extended outpatient treatment visits –** Psychotherapy lasting 53 minutes or longer with or without medication management or any treatment routinely involving more than one outpatient visit in a day.
- **Psychological testing**
- **Applied Behavior Analysis (ABA) services for the treatment of Autism**

- **Transcranial Magnetic Stimulation (TMS)**

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, please contact Member Services at **1–877–907–4742**.

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

b) **For Medical Services from a Non-Plan Provider or Plan Provider Outside the Service Area**

Prior Approval must be obtained before receiving any of the medical services or Medical Drugs from a Non-Plan Provider or Plan Provider outside the Service Area. To obtain Prior Approval for medical services you should call **1-800-708-4414**. To obtain Prior Approval for Medical Drugs you or your provider should call **1–844–387–1435**.

The following services require Prior Approval when obtained from a Non-Plan Provider or Plan Provider Outside the Service Area:

- **Inpatient services**
- **Outpatient services and treatments** including, but not limited to: genetic testing, home health care, advanced radiology; and pain management. Please see the detailed list of all the services and treatments that require Prior Approval on our website at **www.harvardpilgrim.org**.
- **Outpatient surgery**
- **Medical Drugs**
- **Diabetic equipment**
- **Positive airway pressure devices, including CPAP and BIPAP devices**
- **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.)

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, please contact Member Services at **1–877–907–4742**.

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

2. How to Obtain Prior Approval

To seek Prior Approval for medical services, Medical Drugs or mental health and substance use disorder treatment received from a Non-Plan Provider or a Plan Provider outside the Service Area, you should call:

- **1-800-708-4414** for medical services
- **1–844–387–1435** for Medical Drugs
- **1-888-777-4742** 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 telephone number
- The diagnosis for which care is ordered
- The treatment ordered and the date it is expected to be performed

For inpatient admission to a Non-Plan Provider 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 telephone number
- The admitting diagnoses and date of admission
- The name of any procedure to be performed and the date it is expected to be performed

3. The Effect of Prior Approval on Coverage

If you obtain Prior Approval when required, the Plan will pay 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, you will only receive coverage for services later determined to be Medically Necessary and will be responsible for any applicable Member Cost Sharing. For services received from Non-Plan Provider, you will also be responsible for paying 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 will be responsible for 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.

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

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

If the Prior Approval Program conducts a medical review of a service, you and your attending Physician will be notified of the Plan's decision to approve or not to approve the care proposed. 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, in the case of Medical Drugs or mental health and substance use disorder treatment, a qualified clinician) in accordance with written Medical Necessity Guidelines. Medical review criteria will be based on many sources including medical policy and clinical guidelines. The relevant criteria will be made available to Providers and Members upon request.

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

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

1. Disenrollment of a Plan provider

If your Provider is disenrolled as a Plan Provider for reasons unrelated to fraud or quality of care, we will use our best efforts to provide you with written notice at least 60 days prior to the date of your Plan Provider's disenrollment. That notice will also explain the process for selecting a new Plan Provider. You may be eligible to continue to receive In-Network coverage for services provided by 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 you receive notice of disenrollment (whichever is later):

i. Active Course of Treatment

Except for pregnancy and terminal illness as described below, if you are undergoing an active course of treatment for an illness, injury or condition, we may authorize additional coverage through the active course of treatment or up to 90 days (whichever is shorter). An active course of treatment includes when a member has a "serious and complex condition", is currently undergoing a course of institutional or inpatient care, or has scheduled nonelective surgery including any related postoperative care.

The term "serious and complex condition" is an acute illness that is serious enough to require 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

If you are a female Member and are pregnant, you may continue to receive In-Network coverage for services

from your disenrolled provider through delivery and up to 12 months of postpartum visits immediately following childbirth.

iii. Terminal Illness

A Member with a terminal illness may continue to receive In-Network coverage for services delivered by the disenrolled provider until the Member's death.

2. New Membership

If you are a new Member, we will provide coverage for services delivered by a physician who is not a Plan Provider, under the terms of this Handbook and your Schedule of Benefits, 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.

With respect to a Member in her second or third trimester of pregnancy, this provision shall apply to services rendered through the first postpartum visit. With respect to 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 in the paragraphs 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 and not to impose Member Cost Sharing with respect to the Member in an amount that would exceed the Member Cost Sharing that could have been imposed if the provider had not been terminated;
- Adhere to our policies and procedures, including procedures regarding Referrals, obtaining Prior Approval and providing Covered Benefits pursuant to a treatment plan, if any, approved by us.

H. MEDICAL NECESSITY GUIDELINES

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our Medical Necessity Guidelines applicable to a service or procedure for which coverage is requested. Medical Necessity Guidelines may be obtained by calling **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, in addition to the benefits covered by the Plan. Examples of such special Physician services might include: telephone access to a Physician 24-hours a day; waiting room amenities; assistance with transportation to medical appointments; guaranteed same day or next day appointments when not Medically Necessary; or providing a Physician to accompany a patient to an appointment with a specialist. Such services are not covered by the Plan. The Plan does not cover fees for any service that is not included as a Covered Benefit under this Evidence of Coverage.

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

J. BUNDLED PAYMENT ARRANGEMENTS

The Plan may participate in bundled payment arrangements with certain Providers under which a specific service or treatment is paid for based on a fixed sum for all of the Covered Benefits 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 the Member Services Department at **1-877-907-4742** for a list of Providers who have bundled payment arrangements with Harvard Pilgrim and their corresponding services. We may revise the list of Providers or services who have bundled payment arrangements upon 30 days notice to Members.

K. COUNSELING PROGRAMS

Harvard Pilgrim offers certain counseling programs to Members receiving care covered under the Plan. These services may include counseling sessions held in person, virtually by telephone or video, or online through secure digital messaging. Counseling sessions are designed to treat depression, anxiety or stress that may accompany chronic conditions or life events.

These counseling sessions may be available to you at lower Member Cost Sharing. Please log into your secure online account at **www.harvardpilgrim.org** or call the Member Services Department at **1-877-907-4742** for more information concerning these programs and their Member Cost Sharing obligations.

L. 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 identify and 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 or determine alternatives to a Member's current treatment plan. Covered Benefits provided through a care management program may apply Member Cost Sharing.

II. Glossary

This section lists words with special meaning within the Handbook.

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.

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

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

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

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

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

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

a. If you receive Out-of-Network services in the states of Massachusetts, New Hampshire, Maine, Rhode Island, Vermont and Connecticut, the Allowed Amount is defined as follows:

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

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

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

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

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

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

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

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

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

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

Anniversary Date The date upon which your yearly premium rate is adjusted and benefit changes become

effective. This Handbook, Schedule of Benefits, and Prescription Drug Brochure, will terminate unless renewed on the Anniversary Date.

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

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

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

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

FOR EXAMPLE: If your Plan offers 30 visits per 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.

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.

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, Connecticut, Rhode Island or New Hampshire, when received from designated Centers of Excellence.

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.

Coinsurance A percentage of the Allowed 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. 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.)

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.

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

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

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

Deductible A specific dollar amount that is payable by a Member for Covered Benefits received each 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 family Deductible applies to your Plan, it will be stated in your 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.

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

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

Evidence of Coverage 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.

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 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.

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

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.

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

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.

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.

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.

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

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

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

Medical Emergency The sudden and, at the time, unexpected onset of a physical or mental 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.

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.
  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.

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

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**.

Medicare The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Member Any Subscriber or Dependent covered under the Plan.

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

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

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.

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

Out-of-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.

Out-of-Pocket Maximum An Out-of-Pocket Maximum is a limit on the amount of Copayments, Coinsurance and Deductibles that you must pay for Covered Benefits in a Calendar Year. The Out-of-Pocket Maximum is specified in your Schedule of Benefits.

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

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

Penalty The amount that a Member is responsible to pay for certain Out-of-Network services when 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.

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.

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.

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

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

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

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

Prior Approval or Prior Approval Program (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.

Provider Providers include, but are not limited to a 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.

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**.

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.

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

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

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.

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.

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

Sickness An illness or disease of an insured person.

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

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

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

Surprise Bill An unexpected bill you may receive if: (1) 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 (2) 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.

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

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

III. Covered Benefits

This section describes all of the benefits available under the Plan. Please see your Schedule of Benefits for your specific Covered Benefits. 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.
- Provided by or upon Referral from your PCP. This requirement does not apply to care needed in a Medical Emergency and care received outside of the Plan Service Area. Please see section *I.D.2. Your PCP Manages Your Health Care* for other exceptions that may apply.
- Some services require Prior Approval by the Plan. Please see section *I.F. PRIOR APPROVAL* for information on the Prior Approval Program.
- In Massachusetts, Maine, Connecticut, 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.

Benefit	Description
1 . Acupuncture Treatment for Injury or Illness	
	The Plan covers acupuncture treatment for illness or injury, including electro-acupuncture, that is provided for the treatment of neuromusculoskeletal pain.
2 . 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. For In-Network coverage, services must be arranged by a Plan 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

Benefit	Description
Ambulance and Medical Transport (Continued)	
	for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
3 . Autism Spectrum Disorders Treatment	
	The Plan covers the following services for the treatment of autism spectrum disorders to the extent required by Maine law: • Any assessment, evaluations or tests by a licensed Physician or psychologist to diagnose whether a Member has an autism spectrum disorder. • 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. A licensed Physician or licensed psychologist must determine that the service is Medically Necessary. Such determination must be renewed annually. For the purposes of this section the following terms are defined as follows: "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior. "Autism spectrum disorders" means any of the pervasive developmental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified **Please Note:** The Plan may require a licensed Physician or licensed psychologist to demonstrate ongoing Medical Necessity for coverage provided under this benefit, on an annual basis.
4 . 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 Medical Necessity Guidelines to evaluate whether bariatric surgery is Medically Necessary. If you are planning to receive bariatric surgery services, we recommend that you review

Benefit	Description
Bariatric Surgery (Continued)	
	the current Medical Necessity Guidelines. To obtain a copy, please call **1-877-907-4742.**
5 . 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.
6 . 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
7 . 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
8 . Clinical Trials	
	The Plan covers services for Members enrolled in a qualified clinical trial for the treatment, prevention or detection of any form of cancer or other life-threatening disease under the terms and conditions provided for under Maine and federal law. All of the requirements for coverage under the Plan apply to coverage under this benefit. Coverage is provided under this benefit for services that are Medically Necessary for the treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the Plan.

Benefit	Description
9 . 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. • 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.
10 . Dental Services	
	Important Notice: The Plan does not provide dental insurance. It covers only the limited Dental Care described below. No other Dental Care is covered. **Emergency Dental Care:** The Plan covers emergency Dental Care needed due to an injury to sound, natural teeth, 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 **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.

Benefit	Description
Dental Services (Continued)	
	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
11 . Diabetes Services and Supplies	
	Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care: The Plan covers outpatient self-management education and training programs provided by the ambulatory diabetes education facilities authorized by the Diabetes Control Project within the Maine Bureau of Health for the treatment of diabetes, including medical nutrition therapy services, used to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes. Services must be provided on an individual basis and for In-Network coverage, be provided by a Plan Provider. Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care. The following items are also covered: **Diabetes Equipment:** • Blood glucose monitors

Benefit	Description
Diabetes Services and Supplies (Continued)	
	• 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 **Pharmacy Supplies:** • 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 the Member Services Department at **1-877-907-4742**. **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.
12 . 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. For In-Network coverage, your PCP must direct you to a Plan Provider for dialysis care. **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 within the Service Area, he/she 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.

Benefit	Description
13 . Drug Coverage	
	You have limited coverage for drugs received during inpatient and outpatient treatment and also for certain medical supplies you purchase at a pharmacy under this Benefit Handbook. This coverage is described in Subsection 1, below. You also have coverage for outpatient prescription drugs you purchase at a pharmacy under the plan's outpatient prescription drug coverage. Subsection 2, below, explains more about this coverage. **1. Your Coverage under this Benefit Handbook** This Benefit Handbook covers the following: a. Drugs Received During Inpatient Care. The drug is administered to you while you are an inpatient at a Hospital, Skilled Nursing Facility or other medical facility at which Covered Benefits are provided to you on an inpatient basis; b. Drugs Received During Outpatient or Home Care. These drugs are known as "Medical Drugs." A Medical Drug is administered to you either (1) in a doctor's office or other outpatient medical facility, or (2) at home while you are receiving home care services or receiving drugs administered by home infusion services. Medical Drugs cannot be self-administered. The words "cannot be self-administered" mean that the active participation of skilled medical personnel is always required to take the drug. When a Member is receiving drugs in the home, the words "cannot be self-administered" will also include circumstances in which a family member or friend is trained to administer the drug and ongoing supervision by skilled medical personnel is required. An example of a drug that cannot be self-administered is a drug that must be administered intravenously. Examples of drugs that can be self-administered are drugs that can be taken in pill form and drugs that are typically self-injected by the patient. c. Drugs and supplies required by law. Coverage is provided for: (1) certain diabetes supplies; and (2) certain prescribed self-administered anti-cancer medications used to kill or slow the growth of cancerous cells are covered after the Deductible has been met . Please see the benefit for "Diabetes Services and Supplies" for the details of that coverage. No coverage is provided under this Benefit Handbook for: (1) drugs that have not been approved by the United States Food and Drug Administration; (2) drugs the Plan excludes or limits, including, but not limited to, drugs for cosmetic purposes; and (3) any drug that is obtained at an outpatient pharmacy except covered diabetes supplies, 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: **1-844-387-1435**. 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 the Plan's outpatient prescription drug rider. That rider provides coverage for most prescription drugs purchased at an outpatient pharmacy.

Benefit	Description
Drug Coverage (Continued)	
	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, including coverage of Nicotine Replacement Therapy, can be found in the Prescription Drug Brochure or on our website at **www.harvardpilgrim.org**.
14 . Durable Medical Equipment (DME)	
	The Plan covers DME when Medically Necessary and ordered by a Provider. We will rent or buy all equipment. The cost of the repair and maintenance of covered equipment is also covered. In order to be covered, all equipment must be: • Able to withstand repeated use; • Not generally useful in the absence of disease or injury; • Normally used in the treatment of an illness or injury or for the rehabilitation of an abnormal body part; and • Suitable for home use. Coverage is only available for: • The least costly equipment adequate to allow you to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports; and • One item of each type of equipment that meets the Member's need. No back-up items or items that serve a duplicate purpose are covered. For example, the Plan covers a manual or an electric wheelchair, not both. Covered equipment and supplies include: • Canes • Certain types of braces • Crutches • Hospital beds • Oxygen and oxygen equipment • Respiratory equipment • Walkers • Wheelchairs • 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 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. 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.

Benefit	Description
15 . Early Intervention	
	The Plan covers early intervention services for children with an identified developmental disability or delay. Coverage is provided for children from birth until three years of age. The Plan covers early intervention services up to the Benefit Limit stated in your Schedule of Benefits. Coverage under this benefit is only available for services rendered by the following types of providers: • Occupational therapists • Physical therapists • Speech-language pathologists • Clinical social workers
16 . Emergency Room Care	
	If you have a Medical Emergency, you are covered for care in a Hospital emergency room. Please remember the following: • If you are in the Service Area and need follow-up care after you are treated in an emergency room, you must call your PCP. For In-Network coverage, your PCP will provide or arrange for the care you need. • To obtain In-Network coverage outside of the Service Area, you must see Plan Providers for all follow up care. • If you are hospitalized, you must call the Plan at **1-877-907-4742** within 48 hours or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to the Plan or PCP by an attending emergency Physician no further notice is required
17 . 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.*
18 . 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 have outpatient prescription drug coverage under this Plan. 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 the 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 Handbook. **Prior Approval Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider located within the Service

Benefit	Description
Gender Affirming Services (Continued)	
	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.
19 . 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
20 . 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. There must also be a defined medical goal that your Provider expects you will meet in a reasonable period of time. When you qualify for home health care services as stated above, the Plan covers the following services: • Durable medical equipment and supplies (must be a component of the home health care being provided) • 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

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

Benefit	Description
Hospital – Inpatient Services (Continued)	
	• 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, Connecticut, 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.
23 . House Calls	
	The Plan covers house calls.
24 . 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.

Benefit	Description
25 . 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: • Diagnostic screening and tests, including allergy testing, 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 Plan Provider when the initial radiologic procedure results are not definitive. Non-routine mammograms are covered when Medically Necessary. • 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 participating in the National Marrow Donor Program, or its successor organization. The consent form must acknowledge the Member's willingness to be a bone marrow donor if a suitable match is found. Only one test is covered in a Member's lifetime. **Please Note:** Your Plan will cover certain preventive services and tests with no Member Cost Sharing. Please see your Schedule of Benefits for the coverage that applies to your Plan. **Prior Approval 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.
26 . Low Protein Foods	
	The Plan covers special modified low protein food products prescribed by a licensed Physician for a person with an inborn error of metabolism as required by Maine law.

Benefit	Description
27 . Maternity Care	
	The Plan covers the following maternity services: • Routine outpatient prenatal care, including evaluation and progress screening, physical exams, recording of weight and blood pressure monitoring. • Prenatal genetic testing (For In-Network coverage, office visits require a Referral). • Delivery, including a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean section. Any decision to shorten the inpatient stay for the mother and her newborn child will be made by the attending Physician and the mother. • Routine newborn care, including Hospital nursery care, Physician services, vaccines and immunizations, and vitamins prior to discharge. • Routine outpatient postpartum care for the mother up to 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.
28 . Medical Formulas	
	The Plan covers the following to the extent required by Maine law: 1) Metabolic formulas prescribed by a licensed Physician for a person with an inborn error of metabolism 2) Amino acid-based elemental infant formula for children two years of age and under without regard to the method of delivery of the formula to the extent Medically Necessary as defined below. Coverage will be provided when a licensed Physician has diagnosed, and through medical evaluation has documented, one of the following conditions: • Symptomatic allergic colotis or proctitis • Laboratory or biopsy-proven allergic or eosinophilic gastroenteritis • A history of anaphylaxis • Gastroesophageal reflux disease that is non-responsive to standard medical therapies • Severe vomiting or diarrhea resulting in clinically significant dehydration requiring medical treatment • Cystic fibrosis • Malabsorption of cow milk-based or soy milk-based infant formula In addition to meeting the conditions stated in the definition of Medically Necessary, amino acid-based elemental infant formula will be considered Medically Necessary when the following conditions are met: • The amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater; and

Benefit	Description
Medical Formulas (Continued)	
	• 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. **Prior Approval Required:** You must obtain Prior Approval for outpatient formulas and enteral nutrition. 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.
29 . 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 from the Behavioral Health Access Center by calling **1-888-777-4742.** The mental health and substance use disorder treatment for which Prior Approval is required are as follows: • **Inpatient services** • **Partial Hospitalization Programs (PHPs) and day treatment programs** • **Residential treatment** • **Extended outpatient treatment visits –** Psychotherapy lasting 53 minutes or longer with or without medication management or any treatment routinely involving more than one outpatient visit in a day. • **Psychological testing** • **Applied Behavior Analysis (ABA) services for the treatment of Autism** • **Transcranial Magnetic Stimulation (TMS)** Even when Prior Approval is not required, mental health and substance use disorder treatment may be arranged through the Behavioral Health Access Center by calling **1–888–777–4742**. (The only exception applies to care required in a Medical Emergency.) The Behavioral Health Access Center phone line is staffed by licensed mental health clinicians. They will assist you in finding appropriate Plan Providers and arranging the services you require. In a Medical Emergency you should go to the nearest emergency facility or call 911 or your local emergency number. **Services for Biologically Based Mental Illness** Under Maine law, the Plan covers Medically Necessary treatment of Biologically Based Mental Illness at the same level as for any other medical condition. Biologically Based Mental Illnesses include the following diagnoses: psychotic disorders including paranoia and schizophrenia; dissociative disorders; mood disorders including bipolar disorder and major depressive disorder; anxiety disorders including panic disorder and obsessive compulsive disorder; personality disorders; paraphilias; attention deficit and disruptive behavior disorders; pervasive developmental

Benefit	Description
Mental Health and Substance Use Disorder Treatment (Continued)	
	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 testing Coverage for substance use disorder treatment includes: • Inpatient substance use disorder treatment, including partial hospitalization if you and your Provider agree that this treatment is best for you • 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. (The only exception is conditions for which only a "Z Code" designation applies, which means that the condition is not attributable to a mental disorder.) Services for all other conditions not identified above will be covered to the extent Medically Necessary. Please refer to your Schedule of Benefits for the Member Cost Sharing that apply to the coverage of these services. 1. **Inpatient Mental Health Services** • Inpatient care is covered as described in your Schedule of Benefits • Coverage includes care in a partial hospitalization program. Partial hospitalization is an intensive outpatient program that provides coordinated services in a therapeutic setting. Partial hospitalization will only be covered if you and your Provider agree that this treatment is best for you. • Inpatient mental health care in a licensed general Hospital is covered as long as it is Medically Necessary. 2. **Outpatient Mental Health Services** The Plan covers outpatient mental health care (including online counseling through secure digital messaging), including evaluation, diagnosis, treatment and crisis intervention and methadone maintenance. Coverage is provided as described in your Schedule of Benefits. 3. **Psychological Testing** The Plan covers psychological testing when Medically Necessary. For In-Network coverage, a Plan Provider must refer you for such testing and obtain HPHC approval for coverage in advance of obtaining services.

Benefit	Description
30 . 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.
31 . 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
32 . 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.
33 . Physician and Other Professional Office Visits	
	Physician services, including services of all covered medical professionals, can be obtained on an outpatient basis at a Physician's office or a Hospital. These services may include: • Routine physical examinations, including annual gynecological examination (screening Pap tests, routine pelvic and clinical breast examinations) and annual digital rectal test for the early detection of prostate cancer between ages 50 and 72 • Follow-up care provided by an obstetrician or gynecologist for obstetrical or gynecological conditions identified during maternity care or annual gynecological visit • Immunizations, including childhood immunizations as recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention and the American Academy of Pediatrics • Second opinions • 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

Benefit	Description
Physician and Other Professional Office Visits (Continued)	
	• Medication management • Chemotherapy • Radiation therapy • Inhalation 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 of preventive health services, Member Cost Sharing will be applied. Please see your Schedule of Benefits for the coverage that applies to your Plan.
34 . 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.
35 . 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.) • 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/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.

Benefit	Description
36 . Reconstructive Surgery	
	The Plan covers reconstructive and restorative surgical procedures as follows: • Reconstructive surgery is covered when the surgery can reasonably be expected to improve or correct a Physical Functional Impairment resulting from an Accidental Injury, illness, congenital anomaly, birth injury or prior surgical procedure. If reconstructive surgery is performed to improve or correct a Physical Functional Impairment, as stated above, Cosmetic Services that are incidental to that surgery are also covered. After a Physical Functional Impairment is corrected, no further Cosmetic Services are covered by the Plan. • Restorative surgery is covered to repair or restore appearance damaged by an Accidental Injury. (For example, this benefit would cover repair of a facial deformity following an automobile Accident.) Benefits are also provided for post mastectomy care, including coverage for: • Prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient; • Reconstruction of the breast on which the mastectomy was performed; and • Surgery and reconstruction of the other breast to produce a symmetrical appearance. Benefits include coverage for procedures that must be done in stages, as long as you are an active member. Membership must be effective on all dates on which services are provided. There is no coverage for Cosmetic Services or surgery except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an Accidental Injury, (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.

Benefit	Description
37 . 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.
38 . 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: • 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 the section *III. Covered Benefits, Home Health Care*. **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. **Prior Approval Required:** You must obtain Prior Approval for coverage of outpatient pulmonary rehabilitation. 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.

Benefit	Description
39 . 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.
40 . 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.
41 . 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, Connecticut, 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.

Benefit	Description
42 . 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.
43 . Urgent Care Services	
	The Plan covers Urgent Care services that you receive at (1) a convenience care clinic (retail health clinics), (2) an urgent care center, or (3) a Hospital urgent care center. **(1) Convenience care clinics (retail health clinics):** Convenience care clinics provide treatment for minor illnesses and injuries. They are usually staffed by non-Physician providers, such as Nurse practitioners, and are located in stores, supermarkets, or pharmacies. To see a list of convenience care clinics (retail health clinics) covered by the Plan, please refer to your Provider Directory and search under "convenience care." **(2) Urgent care centers:** Urgent care centers provide treatment for illnesses and injuries that require urgent attention but are not life threatening. Urgent care centers are independently owned and operated centers that are considered standalone facilities, not departments of a Hospital. They are staffed by doctors, Nurse practitioners, and Physician assistants. To see a list of urgent care centers covered by the Plan, please refer to your Provider Directory and search under "urgent care." **(3) Hospital urgent care centers:** Some Hospitals provide treatment for urgent care services as part of the Hospital's outpatient services. A Hospital urgent care center may be located within a Hospital, or at a satellite location separate from the Hospital. These urgent care centers are owned and operated by the Hospital and are considered a department of the Hospital. They are staffed by doctors, Nurse practitioners and physician assistants and provide treatment for illnesses and injuries that require urgent attention but are not life threatening. Because the services provided are considered outpatient Hospital services, only the Hospitals are listed in the Provider Directory. These services may require higher Member Cost Sharing than urgent care services received at independent urgent care centers. **Please note:** Hospital urgent care center services are treated differently than similar services received in a Hospital emergency room. For information on services received in a Hospital emergency room, please see the Emergency Room Care benefit above, and in your Schedule of Benefits. Please refer to your Schedule of Benefits for the Member Cost Sharing applicable to each type of Urgent Care service.

Benefit	Description
Urgent Care Services (Continued)	
	Coverage for Urgent Care is provided for services that are required to prevent deterioration to your health resulting from an unforeseen Sickness or injury. Covered services include, but are not limited to, the following: • Care for minor cuts, burns, rashes or abrasions, including suturing • Treatment for minor illnesses and infections, including ear aches • Treatment for minor sprains or strains You do not need to obtain a referral from your PCP to be covered for Urgent Care. Whenever possible, you should contact your PCP prior to obtaining Urgent Care. Your PCP may be able to provide the services you require at a lower out-of-pocket cost. In addition, your PCP is responsible for coordinating your health care services and should know about the services you receive. **Important Notice:** Urgent Care is not emergency care. You should call 911 or go directly to a Hospital emergency room if you suspect you are having an Medical Emergency. These include heart attack or suspected heart attack, shock, major blood loss, or loss of consciousness. Please see the section *I.D.6. Medical Emergency Services* for more information.
44 . Vision Services	
	Urgent Eye Care: The Plan covers urgent eye care services. You do not need a Referral for up to 2 visits, the initial visit and one follow-up visit, per urgent event. For In-Network coverage you must obtain care from a Plan Provider and a PCP Referral is required for any visits after the second urgent eye care visit. Urgent eye care services are services provided to treat conditions, illnesses or diseases of the eye that if not treated within 24 hours present a serious risk of harm. **Routine Eye Examinations:** The Plan covers routine eye examinations. Please see your Schedule of Benefits for additional information. **Pediatric Vision Care:** The Plan covers 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: • 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.

Benefit	Description
Vision Services (Continued)	
	• 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:** If you have prescription drug coverage, 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:** Not all Plans include prescription drug coverage. If you have outpatient prescription coverage, 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**.
45 . Voluntary Sterilization	
	The Plan covers voluntary sterilization, including tubal ligation and vasectomy.
46 . 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. 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 disease 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.
8 . Mental Health Care	
	1. Biofeedback. 2. Educational services or testing, except services covered under the benefit for Early Intervention Services. No benefits are provided: (1) for educational services intended to enhance educational achievement; (2) to resolve problems of school performance; or (3) to treat learning disabilities. 3. Sensory integrative praxis tests. 4. Services for any condition with only a "Z Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder. 5. 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. 6. Services or supplies for the diagnosis or treatment of mental health and substance use disorders that, in the reasonable judgment of the Behavioral Health Access Center, 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.

Exclusion	Description
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. 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 an 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, Connecticut, 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, Connecticut, 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.

Exclusion	Description
Procedures and Treatments (Continued)	
	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.
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. Infertility treatment and drugs. 2. Consultations, evaluations and laboratory tests for the diagnosis of infertility. 3. Any form of Surrogacy or services for a gestational carrier other than covered maternity services. 4. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). 5. Sperm collection, freezing and storage. 6. Sperm identification when not Medically Necessary (e.g., gender identification). 7. 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.

Exclusion	Description
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.
15 . Types of Care	
	1. Custodial Care. 2. Rest or domiciliary care. 3. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. 4. Pain management programs or clinics. 5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. 6. Private duty nursing. 7. Sports medicine clinics. 8. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
16 . Vision and Hearing	
	1. Eyeglasses, contact lenses and fittings, except as listed in this Benefit Handbook and any associated Riders. 2. Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of 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 or supply (with the exception of contact lenses) purchased from the internet. 4. Beauty or barber service. 5. Diabetes equipment replacements when solely due to manufacturer warranty expiration. 6. Donated or banked breast milk. 7. Externally powered exoskeleton assistive devices and orthoses. 8. Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law and as prescribed for Members who meet HPHC policies for enteral tube feedings. 9. Guest services. 10. Medical equipment, devices or supplies except as listed in this Benefit Handbook.

Exclusion	Description
All Other Exclusions (Continued)	
	11. 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. 12. Reimbursement for travel expenses. 13. Services for non-Members. 14. Services for which no charge would be made in the absence of insurance. 15. Services for which no coverage is provided in this Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure. 16. Services that are not Medically Necessary. 17. Taxes or governmental assessments on services or supplies. 18. 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. 19. Voice modification surgery, except when Medically Necessary for gender affirming services. 20. The following products and services: • Air conditioners, air purifiers and filters, dehumidifiers and humidifiers. • Car seats. • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners. • Electric scooters. • Exercise equipment. • Home modifications including but not limited to elevators, handrails and ramps. • Hot tubs, jacuzzis, saunas or whirlpools. • Mattresses. • Medical alert systems. • Motorized beds. • Pillows. • Power-operated vehicles. • Stair lifts and stair glides. • Strollers. • Safety equipment. • Vehicle modifications including but not limited to van lifts. • Telephone. • Television.

V. Reimbursement and Claims Procedures

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

A. BILLING BY PROVIDERS

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

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

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 Medical 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 applicable Member Cost Sharing online at **www.harvardpilgrim.org** or by calling the Member Services Department at **1-877-907-4742**.

B. REIMBURSEMENT FOR BILLS YOU PAY

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

Claims for Mental Health and Substance Use Disorder Treatment:

Behavioral Health Access Center
P.O. Box 30602
Salt Lake City, UT 84130–0602

Pharmacy Claims:

OptumRx
Manual Claims
P.O. Box 29044
Hot Springs, AR 71903

All Other Claims:

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

If you request a claim form from HPHC's Member Services Department, one will be provided to you within 15 days.

To obtain reimbursement for a bill you have paid, other than for pharmacy items, you must submit an HPHC medical reimbursement 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 medical reimbursement 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 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
- Other insurance information

Important Notice: We may need more information for some claims. If you have any questions about claims, please call our Member Services Department at **1–877–907–4742**.

A medical reimbursement form can be obtained online at **www.harvardpilgrim.org** or by calling the Member Services Department 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 an HPHC medical 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 the Member Services Department.

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

The following information must be on the Prescription Claim Form:

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

If you have a question regarding your reimbursement, you should contact the Member Services Department 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 is 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.

Please contact the Member Services Department at **1–877–907–4742** or call **711** for TTY service if you have questions about the Allowed Amount that may be permitted by HPHC for a service provided by a Non-Plan Provider.

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

A. BEFORE YOU FILE AN APPEAL

On occasion, claim denials result from a misunderstanding with a provider or a claim processing error. Since these problems can be easy to resolve, we recommend that Members contact a Member Service Representative before filing an appeal. A Member Service Representative can be reached toll-free at **1–877–907-4742** or call **711** for TTY service. The Member Service Representative will investigate the claim and either resolve the problem or explain why the claim is being denied. If you are dissatisfied with the response of the Member Service Representative, you may file an appeal using the procedures outlined below.

B. OUR MEMBER APPEAL PROCEDURES

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

1. Initiating Your Appeal

To initiate your appeal, please mail or fax a letter to us or call us about the coverage you are requesting and why you feel it should be granted. Please be as specific as possible. We need all the important details in order to make a fair decision, including pertinent medical records and itemized bills. A request for appeal must be filed within 180 days of the date of service, or payment for a service, when denied.

Please send your appeal to the following address:

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

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

Appeals concerning mental health and substance use disorder treatment should be submitted to:

United Behavioral Health
Attn: Appeals Department
P.O. Box 30512
Salt Lake City, UT 84130-0512
Telephone: 1–877–447-6002
Fax: 1–855–312–1470

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

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

2. First-Level Appeal Process

Standard Review Procedure: Your Appeals and Grievances Analyst will investigate your appeal, determine if additional information is required and request any needed information from you. Such information may include statements from your doctors, medical records and bills and receipts for services you have received. If your appeal involves a medical determination, an appropriate Clinical Peer will review it. An independent review will be conducted by Clinical Peers not involved in the previous decision.

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

Expedited Review Procedure: If your appeal involves services which, if delayed, could seriously jeopardize your health or your ability to regain maximum function, please inform us and we will provide an expedited review. We will grant an expedited review to any appeal for services concerning (1) an inpatient admission, (2) availability of care, or (3) continued health care or services for a Member who has received emergency services and has not been discharged from the Hospital where emergency care was provided. You, your representative or your doctor may request an expedited review.

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

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

3. Second-Level Appeal Process

If you are dissatisfied with the decision of the first level appeal process, you may ask that your appeal be reviewed by our review committee. You have a right to attend the meeting to discuss your case with the review committee. Just let your Appeals and Grievances Analyst know if you wish to attend. Please be advised that an attorney representative from the health plan will be present and you have the right to obtain your own legal representation. You may also participate in the meeting by telephone if you wish. We will hold a review meeting within 45 days after receiving your request for a second-level appeal. You will be notified in writing at least 15 days in advance of the review meeting. You may submit supporting materials before and at the review meeting. You also may be represented by someone at the review meeting. You may also obtain your medical file and information relevant to the appeal free of charge upon request. The decision of the review committee will be sent to you in writing within 5 working days of the meeting. The decision of the review committee is the final decision, subject to any right to external review as discussed below.

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

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

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

C. INDEPENDENT EXTERNAL REVIEW OF APPEALS

Appeal decisions involving an Adverse Health Care Treatment Decision by the Plan are eligible for review by an independent review organization designated by the Maine Bureau of Insurance. You are required to complete our first level appeals process to be eligible for external review. You may be eligible for an independent external review if (1) Harvard Pilgrim has failed to make a decision on your first or second level appeal in the time frames noted above; (2) you and the Plan mutually agree to bypass the member appeals process; (3) your life or health is in jeopardy; (4) the Member for whom external review is requested has died; or (5) Adverse Health Care Treatment Decision to be reviewed concerns an admission, availability of care, a continued stay or health care services when the Member has received emergency services but has not been discharged from the facility that provided the emergency services.

External review of Adverse Health Care Treatment Decisions for Experimental, Unproven or Investigational treatments or services have at least all of the protections that 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 to the Maine Bureau of Insurance at 34 State House Station, Augusta, ME 04333 and must be made within 12 months of our final denial of Covered Benefits prior to the initiation of the appeals process. You also may name someone you trust to file an appeal for you. However, you must give that person written permission to do so.

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

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

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, except mental health and substance use disorder treatment complaints, please call or write to us at:

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

Appeals concerning mental health and substance use disorder treatment should be submitted to:

HPHC Behavioral Health Complaints
c/o Optum Behavioral Health Complaints
P.O. Box 30768
Philadelphia, PA 191071
Telephone: 1–888–777-4742
Fax: 1-248-524-7603

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

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

Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333
Telephone: 1–800–300-5000 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 two years during the Member's lifetime.

VII. Eligibility

This section describes eligibility requirements for Members who receive no employer financial contribution toward the cost of health care premiums under this Plan.

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

A. ELIGIBILITY

1. Subscriber Eligibility

To be a Subscriber under this Plan, you must:

1) Be a resident of Maine, and
2) Not be enrolled in Medicare or Medicaid.

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

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

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 also see section *VII.E. SPECIAL ENROLLMENT RIGHTS*.

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 grace 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 more information applicable to your plan.

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

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 Marketplace coverage*
- 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 the Marketplace, you may have additional special enrollment rights as determined by the Marketplace, 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 eligibility guidelines for Exceptional Circumstances as determined by the Marketplace

*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 contact the Member Services Department at **1-877-907-4742**.

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

If your membership happens to begin while you are hospitalized, coverage starts on the day membership is effective. To obtain coverage, you must call both your PCP and the Plan and allow us to manage your care. This may include transfer to a Plan affiliated facility, if medically appropriate. All other terms and conditions of coverage under this Handbook will apply.

If you are hospitalized at an Out-of-Network Hospital, you must notify HPHC by calling **1-800-708-4414** for medical services. Your benefits at the out-of-network Hospital will be covered at the out of network level. For all mental health and substance use disorder treatment please call **1-888-777-4742**. Please 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 the Maine State-Based Health Insurance Marketplace must submit their application and enroll directly through the Marketplace. Administrative changes concerning coverage under this plan, including changes in address, effective dates of coverage or termination of coverage must be made through the Marketplace.

VIII. Premiums

A. PREMIUM AMOUNT

You are responsible for paying the premium for Covered Benefits under the Policy. Your initial 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 the Maine State-Based Health Insurance Marketplace, your initial premium payment is due 30 days from the day we receive your enrollment application from the Marketplace or the effective date of the coverage period, whichever is later. Premium payment for coverage thereafter is due by the date stated on your invoice which is generally the 1st day of the month.

Any misrepresentation or omission on your application may cause HPHC to change your premium retroactive back to the effective date. If the age of a Member under this Policy has been misstated, all amounts payable under the Policy shall be such as the premium paid that the Member would have purchased at the current age.

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 in which to pay your premium following the due date. 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 be terminated 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. We must receive notification in writing within 15 days of the date you want your membership to end. HPHC will refund you any premiums paid for coverage beyond the termination date. If you have coverage through the Maine State-Based Health Insurance Marketplace, you must contact the Maine State Based Health Insurance Marketplace to cancel your policy. Termination may be processed for the same day that you notify the Maine State Based Health Insurance Marketplace 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

HPHC may end a Member's 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 this Handbook for a person who is not a Member.
- Termination for nonpayment of premium by the Subscriber.

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

Maine State Based Health Insurance Marketplace Members Receiving Advance Premium Tax Credits (APTCs): Maine State Based Health Insurance Marketplace 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 FOR PRODUCT DISCONTINUANCE

HPHC may terminate this coverage by giving written notice to the Subscriber at least 90 days prior to the date HPHC will cease to offer the Plan in Maine. In the event of termination due to the product discontinuance, the Subscriber may purchase any other individual health coverage HPHC offers in Maine for which the Subscriber is eligible.

E. TERMINATIONS FOR OTHER REASONS

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

- If HPHC elects to discontinue this Plan or type of coverage in one or more markets in Maine, on ninety (90) days notice, in accordance with the requirements of Maine law.
- If HPHC elects to discontinue all coverage, including under this Plan, for one or more markets in Maine, on one hundred eighty (180) days notice, in accordance with the requirements of Maine law.

F. REINSTATEMENT

If you're purchasing coverage through the Maine State-Based Health Insurance Marketplace there is no reinstatement of this policy unless the coverage was terminated due to an error on the part of HPHC or the Maine State-Based Health Insurance Marketplace.

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.

X. When You Have Other Coverage

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

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

A. BENEFITS IN THE EVENT OF OTHER INSURANCE

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

Coordination of benefits will be based upon the Allowed Amount, or Recognized Amount, if applicable, for any service that is covered at least in part by any of the plans involved. If benefits are provided in the form of services, or if a provider of services is paid under a capitation arrangement, the reasonable value of these services will be used as the basis for coordination. No duplication in coverage of services will occur among plans. For prescription drug claims, we will coordinate benefits pursuant to our secondary payer allowed amount in all cases.

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

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

1. Employee/Dependent

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

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

ii. Dependent Child/Separated or Divorced Parents

Unless a court order, of which HPHC has knowledge of, specifies one of the parents as responsible for the health care benefits of the child, the order of benefits is determined as follows:

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

3. Active Employee or Retired or Laid Off Employee

The benefits of a plan that covers the person as an active employee or as a dependent of an active employee are determined before those of the plan that covers the person as an individual who is retired or laid-off or as a dependent of an individual who is retired or laid off.

4. COBRA or State Continuation
The benefits of a plan that covers the person as an employee, member, subscriber or retiree, or as a dependent thereof, are determined before those of the plan that covers the person as an individual under COBRA or other right to continuation of coverage under state or federal law.

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

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

B. PAYMENT WHEN HPHC COVERAGE IS PRIMARY OR SECONDARY

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

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

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

C. WORKER'S COMPENSATION/GOVERNMENT PROGRAMS

If HPHC has information indicating that services provided to you are covered under Worker's Compensation, employer's liability or other program of similar purpose, or by a federal, state or other government agency, HPHC may suspend payment for such services until a determination is made whether payment will be made by such program, unless a notice of controversy has been filed with the Workers' Compensation Board contesting the work-relatedness of the claimant's condition and no decision has been made by the Board. If HPHC provides or pays for services for an illness or injury covered under Worker's Compensation, employer's liability or other program of similar purpose, or by a federal, state or other government agency, HPHC will be entitled to recovery of its expenses from the provider of services or the party or parties legally obligated to pay for such services.

D. SUBROGATION AND REIMBURSEMENT

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

If another person or entity is, or may be, liable to pay for services related to a Member's illness or injury, which have been paid for or provided by HPHC, HPHC will be subrogated and succeed to all rights of the Member to recover against such person or entity 100% of the value of the services paid for or provided by the Plan, subject to the provisions of the following paragraph. HPHC will have the right to seek such recovery from, among others, the person or entity that caused the injury or illness, his/her liability carrier, 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, subject to the provisions of the following paragraph. HPHC will also be entitled to recover from a Member 100% of the value of services provided or paid for by HPHC when a Member has been, or could be, reimbursed for the cost of care by another party, subject to the provisions of the following paragraph. The subrogation and recovery provisions in this section apply whether or not the Member recovering money is a minor.

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

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

In the event of a dispute as to the application of any such provision or the amount available for payment to those claiming payment for services or reimbursement, that dispute must be determined, if the action is pending, before the court in which it is pending; or if no action is pending, by filing an action in any court for determination of the dispute.

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

E. MEDICAL PAYMENT POLICIES

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

F. MEMBER COOPERATION

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

G. HPHC'S RIGHTS

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

H. MEMBERS ENROLLED IN MEDICARE

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

XI. Plan Provisions and Responsibilities

A. IF YOU DISAGREE WITH RECOMMENDED TREATMENT

You enroll in HPHC with the understanding that Plan Providers are responsible for determining treatment appropriate to your care. You may disagree with the treatment recommended by Plan Providers for personal or religious reasons. You may demand treatment or seek conditions of treatment that Plan Providers judge to be incompatible with proper medical care. In the event of such a disagreement, you have the right to refuse the recommendations of Plan Providers. Benefits for such non-recommended treatment will be subject to all Plan provisions.

B. LIMITATION ON LEGAL ACTIONS

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

C. ACCESS TO INFORMATION

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

You can obtain a copy of the Notice of Privacy Practices through the Harvard Pilgrim website, **www.harvardpilgrim.org** or by calling the Member Services Department at **1-877-907-4742**.

D. SAFEGUARDING CONFIDENTIALITY

HPHC values individuals' privacy rights and is committed to safeguarding protected health information (PHI) and personal information (PI). To support this commitment, HPHC has established a number of Privacy and Security policies, including those describing the administration of its privacy and security programs, requirements for staff training, and permitted uses and disclosures of PHI and PI. We may collect, use, and disclose financial and medical information about you when doing business with you or with others. We do this in accordance with our privacy policies and applicable state and federal laws. HPHC also requires its business partners who administer health care coverage to you on our behalf to protect your information in accordance with applicable state and federal laws.

You can obtain a copy of the Notice of Privacy Practices through the Harvard Pilgrim website, **www.harvardpilgrim.org** or by calling the Member Services Department at **1-877-907-4742**.

E. NOTICE

Any Member mailings, including but not limited to, notices, plan documents, invoices, and activity statements will be sent to the Member's last address of the Member on file with HPHC. It is the Member's responsibility to notify HPHC of an address change to ensure mailed materials are sent to the appropriate address. HPHC is not responsible for mailed materials being sent to the incorrect address if a Member has not updated his/her address with HPHC prior to the materials being mailed out. Notice to HPHC, other than a request for Member appeal, should be sent to:

HPHC Member Services Department
1 Wellness Way
Canton, MA 02021

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

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

F. MODIFICATION OF THIS HANDBOOK

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

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

G. OUR RELATIONSHIP WITH PLAN PROVIDERS

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

H. WELLNESS INCENTIVES

As a member of the Plan, you may be able to receive incentives for participation in wellness and health improvement programs.HPHC may provide incentives, including reimbursement for certain fees that you pay for when participating in fitness or weight loss programs, or other wellness incentive programs. The award of incentives is not contingent upon the outcome of the wellness or health improvement program. Please visit our website at **www.harvardpilgrim.org** for more information or see your Schedule of Benefits or other Plan documents for the amount of incentives, if any, available under your Plan. For tax information, please consult with your tax advisor.

I. IN THE EVENT OF A MAJOR DISASTER

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

J. EVALUATION OF NEW TECHNOLOGY

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

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

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

K. GOVERNING LAW

This Evidence of Coverage is governed by Maine law.

L. UTILIZATION REVIEW PROCEDURES

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

- **Prospective Utilization Review (Prior Approval).** We review selected inpatient admissions, surgical day care, outpatient/ambulatory procedures, and Medical Drugs prior to the provision of such to determine whether they meet Medical Necessity Guidelines for coverage. Please see section *I.F. PRIOR APPROVAL* for further information on HPHC's Prior Approval requirements, including procedures for which Prior Approval is required. Prior Approval review determinations will be made within 72 hours or two working days, whichever is less, after obtaining all necessary information. In the case of a determination to approve an admission, procedure or service, we will give notice via the HPHC provider portal within 24 hours of the decision and will send written confirmation to you and the provider within 72 hours or two working days, whichever is less. If a determination is not made within 72 hours, the request for Prior Approval is granted. In the case of a determination to deny or reduce benefits ("an adverse determination"), we will notify the provider rendering the service by telephone within 24 hours of the decision and will

send a written or electronic confirmation of the telephone notification to you and the provider within one working day thereafter. In the case of an urgent care determination not involving concurrent review, we will notify you of a decision within 48 hours after receiving all necessary information.

Special rules apply to any request for a drug in 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.

HPHC will make a prospective review decision for a medical service that meets criteria a. or b., above, as soon as possible, but not later than 24 hours after receiving the information necessary to make a decision.

- **Concurrent Utilization Review.** We review selected ongoing admissions to inpatient Hospitals, including acute care Hospitals, rehabilitation Hospitals, skilled nursing facilities and skilled home health services to assure that services being provided meet Medical Necessity Guidelines for coverage. Concurrent review decisions will be made within one working day of obtaining all necessary information. In the case of either a determination to approve additional services or an adverse determination, we will notify the provider rendering the service by telephone within 24 hours of the decision. We will send a written or electronic confirmation of the telephone notification to you and the provider within one working day. In the case of ongoing services, coverage will be continued without liability to you until you have been notified of an adverse determination.

  Active case management and discharge planning is incorporated as part of the concurrent review process and may also be provided upon the request of your Provider.

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

- **Retrospective Utilization Review.** Retrospective utilization review may be used in circumstances where services were provided before authorization was obtained. This will include the review of emergency medical admissions for appropriateness of level of care. Retrospective utilization review decisions will be made within 30 days after obtaining all information. In the case of an adverse determination involving clinical review, you will receive written notification that cites the specific rationale upon which the decision was made and includes information about the appeals process and the right to request in writing copies of any Medical Necessity Guidelines applied in a denial of coverage decision.

If you wish to determine the status or outcome of a clinical review decision you may call the Member Services Department toll free at **1-877-907-4742**. For information about decisions concerning mental health and substance use disorder treatment, you may call the Behavioral Health Access Center at **1-888-777-4742**.

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

M. QUALITY ASSURANCE PROGRAMS

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

- **Verification of Provider Credentials** – HPHC credentials our contracted providers by obtaining, verifying and assessing the qualifications to provide care or services by obtaining evidence of licensure, education, training and other experience and/or qualifications.
- **Verification of Facility Credentials** – HPHC credentials our contracted providers by reviewing licensures and applicable certifications based on facility type.
- **Quality of Care Complaints** – HPHC follows a systematic process to investigate, resolve and monitor Member complaints regarding medical care received by a contracted provider.

- **Evidence Based Practice** – HPHC compiles clinical guidelines, based upon the most current evidence-based standards, to assist clinicians by providing an analytical framework for the evaluation and treatment of common health conditions.
- **Performance monitoring** – HPHC participates in collecting data to measure outcomes related to the Health Care Effectiveness Data and Information Set (HEDIS) 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 for our members. The Quality Program is documented, tracked and evaluated against milestones and target objectives. The full program description and review is available on our website at **https://www.harvardpilgrim.org/public/about-us/quality**.

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

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

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

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

O. 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 in accordance with standards established by The National Committee for Quality Assurance (NCQA), and reviewed (and revised, if needed) at least annually, or more often if needed to accommodate current standards of practice. This process applies to clinical criteria for both physical and mental health services.

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

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

P. NEW TO MARKET DRUGS

New prescription drugs that are introduced into the market are reviewed by the Plan prior to coverage to ensure that the drug is safe and effective. New to market drugs will be reviewed by Harvard Pilgrim's Medical Policy Department and New Technology Assessment Committee or Pharmacy Services Department along with the Pharmacy and Therapeutics Committee within the first 180 days of their introduction to the market. If the new to market drug is covered by the Plan, Prior Authorization and coverage limitations may apply.

Q. PAYMENT RECOVERY

If we determine that benefit payments under the Plan were made erroneously, we reserve the right to (1) seek recovery of such payments from the Provider or Member to whom the payments were made, and (2) offset subsequent benefit payments to a Provider (regardless of payment source) or Member by the amount of any such overpayment.

XII. MEMBER RIGHTS & RESPONSIBILITIES

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

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

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

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

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

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

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

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

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

Members have a right to assign benefits for their cause to the provider of the care. Any such assignment does not affect or limit the payment of benefits otherwise payable under the Plan.

Harvard Pilgrim Health Care, Inc.

1 Wellness Way
Canton, MA 02021–1166
1–888–333–4742
www.harvardpilgrim.org