



HPHC Insurance  
Company

# Benefit Handbook

THE BEST BUY HSA PPO PLAN FOR INDIVIDUAL MEMBERS  
*MAINE*

[This certificate [does not] provide[s] 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. ]



# INTRODUCTION

Welcome to The Best Buy HSA PPO Plan for Individual Members offered by HPHC Insurance Company (HPHC). 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 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 VIII. *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.

## Using your Plan

To use the Plan effectively, you will want to review this Handbook and the Schedule of Benefits, which describe your In-Network and Out-of-Network benefits. This Plan has been designed to offer you the flexibility of obtaining Covered Benefits through the Plan's network of Plan Providers or the Non-Plan Provider of your choice. Benefits are covered both In-Network and Out-of-Network. However, in most cases, your In-Network benefits provide you with a higher level of coverage. In addition, when you use In-Network benefits you will never be responsible for charges in excess of the Allowed Amount for the service.

All In-Network care must be provided by the Plan's network of Plan Providers, except in a Medical Emergency.

If you choose to receive Covered Benefits from a provider or at a facility that is not a Plan Provider, your benefits will be covered at the Out-of-Network level.

Some benefits have limits on the amount of coverage provided in a [calendar year][Plan 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. Please see your Schedule of Benefits for detailed information regarding benefit limits on your coverage.

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

As a Member, you can take advantage of a wide range of helpful online tools and resources. For instance, **[HPHConnect]** offers you a secure place to help manage your health care. You are able to check your Schedule of Benefits and Benefit Handbook, review prescription drug and medical claim histories, compare hospitals and much more! For details on how to register for an **[HPHConnect]** account, log on to **[www.harvardpilgrim.org]**.

You may also call the Member Services Department if you have any questions. Member Services staff are available to help you with questions about the following:

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

We can 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 by calling our TTY machine at **[1-800-637-8257]**.

As 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.

**HPHC Insurance Company, Inc.**  
**Member Services Department**  
**[1600 Crown Colony Drive]**  
**[Quincy], [MA ][02169]**  
**[1-888-333-4742]**  
**[www.harvardpilgrim.org]**

### **Clinical Review Criteria**

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our clinical review criteria applicable to a service or procedure for which coverage is requested. Clinical review criteria may be obtained by calling **[1-888-888-4742 ext. 38723]**.

[Spanish]

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

[Russian]

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

[Arabic]

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

[Portuguese]

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

[French]

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

[Greek]

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

[Haitian Creole]

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

[Italian]

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

[Traditional Chinese]

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

[Lao]

ຂະນາສິກ ອັງ ຂອາຍ ທີ່ ບໍ່ ທາກ ມາສາ ອັງກິດ ບໍ່ ຜົນກໍ່ ສາມາດ ຕິດ ຕໍ່ ກັບ ພະນັກ ບໍລິການ ສູນ ຄຳ ຂອງ ໂຄງ ການ ຮັກສາ ສຸຂະພາບ Harvard Pilgrim ໄດ້ ໂດຍ ໂທ ໂປ ຫາ 1-888-333-4742 ຜົນ ຂໍ ຄາຍ ຄຳ ຕອບ ຂອງ ຄຳ ຖາມ ຕ່າງໆ ຂອງ ຕົນ. ໂຄງ ການ ນີ້ ຂໍ ສະ ບັ ບໍລິການ ຜ່ານ ມາສາ ໃນ ຂອາຍ ກວ່າ 120 ມາສາ ໂດຍ ບໍ່ ຈິດ ຄຳ ບໍລິການ ໂຄງ ອັງ ສິມ.

[Cambodian]

សមាជិកដែលមិនចេះនិយាយភាសាអង់គ្លេស ក៏អាចទូរស័ព្ទទៅភារិយាល័យផ្នែកសេវាមជ្ឈមណ្ឌលសមាជិកនៃ ផែនការសុខភាព Harvard Pilgrim Health Care លេខ 1-888-333-4742 ដើម្បីឲ្យគេភ្លើយសំនួរចំពោះជំនួញ។ ផែនការសុខភាពនេះមានផ្តល់ជូនសេវាបកប្រែភាសាដោយ ឥតគិតថ្លៃ រហូតដល់ 120 ភាសា ។

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

# Benefit Handbook

## The Best Buy HSA PPO Plan for Individual Members MAINE

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

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

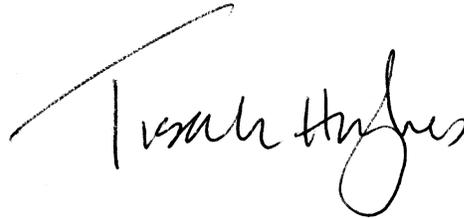
Please refer to your Benefit Handbook for information about your eligibility and continuation of coverage rights under this Plan.

By signing and returning the membership application, and/or by paying any applicable premiums, the Subscriber applies for membership and coverage under this Handbook and agrees to all of its terms.

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



Eric H. Schultz  
President  
HPHC Insurance Company, Inc.



Tisa K. Hughes  
Clerk  
HPHC Insurance Company, Inc.

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# I. How the Plan Works

This section describes how to use your Benefit Handbook and how your coverage works under the Plan. The Plan provides you with two levels of benefits known as In-Network coverage and Out-of-Network coverage. You receive In-Network coverage when you obtain Covered Benefits from Providers participating in the Plan. These Providers are referred to as “Plan Providers” and they have agreed to accept our payment minus the Member Cost Sharing as payment in full.

You receive Out-of-Network coverage when you obtain Covered Benefits from Non-Plan Providers. The Plan does not have agreements or contracts with these Providers. We pay a percentage of the cost of care you receive from Non-Plan Providers, up to the Allowed Amount for the service. Your In-Network and Out-of-Network coverage is described further below.

## 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:

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

You can view your Benefit Handbook[,], [and] Schedule of Benefits[,], [and] [Prescription Drug Brochure ],[,], [and] [any applicable pediatric vision and pediatric dental riders] [and amendments] online by using [HPHConnect] at [[www.harvardpilgrim.org](http://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

The Provider Directory lists the Plan Providers you may use to obtain In-Network Benefits. You may view the Provider Directory online at our web site, [[www.harvardpilgrim.org](http://www.harvardpilgrim.org)]. You can also get a paper copy of the Provider Directory, free of charge, by calling the Member Services Department at [[1-888-333-4742](tel:1-888-333-4742)].

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

**Please Note:** The physicians and other medical professionals in the Plan’s provider network 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.

## C. MEMBER OBLIGATIONS

### 1. Show Your Identification Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the Provider may not bill us for Covered Benefits, and you may be responsible for the cost of the service. You can order a new ID card online by

using [HPHConnect] at [www.harvardpilgrim.org] or by calling the Member Services Department.

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

## 3. Obtain Prior Approval

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

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

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

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

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

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

### 1. How Your In-Network Benefits Work

In-Network benefits are available when you receive Covered Benefits from a Plan Provider. Your Member Cost Sharing is generally lower for In-Network benefits. In-Network coverage applies to Plan Providers in Massachusetts, Maine, New Hampshire, Rhode Island, Vermont, Connecticut and a large number of providers in HPHC’s affiliated national network around the country. Since we pay Plan Providers directly, you do not have to file a claim when you use your In-Network benefits.

Plan Providers are under contract to provide Covered Benefits to Members of the Plan. They are listed in the Plan Provider Directory. Although every effort is made to keep the Provider Directory up-to-date, changes may occur for a variety of reasons. Members should contact the Member Services Department at [1-888-333-4742] to verify a Provider’s status. Members are responsible for advising Providers of their membership in the Plan by showing them their identification card before receiving services.

### 2. How Your Out-of-Network Benefits Work

Out-of-Network Benefits are available when you receive Covered Benefits from Non-Plan Providers. The Plan pays only a percentage of the cost of Covered Benefits 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 *F. NOTIFICATION AND PRIOR APPROVAL* for information on the Prior Approval Program.

To request Prior Approval, please call:

- [1-800-708-4414] for Medical Services
- [1-888-777-4742] for Mental Health and Drug and Alcohol Rehabilitation Services

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

### 3. Selecting a Plan Provider

To obtain In-Network benefits you must receive services from a Plan Provider. Your out-of-pocket costs will almost always be lower if you use your In-Network benefits by using a Plan Provider. Plan Providers include a large number of specialists and health care institutions in Maine and surrounding states. In addition, HPHC offers a large national network of Plan Providers across the United States. You may use the Harvard Pilgrim Provider Directory to find Plan Providers. The Provider Directory identifies the Plan's participating specialists, hospitals and other providers. It lists providers by state and town, specialty, and languages spoken. You may view the Provider Directory online at our web site, [www.harvardpilgrim.org]. You can also get a copy of the Provider Directory, free of charge, by calling the Member Services Department at [1-888-333-4742].

**Please Note:** The physicians and other medical professionals in the Plan's provider network 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.

### 4. Covered Benefits from Our Affiliated National Network of Providers

HPHC offers a comprehensive network of Plan Providers located in Massachusetts, New Hampshire, Rhode Island, Vermont, Connecticut and Maine. In addition, HPHC's national provider network allows Members to obtain In-Network benefits outside of those states. As of the issuance of this Handbook, the national network includes nearly 450,000 physicians and over 4,000 hospitals. To locate one of these Providers, log onto our website at [www.harvardpilgrim.org] or call Member Services at [1-888-333-4742].

### 5. How to get Care After Hours

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

### 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 [1-888-333-4742] within 48 hours or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to the Plan by an attending emergency physician no further notice is required. If notification is not received when the Member's condition permits, the Member is responsible for the Penalty Payment.

## E. MEMBER COST SHARING

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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 Cost Sharing details that are specific to your Plan.

### 1. Copayment

If the Covered Benefit you are receiving is subject to a Copayment, the Copayment is payable at the time of the visit or when billed by the provider. Copayment amounts are specified in 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][Plan Year] before any benefits subject to the Deductible are payable by the Plan. If a family Deductible applies, it is met when any combination of Members in a covered family incur expenses for services to which the Deductible applies. Deductible amounts are incurred on the date of service. You may have different Deductibles that apply to different Covered Benefits under your Plan.

Your Plan Deductible may or may not apply to a list of preventive care services covered by the Plan.

All Plans have one or more individual Deductibles or family Deductibles. Your Plan may have separate Deductibles that apply to In-Network and Out-of-Network services.

**Individual Deductibles.** Individual Deductibles apply when only a single individual is covered under the Plan.

**Family Deductibles.** Family Deductibles apply when you have coverage for a Subscriber and one or more family members under the Plan. Your Plan may have (1) a family Deductible or (2) a family Deductible with an embedded individual Deductible. Requirements for meeting the Deductible are different for the two types of family Deductibles.

If your Plan has a family Deductible, 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][Plan Year]. At that point, the family Deductible would also be met for the entire family for that [calendar year][Plan Year].

If your Plan has 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 services for that Member that are subject to that Deductible are covered by the Plan for the remainder of the [calendar year][Plan Year].
- b. If any number of Members in a covered family collectively meet the family Deductible, then all Members of the covered family receive coverage for services subject to that Deductible for the remainder of the [calendar year][Plan Year]. No

one family member may contribute more than the individual Deductible amount to the family Deductible.

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][Plan Year], expenses that Member incurred for Covered Benefits toward the Deductible under the prior coverage will apply toward the Deductible limit under their 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 their Schedule of Benefits.

## 3. Coinsurance

After the appropriate Deductible amount is met, you may be responsible for paying a Coinsurance amount. When using Plan Providers, the Allowed Amount is based on the contracted rate between HPHC and the Provider. When using Non-Plan Providers, the amount we pay for Covered Benefits 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][Plan 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][Plan Year]. Once a family Out-of-Pocket Maximum has been met in a [calendar year][Plan 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][Plan Year]. 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. Your Plan may have separate Out-of-Pocket Maximums that apply to In-Network and Out-of-Network services.

**Individual Out-of-Pocket Maximums.** Individual Out-of-Pocket Maximums apply when only a single individual is covered under the Plan.

**Family Out-of-Pocket Maximums.** Family Out-of-Pocket Maximums apply when you have coverage for a Subscriber and one or more family members under the Plan. Your Plan may have (1) only a family Out-of-Pocket Maximum or (2) a family Out-of-Pocket Maximum with an embedded individual Out-of-Pocket Maximum. Requirements for meeting the Out-of-Pocket Maximum are different for the two types of family Out-of-Pocket Maximums.

If your Plan has only a family Out-of-Pocket Maximum, the Out-of-Pocket Maximum may 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][Plan Year]. At that point, the family Out-of-Pocket Maximum would be met for the entire family for that [calendar year][Plan Year].

If your Plan has 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][Plan 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][Plan 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][Plan 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][Plan 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 amount of the Allowed Amount payable by the Plan. This means that you will be responsible for paying the full amount above the Allowed Amount. Amounts charged by a Non-Plan Provider in excess of the Allowed Amount do not count toward the Out-of-Pocket Maximum. You may contact the Member Services Department at [1-888-333-4742] or at [1-800-637-8257] for TTY service if you have questions about the maximum Allowed Amount that may be permitted by HPHC for a service.

### 6. Penalty

The amount that a Member is responsible to pay for certain Out-of-Network services when notification or Prior Approval has not been received before obtaining the services. The Penalty charge is in addition to any Member Cost Sharing amounts. Penalty charges do not count towards any Out-of-Pocket Maximum. Please see your Schedule of Benefits for your Out-of-Network Penalty Payment amount. Please see section *F. NOTIFICATION AND 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 are limited to the Allowed Amount.

## F. NOTIFICATION AND PRIOR APPROVAL

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

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

### 1. Notification of Planned Inpatient Admissions

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

To provide notification for medical services, you should contact HPHC at [1-800-708-4414] at least five (5) business days in advance of the admission. To provide notification for mental health and drug and alcohol rehabilitation services, you should contact the Behavioral Health Access Center at [1-888-777-4742]. You do not need to provide advance notification to HPHC or the Behavioral Health Access Center if you are hospitalized in

a Medical Emergency. In the event of a Medical Emergency admission, you or your physician must notify HPHC or the Behavioral Health Access Center, as applicable, within 48 hours or as soon as possible.

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

### 2. When Prior Approval is Required

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

#### 1) For Mental Health and Drug and Alcohol Rehabilitation Services

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

- **Intensive Outpatient Program Treatment**  
– Treatment programs at an outpatient clinic or other facility generally lasting three or more hours a day for two or more days a week.
- **Partial Hospitalization and Day Treatment Programs**
- **Extended Outpatient Treatment Visits** – Outpatient visits of more than 50 minutes duration with or without medication management or any treatment routinely involving more than one outpatient visit in a day.
- **Outpatient Electro-Convulsive Treatment (ECT)**
- **Psychological Testing**
- **Applied Behavior Analysis (ABA) for the treatment of Autism**

**Please Note:** You may also contact the Behavioral Health Access Center at [1-888-777-4742] for assistance in obtaining covered mental health services (including

substance abuse treatment), even if Prior Approval is not required for the service you require.

## 2) For Medical Services.

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

- **Cosmetic, reconstructive and restorative procedures** – All Covered Benefits, including, but not limited to, blepharoplasty, breast reduction mammoplasty, gynecomastia surgery, panniculectomy, ptosis repair, rhinoplasty, and scar revision. (Please note that the Plan provides very limited coverage for Cosmetic Services. Please see “Reconstructive Surgery” in section III. *Covered Benefits* for details.)
- **Dental and Oral Surgery** – All Covered Benefits. (Please note that the Plan provides very limited coverage for Dental Care. Please see “Dental Services” in section III. *Covered Benefits* for details.)
- **Durable Medical Equipment** – Continuous glucose monitoring systems only.
- **Formulas and enteral nutrition** – Outpatient services only.
- **Home health care** – Including, but not limited to, home infusion (including treatment of Lyme Disease) and home hospice care.
- **Occupational therapy** – Outpatient services only.
- **Physical therapy** – Outpatient services only.
- **Pulmonary rehabilitation** – Outpatient services only
- **Radiology – High End Radiology**- Computerized axial tomography (CAT and CT and CTA scans); Magnetic resonance imaging (MRI and MRA scans); Nuclear cardiac studies; and Positron emission tomography (PET scans)

- **Speech and language therapy** – Outpatient services only
- **Surgery (both inpatient and outpatient)** – All Covered Benefits for surgical procedures, including but not limited to, bariatric Surgery (weight loss surgery), breast reduction and reconstructive surgery, including breast implant removal and gynecomastia; septoplasty; surgical treatment of obstructive sleep apnea, including uvulopalatopharyngoplasty (UPPP); and treatment of varicose veins.

Please refer to HPHC's Internet site, [[www.harvardpilgrim.org](http://www.harvardpilgrim.org)], for a current list of all services under these categories that are subject to Prior Approval.

## 3. How to Obtain Prior Approval

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

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

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

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

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

## 4. The Effect of Notification and Prior Approval on Coverage

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

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

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

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

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

## **5. What Notification and the Prior Approval Program Do**

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

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

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

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

## **G. CLINICAL REVIEW CRITERIA**

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We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our clinical review criteria applicable to a service or procedure for which coverage is requested. Clinical review criteria may be obtained by calling [1-888-888-4742 ext. 38723].

## **H. PROVIDER FEES FOR SPECIAL SERVICES (CONCIERGE SERVICES)**

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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 Plan Primary Care Providers (PCPs) to provide both an answering service that can be contacted 24-hours a day and prompt appointments when Medically Necessary.

## II. Glossary

This section lists words with special meaning within the Handbook.

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

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

**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, Vermont, Rhode Island, Connecticut or Maine, the Allowed Amount is defined as follows:

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

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

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

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

The Allowed Amount is determined based on [150 - 200]% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.

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

For services other than Pharmaceutical Products, we use a methodology called a relative

value scale, which is based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by Optuminsight, Inc. If the Optuminsight, Inc. relative value scale becomes no longer available, a comparable scale will be used.

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

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

Pricing of the Allowed Amount will be conducted by UnitedHealthcare, Inc. UnitedHealthcare, 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 drug and alcohol rehabilitation services. You may contact the Behavioral Health Access Center by calling [1-888-777-4742]. The Behavioral Health Access Center will assist you in finding an appropriate Plan Provider and arranging the services you require.

**Benefit Handbook (or Handbook)**

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

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

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

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

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

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

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

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

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

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

**Deductible** A specific dollar amount that is payable by a Member for Covered Benefits received each [calendar year][Plan Year] before any benefits subject to the Deductible are payable by the Plan. If a family Deductible applies, it is met when any combination of Members in a covered family incur expenses for services to which the Deductible applies in a [calendar year][Plan Year]. Deductible amounts are incurred on the date of service. If a Deductible applies to your plan, it will be stated in the Schedule of Benefits. The Deductible does not apply to non-Covered Benefits.

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

**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).

## THE BEST BUY HSA PPO PLAN FOR INDIVIDUAL MEMBERS - MAINE

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

**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.

**HPHC Insurance Company, Inc. (HPHC)** HPHC Insurance Company, Inc. is an insurance company that underwrites the health care benefits under this plan. HPHC provides or arranges for health care benefits to its Members through its network of physicians, specialists, and other Providers.

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

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

**Medical Emergency** The onset of an illness or medical condition, sufficiently severe that the absence of immediate medical attention could reasonably be expected by the Member to result in; (a) placing the Member's

physical and/or mental health in serious jeopardy (or with respect to pregnant woman, the health of the woman or her unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Examples of Medical Emergencies are: heart attack or suspected heart attack, stroke, shock, major blood loss, choking, severe head trauma, loss of consciousness, seizures, and convulsions. A Medical Emergency includes a situation involving a pregnant woman who is having contractions where there is either inadequate time to safely transfer her to another hospital before delivery or any transfer may pose a threat to the safety of the woman or unborn child.

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

**Medically Necessary or Medical Necessity** Health care services or products provided to a Member for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:

- Consistent with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Demonstrated through scientific evidence to be effective in improving health outcomes;
- Representative of best practices in the medical profession; and
- Not primarily for the convenience of the enrollee or physician or the other health care practitioner.

**Member** Any Subscriber or Dependent covered under the Plan.

**Member Cost Sharing** The responsibility of Members to assume a share of the cost of the benefits

provided under the Plan. Member Cost Sharing may include Copayments, Coinsurance and Deductibles. Please refer to your Schedule of Benefits for the specific Member Cost Sharing that applies to your Plan.

**Non-Plan Provider** A Provider who does not have a special agreement or contract with HPHC or its affiliates. The payment schedule for services received from Non-Plan Providers is based on the Allowed Amount. When care is received from a Non-Plan Provider, Member's are responsible for the applicable Deductible and Coinsurance plus any amounts in excess of the payment schedule. These financial responsibilities are described in your Schedule of Benefits.

**Notification** A Process to (1) verify that certain Covered Benefits are and continue to be, Medically Necessary and provided in an appropriate and cost-effective manner or (2) to arrange for the payment of benefits. Members are required to notify HPHC before the start of any planned inpatient admission to a Non-Plan medical facility. This requirement applies to admissions to all types of Non-Plan inpatient medical facilities, including hospitals, Skilled Nursing Facilities (SNFs) and rehabilitation hospitals. Please see section *F. NOTIFICATION AND PRIOR APPROVAL* for a detailed explanation of the Notification process.

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

**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][Plan Year]. Some types of Member Cost Sharing may be excluded from your Out-of-Pocket Maximum. The Out-of-Pocket Maximum is specified in your Schedule of Benefits.

**Please Note:** Penalty payments and charges above the Allowed Amount

never apply to the Out-of-Pocket Maximum.

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

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

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

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

**Plan** This package of health care benefits offered by HPHC Insurance Company, Inc.

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

Benefits. Plan Providers are listed in the Provider Directory.

**[Plan Year]** The one-year period for which benefits are purchased and administered. Benefits for which limited yearly coverage is provided renew at the beginning of the Plan Year. Benefits for which limited coverage is provided every two years renew at the beginning of every second Plan Year. Generally, the Plan Year begins on the Plan's Anniversary Date. Please see your Schedule of Benefits for your Plan Year information.

✓ FOR EXAMPLE: A Plan Year could begin on April 1st and end on March 31st or begin on January 1st and end on December 31st. Please see your Schedule of Benefits for your specific Plan Year information.]

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

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

Please see section *F. NOTIFICATION AND PRIOR APPROVAL* for a detailed explanation of the Prior Approval Program.

**Provider** Providers include, but are not limited to hospitals; Skilled Nursing Facilities; and medical professionals including: physicians, psychiatrists, nurse practitioners, physician assistants, certified nurse midwives, certified registered nurse

anesthetists, registered first nurse assistants, dentists, independent practice dental hygienists, dental hygiene therapists, chiropractors, essential health care providers (rural health clinics), and licensed mental health professionals, including psychologists, clinical social workers, marriage and family therapists, psychiatric/mental health advanced registered nurse practitioners, alcohol and drug counselors, clinical mental health counselors, and pastoral psychotherapists/counselors (except when providing services to a member of his or her church or congregation in the course of his or her duties as a pastor, minister or staff person). Plan Providers are listed in the Provider Directory.

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

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

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

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

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

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

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

**Urgent Care** Medically Necessary services for a condition that requires prompt medical attention but is not a Medical Emergency. Urgent Care is usually care needed because of an unforeseen illness, injury or condition that occurs and does not give reasonable time to obtain care through your Provider.

### III. Covered Benefits

This Section describes all of the benefits available under the Plan. [Not all benefits listed in this Handbook may apply to you.] Please see your Schedule of Benefits for your specific Covered Benefits. Your Plan includes outpatient pharmacy coverage, and pharmacy coverage is described in your Prescription Drug Brochure.

Some benefits have limits on the amount of coverage provided in a [calendar year][Plan 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][Plan 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][Plan Year] basis. [Please see your Schedule of Benefits for your specific Plan Year information.]

#### Basic Requirements for Coverage

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

- Listed as a Covered Benefit in this section.
- Medically Necessary.
- Not excluded in section IV. *Exclusions*.
- Received while an active Member of the Plan.
- In-Network services must be provided by a Plan Provider. The only exception is care needed in a Medical Emergency.
- Some Out-of-Network services require Prior Approval by the Plan. Please see section F. *NOTIFICATION AND PRIOR APPROVAL* for information on the Prior Approval Program.

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

**<Note to Regulator:** The benefits identified in brackets below are optional benefits except where otherwise noted. At the present time HPHC will use the bracketed text referring to the Schedule of Benefits. >

Covered Benefits	Benefit
<b>[#] . Acupuncture Treatment for Injury or Illness</b>	The Plan covers acupuncture treatment for illness or injury, including, electro-acupuncture, that is provided for the treatment of neuromusculoskeletal pain.

Covered Benefits	Benefit
<p><b>[#] . Ambulance Transport</b></p>	<p><b>Emergency Ambulance Transport</b></p> <p>If you have a Medical Emergency, your Plan covers ambulance transport to the nearest hospital that can provide you with Medically Necessary care.</p> <p><b>[Non-Emergency Ambulance Transport ]</b></p> <p>[You're also covered for non-emergency ambulance transport between hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary. Services must be arranged by a Provider.]</p> <p><b>[Please Note:</b> Not all Plans cover this benefit. Please see your Schedule of Benefits.]</p>
<p><b>[#] . Autism Spectrum Disorders Treatment</b></p>	<p>The Plan covers the following services for the treatment of autism spectrum disorders to the extent required by Maine law:</p> <ul style="list-style-type: none"> <li>• Any assessments, evaluations or tests by a licensed physician or psychologist to diagnose whether a Member has an autism spectrum disorder.</li> <li>• Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain and restore the functioning of an individual to the extent possible. To be covered by the Plan, applied behavior analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts.</li> <li>• Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker.</li> <li>• Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist.</li> <li>• Prescription drugs in the same manner as provided for the treatment of any other illness or condition.</li> </ul> <p>A licensed physician or psychologist must determine that the service is Medically Necessary. Such determination must be reviewed annually.</p> <p>For purposes of this section the following terms have defined as follows:</p> <p>“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.</p> <p>“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.</p>

Covered Benefits	Benefit
[#] . Breast Cancer Treatment	<p>The Plan covers breast cancer treatment, including prostheses and the following services:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• Physical complications for all stages of mastectomy, including lymphedemas are covered in a manner determined in consultation with the attending physician and the Member.</li> </ul>
[#] . Chemotherapy and Radiation Therapy	<p>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.</p>
[#] . Chiropractic Care/Treatment by Adjustment or Manipulation	<p>The Plan covers Medically Necessary chiropractic services for musculoskeletal conditions up to the benefit limit stated in your Schedule of Benefits. The following services are covered:</p> <ul style="list-style-type: none"> <li>• Diagnostic x-ray</li> <li>• Care within the scope of standard chiropractic practice</li> </ul> <p>Please see your Schedule of Benefits for any limits that may apply.</p>
[#] . Clinical Trials	<p>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.</p>
[#] . Dental Services	<p><b>Important Notice:</b> The Plan does not provide dental insurance. It covers only the limited Dental Care described below.</p> <p><b>Emergency Dental Care:</b></p> <p>The Plan covers emergency Dental Care needed due to an injury to sound, natural teeth. All services, except for suture removal, must be received within three days of injury. Only the following services are covered:</p> <ul style="list-style-type: none"> <li>• Extraction of the teeth damaged in the injury when needed to avoid infection</li> <li>• Reimplantation and stabilization of dislodged teeth</li> <li>• Repositioning and stabilization of partly dislodged teeth</li> </ul>

Covered Benefits	Benefit
Dental Services (Continued)	<ul style="list-style-type: none"> <li>• Suturing and suture removal</li> <li>• Medication received from the provider</li> </ul> <p><b>Extraction of Teeth Impacted in Bone:</b></p> <p>The Plan covers extraction of teeth impacted in bone. Only the following services are covered:</p> <ul style="list-style-type: none"> <li>• Extraction of teeth impacted in bone Pre-operative and post-operative care, immediately following the procedure</li> <li>• Anesthesia</li> <li>• X-rays</li> </ul> <p>Please Note: Your plan provides coverage for pediatric dental services. Please see your Pediatric Dental Rider for coverage details.</p> <p><b>General Anesthesia for Dentistry:</b></p> <p>The Plan covers general anesthesia and associated facility charges for dental procedures rendered in a hospital for certain conditions. The following conditions are covered:</p> <ul style="list-style-type: none"> <li>• Members, including infants, with physical, intellectual or medically compromising conditions in which general anesthesia is Medically Necessary.</li> <li>• Members for which local anesthesia is ineffective due to acute infection, anatomic variation or allergy.</li> <li>• 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 morbidity.</li> <li>• Members with extensive oral-facial or dental trauma for which local anesthesia would be ineffective or compromised.</li> </ul> <p><b>[Prior Approval or Notification Required:</b> Prior Approval is required for general anesthesia for dentistry. You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: <b>[1-800-708-4414]</b>. Please see section <i>F. NOTIFICATION AND PRIOR APPROVAL</i> for more information.]</p>

Covered Benefits	Benefit
<p><b>[#] . Diabetes Services and Supplies</b></p>	<p><b>Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care:</b></p> <p>The Plan covers outpatient self-management education and training programs provided by the ambulatory diabetes education facilities authorized by the Diabetes Control Project within the Maine Bureau of Health for the treatment of diabetes, including medical nutrition therapy services, used to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes. Services must be provided on an individual basis. Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care. The following items are also covered:</p> <p><b>Diabetes Equipment:</b></p> <ul style="list-style-type: none"> <li>• Blood glucose monitors</li> <li>• Dosage gauges</li> <li>• Injectors</li> <li>• Insulin pumps (including supplies) and infusion devices</li> <li>• Lancet devices</li> <li>• Therapeutic molded shoes and inserts</li> <li>• Visual magnifying aids</li> <li>• Voice synthesizers</li> </ul> <p><b>Pharmacy Supplies:</b></p> <ul style="list-style-type: none"> <li>• Blood glucose strips</li> <li>• Insulin, insulin needles and syringes</li> <li>• Lancets</li> <li>• Oral agents for controlling blood sugar</li> <li>• Urine and ketone test strips</li> </ul> <p>For coverage of pharmacy items listed above, you must get a prescription from your Provider and present it at a participating pharmacy. You can find participating pharmacies online at <a href="http://www.harvardpilgrim.org">[www.harvardpilgrim.org]</a>click Pharmacy Program or by calling the Member Services Department at <a href="tel:1-888-333-4742">[1-888-333-4742]</a>.</p>
<p><b>[#] . Dialysis</b></p>	<p>The Plan covers dialysis on an inpatient, outpatient or at home basis. When federal law permits Medicare to be the primary payer, you must apply for Medicare and also pay any Medicare premium. When Medicare is primary (or would be primary if the Member were timely enrolled), the Plan will cover only those costs that exceed what would be payable by Medicare.</p> <p>Coverage for dialysis in the home includes non-durable medical supplies, and drugs and equipment necessary for dialysis. [Installation of home equipment is covered up to the limit stated in your Schedule of Benefits.]</p> <p><b>[Prior Approval or Notification Required:</b> You must notify HPHC in advance of any planned inpatient admission to a Non-Plan Medical Facility. [Also, Prior approval is required for any services provided in the home.] If you use a Plan Provider, he/she will notify HPHC of your inpatient admission [or seek Prior Approval for you. The Prior Approval process is initiated by</p>

Covered Benefits	Benefit
Dialysis (Continued)	
	calling: [1-800-708-4414].] Please see section <i>F. NOTIFICATION AND PRIOR APPROVAL</i> for more information.]
[#] . Drug Coverage	
	<p>You have limited coverage for prescription drugs under this Benefit Handbook, which is described in Subsection 1, below. You also have the Plan’s coverage for outpatient prescription drugs and certain medical supplies you purchase at a pharmacy. Subsection 2, below, explains the Plan’s pharmacy coverage and how to learn the details of the pharmacy plan.</p> <p><b>1. Your Coverage under this Benefit Handbook</b></p> <p>This Benefit Handbook covers drugs administered to you by a medical professional in either of the following circumstances:</p> <ul style="list-style-type: none"> <li>• 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; or</li> <li>• Drugs that Cannot be Self-Administered. The drug cannot be self-administered and is given to you either (a) in a doctor’s office or other outpatient medical facility, or (b) at home while you are receiving home health care services covered by the Plan.</li> </ul> <p>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 home health care services, the words “cannot be self-administered” will include circumstances in which a family member or friend is trained to administer the drug and ongoing supervision by skilled medical personnel is required.</p> <p>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.</p> <p>This Benefit Handbook also provides coverage for: (a) certain diabetes supplies you purchase at a pharmacy; and (b) certain orally administered medications for the treatment of cancer. There is no Member Cost Sharing for orally administered medications for the treatment of cancer after the Deductible has been met. Please see the benefit for “Diabetes Services and Supplies” for the details of that coverage.</p> <p>No coverage is provided under this Benefit Handbook for: (1) drugs that have not been approved by the United States Food and Drug Administration; (2) drugs the Plan excludes or limits, including, but not limited to, drugs for cosmetic purposes or weight loss; and (3) any drug that is obtained at an outpatient pharmacy except covered diabetes supplies, as explained above.</p> <p><b>2. Outpatient Pharmacy Coverage</b></p> <p>In addition to the coverage under this Benefit Handbook, you also have the Plan’s outpatient pharmacy benefit. That benefit provides coverage for most prescription drugs and certain medical supplies purchased at an outpatient pharmacy.</p>

Covered Benefits	Benefit
<b>Drug Coverage (Continued)</b>	<p>Your Member Cost Sharing for prescription drugs will be listed on your ID Card. Additional details on prescription drug coverage and limitations, including coverage of Nicotine Replacement Therapy, can be found in the Prescription Drug Brochure or on our website at <a href="http://www.harvardpilgrim.org">[www.harvardpilgrim.org]</a>.</p>
<b>[#] . Durable Medical Equipment (DME)</b>	<p>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.</p> <p>In order to be covered, all equipment must be:</p> <ul style="list-style-type: none"> <li>• Able to withstand repeated use;</li> <li>• Not generally useful in the absence of disease or injury;</li> <li>• Normally used in the treatment of an illness or injury or for the rehabilitation of an abnormal body part; and</li> <li>• Suitable for home use.</li> </ul> <p>Coverage is only available for:</p> <ul style="list-style-type: none"> <li>• [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]</li> <li>• [The least costly equipment adequate to allow you to perform Activities of Daily Living. The Plan will pay the Allowed Amount, minus any applicable Member Cost Sharing, for the least costly item of equipment . If you rent or purchase equipment that is more expensive than the least costly item adequate to permit you to perform Activities of Daily Living, you will be responsible for any additional cost. Activities of Daily Living do not include special functions needed for occupational purposes or sports; and]</li> <li>• 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.</li> </ul> <p>Covered equipment and supplies include:</p> <ul style="list-style-type: none"> <li>• Canes</li> <li>• Certain types of braces</li> <li>• Crutches</li> <li>• Hospital beds</li> <li>• Oxygen and oxygen equipment</li> <li>• Respiratory equipment</li> <li>• Walkers</li> <li>• Wheelchairs</li> <li>• 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</li> </ul> <p>Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan.</p>

Covered Benefits	Benefit
<b>[#] . Early Intervention Services</b>	
	<p>The Plan covers early intervention services for children with an identified developmental disability or delay. Coverage is provided for children from birth up to 3 years of age. The Plan covers early intervention services up to the Benefit Limit stated in your Schedule of Benefits.</p> <p>Coverage under this benefit is only available for services rendered by the following types of providers:</p> <ul style="list-style-type: none"> <li>• Occupational therapists</li> <li>• Physical therapists</li> <li>• Speech-language pathologists</li> <li>• Clinical social workers</li> </ul>
<b>[#] . Emergency Room Care</b>	
	<p>If you have a Medical Emergency, you are covered for care in a hospital emergency room. Please remember the following:</p> <ul style="list-style-type: none"> <li>• If you need follow-up care after you are treated in an emergency room, you must get your care from a Plan Provider for coverage to be at the In-Network benefit payment level.</li> <li>• If you are hospitalized, you must call the Plan at [1-888-333-4742] within 48 hours or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to the Plan by an attending emergency physician no further notice is required.</li> </ul>
<b>[#] . Family Planning Services</b>	
	<p>The Plan covers family planning services, including the following:</p> <ul style="list-style-type: none"> <li>• Contraceptive monitoring</li> <li>• Family planning consultation</li> <li>• Pregnancy testing</li> <li>• Genetic counseling</li> <li>• Professional services relating to the injection of birth control drugs and the insertion or removal of birth control implants or devices. However, birth control drugs, implants or devices that must be obtained at an outpatient pharmacy, are covered under your outpatient pharmacy coverage.</li> </ul>
<b>[#] . Hearing Aids</b>	
	<p>The Plan covers the purchase of hearing aids for each hearing impaired ear for Members through the age of 18, in accordance with the following conditions:</p> <ul style="list-style-type: none"> <li>• The Member's hearing loss must be documented by a physician or state-licensed audiologist.</li> <li>• The hearing aid must be purchased from a state licensed audiologist or hearing aid dealer.</li> </ul> <p>Coverage of hearing aids is provided up to the Benefit Limit stated in your Schedule of Benefits.</p>

Covered Benefits	Benefit
<p><b>[#] . Home Health Care</b></p>	<p>If you are homebound for medical reasons, you are covered for home health care services listed below for at least 90 days in a continuous 12 month period. To be eligible for home health care, your Provider must determine that skilled nursing care or physical therapy is an essential part of active treatment. There must also be a defined medical goal that your Provider expects you will meet in a reasonable period of time.</p> <p>When you qualify for home health care services as stated above, the Plan covers the following services:</p> <ul style="list-style-type: none"> <li>• Durable medical equipment and supplies (must be a component of the home health care being provided)</li> <li>• Medical social services</li> <li>• Nutritional counseling</li> <li>• Physical therapy</li> <li>• Occupational therapy</li> <li>• Services of a home health aide</li> <li>• Skilled nursing care</li> <li>• Speech therapy</li> <li>• Home infusion therapy</li> <li>• Enteral and parenteral therapy</li> </ul> <p><b>[Prior Approval or Notification Required:</b> You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: [1-800-708-4414]. Please see section <i>F. NOTIFICATION AND PRIOR APPROVAL</i> for more information.]</p>
<p><b>[#] . Hospice Services</b></p>	<p>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.</p> <p>Covered Benefits include:</p> <ul style="list-style-type: none"> <li>• Care to relieve pain</li> <li>• Counseling</li> <li>• Drugs that cannot be self-administered</li> <li>• Durable medical equipment appliances</li> <li>• Home health aide services</li> <li>• Medical supplies</li> <li>• Nursing care</li> <li>• Physician services</li> <li>• Occupational therapy</li> <li>• Physical therapy</li> <li>• Speech therapy</li> <li>• Respiratory therapy</li> </ul>

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Covered Benefits	Benefit
<b>Hospice Services (Continued)</b>	
	<ul style="list-style-type: none"> <li>• Respite care</li> <li>• Social services</li> <li>• Volunteer services</li> <li>• Bereavement services</li> </ul> <p><b>[Prior Approval or Notification Required:</b> You must obtain Prior Approval for home hospice care. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: [1-800-708-4414]. Please see section <i>F. NOTIFICATION AND PRIOR APPROVAL</i> for more information.]</p>
<b>[#] . Hospital – Inpatient Services</b>	
	<p>The Plan covers acute hospital care including, but not limited to, the following inpatient services:</p> <ul style="list-style-type: none"> <li>• Semi-private room and board, or private room and board when Medically Necessary</li> <li>• Doctor visits, including consultation with specialists</li> <li>• Medications</li> <li>• Laboratory and x-ray services</li> <li>• Intensive care</li> <li>• Blood transfusions</li> <li>• Infusion therapy</li> <li>• Surgery, including related services</li> <li>• Anesthesia, including the services of a nurse-anesthetist</li> <li>• Radiation therapy</li> <li>• Physical therapy</li> <li>• Occupational therapy</li> <li>• Speech therapy</li> <li>• Medically Necessary breast reduction surgery and symptomatic varicose vein surgery, as required by Maine law.</li> <li>• Weight loss surgery (bariatric surgery)</li> </ul> <p><b>[Prior Approval or Notification Required:</b> You must notify HPHC in advance of any planned inpatient admission to a Non-Plan Medical Facility. This requirement applies to admissions to all types of inpatient medical facilities, including hospitals, Skilled Nursing Facilities (SNFs) and rehabilitation hospitals. Please see section <i>F. NOTIFICATION AND PRIOR APPROVAL</i> for more information.]</p>
<b>[#] . House Calls</b>	
	The Plan covers house calls.

Covered Benefits	Benefit
<p><b>[#] . Human Organ Transplant Services</b></p>	<p>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.</p> <p>The Plan covers the following services when the recipient is a Member of the Plan:</p> <ul style="list-style-type: none"> <li>• Care for the recipient</li> <li>• Donor search costs through established organ donor registries</li> <li>• Donor costs that are not covered by the donor's health plan</li> </ul> <p>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.</p>
<p><b>[#] . Laboratory and Radiology Services</b></p>	<p>The Plan covers diagnostic laboratory and x-ray services, including High End Radiology, on an outpatient basis. The term "High End Radiology" means CT scans, PET Scans, MRI and MRA, and nuclear medicine services. Coverage includes:</p> <ul style="list-style-type: none"> <li>• The facility charge and the charge for supplies and equipment.</li> <li>• Charges of anesthesiologists, pathologists and radiologists.</li> </ul> <p>In addition, the Plan covers the following:</p> <ul style="list-style-type: none"> <li>• Diagnostic screening and tests, allergy testing, and blood tests and screenings mandated by state law.</li> <li>• Screening mammograms and non-routine mammograms. Screening mammograms are covered once every five years for women between the ages of 35 and 39, and once every year for women 40 years and over. A screening mammogram also includes an additional radiological procedure recommended by a Provider when the initial radiologic procedure results are not definitive. Non-routine mammograms are covered when Medically Necessary.</li> <li>• Human leukocyte antigen testing necessary to establish bone marrow transplant donor suitability. The Plan provides coverage up to \$150 toward the cost of human leukocyte antigen testing necessary to establish bone marrow transplant donor suitability. Services are subject to the In-Network Deductible. All charges above \$150 will be the responsibility of the Member. In accordance with Maine law, the test must be performed in a nationally accredited laboratory. A member seeking coverage for bone marrow suitability testing under this benefit must, at the time of testing, sign a consent form that authorizes the results of the test to be used for participation in the National Marrow Donor Program, or its successor organization. The consent form must acknowledge the Member's willingness to be a bone marrow donor if a suitable match is found. Only one test is covered in a Member's lifetime.</li> </ul> <p><b>[Please Note:</b> 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.]</p> <p><b>[Prior Approval or Notification Required:</b> You must obtain Prior Approval for computerized axial tomography (CAT and CT and CTA scans); Magnetic resonance imaging (MRI and MRA scans); Nuclear cardiac studies; and Positron emission tomography (PET scans). If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is</p>

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Covered Benefits	Benefit
<b>Laboratory and Radiology Services (Continued)</b>	
	initiated by calling: [1-800-708-4414]. Please see section <i>F. NOTIFICATION AND PRIOR APPROVAL</i> for more information.]
<b>[#] . Low Protein Foods</b>	
	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.
<b>[#] . Maternity Care</b>	
	<p>The Plan covers the following maternity services:</p> <ul style="list-style-type: none"> <li>• Routine outpatient prenatal care, including evaluation and progress screening, physical exams, recording of weight and blood pressure monitoring.</li> <li>• Prenatal genetic testing.</li> <li>• 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.</li> <li>• Routine newborn care, including hospital nursery care, physician services, vaccines and immunizations, and vitamins prior to discharge.</li> <li>• Routine outpatient postpartum care for the mother, including lactation consultations, up to six weeks after delivery.</li> </ul> <p><b>[Prior Approval or Notification Required:</b> You must notify HPHC in advance of any planned inpatient admission to a Non-Plan Medical Facility. This requirement applies to admissions to all types of inpatient medical facilities, including hospitals, Skilled Nursing Facilities (SNFs) and rehabilitation hospitals. Please see section <i>F. NOTIFICATION AND PRIOR APPROVAL</i> for more information.]</p>
<b>[#] . Medical Formulas</b>	
	<p>The Plan covers the following to the extent required by Maine law:</p> <ol style="list-style-type: none"> <li>1) Metabolic formulas prescribed by a licensed physician for a person with an inborn error of metabolism</li> <li>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: <ul style="list-style-type: none"> <li>• Symptomatic allergic colitis or proctitis</li> <li>• Laboratory or biopsy-proven allergic or eosinophilic gastroenteritis</li> <li>• A history of anaphylaxis</li> <li>• Gastroesophageal reflux disease that is non-responsive to standard medical therapies</li> <li>• Severe vomiting or diarrhea resulting in clinically significant dehydration requiring medical treatment</li> <li>• Cystic fibrosis</li> <li>• Malabsorption of cow milk-based or soy milk-based infant formula</li> </ul> </li> </ol> <p>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:</p>

Covered Benefits	Benefit
<p><b>Medical Formulas (Continued)</b></p>	<ul style="list-style-type: none"> <li>The amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater; and</li> <li>Other commercial infant formulas including cow milk-based and soy milk-based formulas have been tried and have failed or are contraindicated</li> </ul> <p>We may require that a licensed physician confirm and document at least annually that the formula remains Medically Necessary.</p> <p><b>[Prior Approval or Notification Required:</b> You must obtain Prior Approval for outpatient formulas and enteral nutrition. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: [1-800-708-4414]. Please see section <i>F. NOTIFICATION AND PRIOR APPROVAL</i> for more information.]</p>
<p><b>[#] . Mental Health and Drug</b></p>	<p><b>and Alcohol Rehabilitation Services</b></p> <p>The Plan covers Medically Necessary inpatient and outpatient mental health and drug and alcohol rehabilitation services.</p> <p>Prior Approval is required for certain mental health care or drug or alcohol rehabilitation services. If you receive these services from a Non-Plan Provider, you should obtain Prior Approval from the Behavioral Health Access Center by calling [1-888-777-4742]. The mental health and drug and alcohol services for which Prior Approval is required are as follows:</p> <ul style="list-style-type: none"> <li><b>Intensive Outpatient Program Treatment</b> –Treatment programs at an outpatient clinic or other facility generally lasting three or more hours a day for two or more days a week.</li> <li><b>Partial Hospitalization and Day Treatment Programs</b></li> <li><b>Extended Outpatient Treatment Visits</b> —Outpatient visits of more than 50 minutes duration with or without medication management or any treatment routinely involving more than one outpatient visit in a day.</li> <li><b>Outpatient Electro-Convulsive Treatment (ECT)</b></li> <li><b>Psychological Testing</b></li> <li><b>Applied Behavior Analysis (ABA) for the treatment of Autism</b></li> </ul> <p>Even when Prior Approval is not required, mental health and drug and alcohol rehabilitation services may be arranged through the Behavioral Health Access Center by calling [1-888-777-4742]. (The only exception applies to care required in a Medical Emergency.) The Behavioral Health Access Center phone line is staffed by licensed mental health clinicians. They will assist you in finding appropriate Plan Providers and arranging the services you require.</p> <p>In a Medical Emergency you should go to the nearest emergency facility or call 911 or your local emergency number.</p> <p><b>Services for Biologically Based Mental Illness</b></p> <p>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</p>

Covered Benefits	Benefit
	<p><b>Mental Health and Drug and Alcohol Rehabilitation Services (Continued)</b></p> <p>deficit and disruptive behavior disorders; pervasive developmental disorders including autism; tic disorders; eating disorders including bulimia and anorexia; and substance abuse-related disorders.</p> <p>Coverage for mental health services includes:</p> <ul style="list-style-type: none"> <li>• Inpatient care</li> <li>• Outpatient care</li> <li>• Outpatient home care</li> <li>• Psychological testing</li> </ul> <p>Coverage for drug and alcohol rehabilitation services includes:</p> <ul style="list-style-type: none"> <li>• Inpatient drug and alcohol rehabilitation, including partial hospitalization if you and your Provider agree that this treatment is best for you</li> <li>• Outpatient drug and alcohol rehabilitation, including evaluation, diagnosis, treatment and crisis intervention</li> <li>• Inpatient detoxification</li> <li>• Outpatient detoxification and medication management</li> </ul> <p><b>Mental Health Care Services for non-Biologically Based Mental Illness</b></p> <p>In addition to the coverage discussed above, the Plan will provide coverage for the care of all other conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. (The only exception is conditions for which only a "V Code" designation applies, which means that the condition is not attributable to a mental disorder.) Services for all other conditions not identified above will be covered to the extent Medically Necessary.</p> <p>Please refer to your Schedule of Benefits for the Member Cost Sharing that apply to the coverage of these services.</p> <p><b>1. Inpatient Mental Health Services</b></p> <ul style="list-style-type: none"> <li>• Inpatient care is covered as described in your Schedule of Benefits</li> <li>• 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.</li> <li>• Inpatient mental health care in a licensed general hospital is covered as long as it is Medically Necessary.</li> </ul> <p><b>2. Outpatient Mental Health Services</b></p> <p>The Plan covers outpatient mental health care, including evaluation, diagnosis, treatment and crisis intervention. Coverage is provided up to the limit described in your Schedule of Benefits.</p> <p><b>3. Psychological Testing</b></p> <p>The Plan covers psychological testing when Medically Necessary.</p>

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Covered Benefits	Benefit
[#] . Ostomy Supplies	<p>The Plan covers ostomy supplies up to the Benefit Limit listed in the Schedule of Benefits. Only the following supplies are covered:</p> <ul style="list-style-type: none"> <li>• Irrigation sleeves, bags and catheters</li> <li>• Pouches, face plates and belts</li> <li>• Skin barriers</li> </ul>
[#] . Physician and Other Professional Office Visits	<p>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:</p> <ul style="list-style-type: none"> <li>• 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</li> <li>• Follow-up care provided by an obstetrician or gynecologist for obstetrical or gynecological conditions identified during maternity care or annual gynecological visit</li> <li>• 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</li> <li>• Second opinions</li> <li>• Non-routine foot care</li> <li>• Well baby and well child care</li> <li>• Health education, including nutritional counseling and smoking cessation counseling</li> <li>• Sickness and injury care</li> <li>• Vision and Hearing screenings</li> <li>• Medication management</li> <li>• Chemotherapy</li> <li>• Radiation therapy</li> <li>• Inhalation therapy</li> <li>• Allergy injections</li> </ul> <p><b>[Please Note:</b> 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.]</p>
[#] . Preventive and Well-Care Services	<p>The Plan covers preventive and well-care services in accordance with Federal law. please see your Schedule of Benefits for additional information.</p>

Covered Benefits	Benefit
<p><b>[#] . Prosthetic Devices</b></p>	<p>The Plan covers prosthetic devices when ordered by a Provider. The cost of the repair and maintenance of a covered device is also covered.</p> <p>In order to be covered, all devices must be able to withstand repeated use. Coverage is only available for:</p> <ul style="list-style-type: none"> <li>• [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]</li> <li>• [The least costly prosthetic device (excluding prosthetic arms and legs) adequate to allow you to perform Activities of Daily Living. The Plan will pay the Allowed Amount, minus any applicable Member Cost Sharing, for the least costly prosthetic device (excluding prosthetic arms and legs). If you purchase a prosthetic device that is more expensive than the least costly item adequate to permit you to perform Activities of Daily Living, you will be responsible for any additional cost. Activities of Daily Living do not include special functions needed for occupational purposes or sports; and]</li> <li>• 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.</li> </ul> <p>Covered prostheses include:</p> <ul style="list-style-type: none"> <li>• Breast prostheses, including replacements and mastectomy bras</li> <li>• 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.)</li> <li>• Prosthetic eyes</li> </ul> <p>Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan.</p>
<p><b>[#] . Reconstructive Surgery</b></p>	<p>The Plan covers reconstructive and restorative surgical procedures as follows:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.)</li> </ul> <p>Benefits are also provided for post mastectomy care, including coverage for:</p> <ul style="list-style-type: none"> <li>• Prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient;</li> </ul>

Covered Benefits	Benefit
<b>Reconstructive Surgery (Continued)</b>	
	<ul style="list-style-type: none"> <li>• Reconstruction of the breast on which the mastectomy was performed; and</li> <li>• Surgery and reconstruction of the other breast to produce a symmetrical appearance.</li> </ul> <p>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.</p> <p>There is no coverage for Cosmetic Services or surgery except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care as described above.</p> <p><b>Important Notice:</b> We use clinical guidelines to evaluate whether different types of reconstructive and restorative procedures are Medically Necessary. If you are planning to receive such treatment, you may review the current guidelines. To obtain a copy, please call [1-888-888-4742 ext. 38732.]</p> <p><b>[Prior Approval or Notification Required:</b> You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: [1-800-708-4414]. Please see section <i>F. NOTIFICATION AND PRIOR APPROVAL</i> for more information.]</p>
<b>[#] . Rehabilitation Hospital Care</b>	
	<p>The Plan covers care in a facility licensed to provide rehabilitative care on an inpatient basis. Coverage is provided when you need daily Rehabilitative Therapies that must be provided in an inpatient setting. Rehabilitative Therapies include cardiac rehabilitation therapy, physical therapy, pulmonary rehabilitation therapy, occupational therapy and speech therapy. The Benefit Limit is listed in the Schedule of Benefits.</p> <p><b>[Prior Approval or Notification Required:</b> You must notify HPHC in advance of any planned inpatient admission to a Non-Plan Medical Facility. This requirement applies to admissions to all types of inpatient medical facilities, including hospitals, Skilled Nursing Facilities (SNFs) and rehabilitation hospitals. Please see section <i>F. NOTIFICATION AND PRIOR APPROVAL</i> for more information.]</p>
<b>[#] . Rehabilitation Therapy – Outpatient</b>	
	<p>The Plan covers the following outpatient rehabilitation therapies:</p> <ul style="list-style-type: none"> <li>• Cardiac rehabilitation therapy</li> <li>• Occupational therapy</li> <li>• Physical therapy</li> <li>• Pulmonary rehabilitation therapy</li> <li>• Speech therapy</li> <li>• Massage therapy when performed by a licensed physical therapist, physical therapy assistant, occupational therapist or certified occupational therapy assistant.</li> </ul> <p>Outpatient rehabilitation therapies are covered up to the Benefit Limit listed in the Schedule of Benefits. Services are covered only:</p>

Covered Benefits	Benefit
<b>Rehabilitation Therapy – Outpatient (Continued)</b>	
	<ul style="list-style-type: none"> <li>• 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</li> <li>• When needed to improve your ability to perform Activities of Daily Living.</li> </ul> <p>Activities of Daily Living do not include special functions needed for occupational purposes or sports.</p> <p>Rehabilitation Therapies are also covered under your inpatient hospital and home health benefits. When such therapies are part of an approved home care treatment plan they are available as described under <i>Home Health Care</i> in section III. <i>Covered Benefits</i>.</p> <p><b>[Prior Approval or Notification Required:</b> You must obtain Prior Approval for coverage of outpatient physical, occupational, pulmonary rehabilitation and speech therapy. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: [1-800-708-4414]. Please see section F. <i>NOTIFICATION AND PRIOR APPROVAL</i> for more information.]</p> <p><b>[Please Note:</b> Outpatient physical and occupational therapies for children under the age of 3 are covered to the extent Medically Necessary. The benefit limit stated in the Schedule of Benefits does not apply.]</p>
<b>[#] . Scopic Procedures – Outpatient Diagnostic</b>	
	<p>The Plan covers diagnostic scopic procedures and related services received on an outpatient basis.</p> <p>Diagnostic scopic procedures are those for visualization, biopsy and/or polyp removal. Scopic procedures are:</p> <ul style="list-style-type: none"> <li>• Colonoscopy</li> <li>• Endoscopy</li> <li>• Sigmoidoscopy</li> </ul> <p>In addition, the Plan covers any screening colonoscopy or sigmoidoscopy and any other colorectal cancer examination and laboratory test recommended by a Plan Provider in accordance with the most recently published colorectal cancer screening guidelines of a national cancer society. Coverage includes colorectal cancer screening for asymptomatic individuals who are 50 years of age or older, or less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society.</p>
<b>[#] . Skilled Nursing Facility Care</b>	
	<p>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.</p> <p><b>[Prior Approval or Notification Required:</b> You must notify HPHC in advance of any planned inpatient admission to a Non-Plan Medical Facility. This requirement applies to admissions to all types of inpatient medical facilities, including hospitals, Skilled Nursing Facilities (SNFs) and rehabilitation hospitals. Please see section F. <i>NOTIFICATION AND PRIOR APPROVAL</i> for more information.]</p>

Covered Benefits	Benefit
<p><b>[#] . Surgery - Outpatient</b></p>	<p>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.</p> <p><b>[Prior Approval or Notification Required:</b> You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: <b>[1-800-708-4414]</b>. Please see section <i>F. NOTIFICATION AND PRIOR APPROVAL</i> for more information.]</p>
<p><b>[#] . Telemedicine Services</b></p>	<p>The Plan covers Medically Necessary telemedicine services for the purpose of diagnosis, consultation or treatment in the same manner as an in-person consultation between you and your Provider. Telemedicine services are limited to the use of real-time interactive audio, video or other electronic media telecommunications as a substitute for in-person consultation with Providers.</p> <p>Cost Sharing for telemedicine services is the same as the Cost Sharing for the same type of service if it had been provided through an in-person consultation. Please refer to your Schedule of Benefits for specific information on Cost Sharing you may be required to pay.</p>
<p><b>[#] . [Urgent Care Center Services]</b></p>	<p>[The Plan covers services that you receive at an Urgent Care Center. Coverage is provided for services that are required to prevent deterioration to your health resulting from an unforeseen sickness or injury.</p> <p>Services you may obtain at an Urgent Care Center include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>• Care for minor cuts, burns, rashes or abrasions, including suturing</li> <li>• Treatment for minor illnesses and infections, including ear aches</li> <li>• Treatment for minor sprains or strains</li> </ul> <p>Please refer to your Schedule of Benefits for your specific Member Cost Sharing requirements.</p> <p><b>Important Notice:</b> Urgent care is not emergency care. You should call 911 or go directly to a hospital emergency room if you suspect you have any life threatening condition. These include heart attack or suspected heart attack, shock, major blood loss, or loss of consciousness. Please see section <i>D.6. Medical Emergency Services</i> for more information.]</p> <p><b>[Please Note:</b> Not all Plans cover this benefit. Please see your Schedule of Benefits.]</p>

Covered Benefits	Benefit
<p>[#] . [Vision Services]</p>	<p><b>[Routine Eye Examinations:</b>                      The Plan covers routine eye examinations.]</p> <p><b>[Please Note:</b> Not all Plans cover this benefit. Please see your Schedule of Benefits.]</p> <p><b>Pediatric Vision Care :</b>                      The Plan covers pediatric vision care.                      Please see your Schedule of Benefits for your coverage details.</p> <p><b>[Vision Hardware for Special Conditions:</b>                      [The Plan provides coverage for contact lenses or eyeglasses needed for the following conditions:]</p> <ul style="list-style-type: none"> <li>• Keratonconus. One pair of contact lenses is covered per [calendar year][Plan Year]. The replacement of lenses, due to a change in the Member's condition, is limited to [3 – 5] per affected eye per [calendar year][Plan Year].</li> <li>• Post cataract surgery with an intraocular lens implant (pseudophakes). Coverage is limited to [\$140 - \$500] 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 - \$500].</li> <li>• Post cataract surgery without lens implant (aphakes). One pair of eyeglass lenses or contact lenses is covered per [calendar year][Plan Year]. Coverage up to [\$50 - \$500] per [calendar year][Plan 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 – 5] per affected eye per [calendar year][Plan Year].</li> <li>• 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][Plan Year] after the date of surgery. For Members who have not previously worn eyeglasses or contact lenses, the Plan covers eyeglass lenses up to [\$50 - \$500] toward the purchase of the frame or pair of contact lenses.]</li> </ul>
<p>[#] . Voluntary Sterilization</p>	
	<p>The Plan covers voluntary sterilization, including tubal ligation and vasectomy.</p>
<p>[#] . Voluntary Termination of Pregnancy</p>	
	<p>The Plan covers voluntary termination of pregnancy.</p>

## 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
<p><b>[#] . Alternative Treatments</b></p>	<ul style="list-style-type: none"> <li data-bbox="542 569 1463 632">[#.] Acupuncture care except when specifically listed as a Covered Benefit (please see your Schedule of Benefits).</li> <li data-bbox="542 642 1354 705">[#.] Acupuncture services that are outside the scope of standard acupuncture care.</li> <li data-bbox="542 716 1393 800">[#.] Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments.</li> <li data-bbox="542 810 1398 852">[#.] Aromatherapy, treatment with crystals and alternative medicine.</li> <li data-bbox="542 863 1430 978">[#.] Health resorts, spas, recreational programs, camps, wilderness programs (therapeutic outdoor programs, outdoor skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs.</li> <li data-bbox="542 989 1446 1083">[#.] Massage therapy when performed by anyone other than a licensed physical therapist, physical therapy assistant, occupational therapist, or certified occupational therapy assistant.</li> <li data-bbox="542 1094 756 1125">[#.] Myotherapy.</li> </ul>
<p><b>[#] . Clinical Trials</b></p>	<p>Coverage is not provided for the following:</p> <ul style="list-style-type: none"> <li data-bbox="542 1209 1235 1251">[#.] The investigational item, device, or service itself; or</li> <li data-bbox="542 1262 1446 1346">[#.] 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.</li> </ul>
<p><b>[#] . Dental Services</b></p>	<ul style="list-style-type: none"> <li data-bbox="542 1388 1438 1451">[#.] Dental Care, except the specific dental services listed in this Benefit Handbook, your Schedule of Benefits, and any associated Riders.</li> <li data-bbox="542 1461 1414 1524">[#.] All services of a dentist for Temporomandibular Joint Dysfunction (TMD).</li> <li data-bbox="542 1535 1471 1598">[#.] Extraction of teeth, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits and any associated Riders).</li> <li data-bbox="542 1608 1455 1671">[#.] Pediatric dental care, except as outlined in your Schedule of Benefits and associated Riders.</li> </ul>

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<b>Exclusion</b>	<b>Description</b>
<b>[#] . Durable Medical Equipment and Prosthetic Devices</b>	
	<p>[#.] Any devices or special equipment needed for sports or occupational purposes.</p> <p>[#.] Any home adaptations, including, but not limited to home improvements and home adaptation equipment.</p> <p>[#.] Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services.</p> <p>[#.] Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.</p>
<b>[#] . Experimental, Unproven or Investigational Services</b>	
	<p>[#.] Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.</p>
<b>[#] . Foot Care</b>	
	<p>[#.] Foot orthotics, except for the treatment of severe diabetic foot disease.</p> <p>[#.] 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.</p>
<b>[#] . Mental Health Care</b>	
	<p>[#.] Biofeedback.</p> <p>[#.] 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.</p> <p>[#.] Methadone maintenance.</p> <p>[#.] Sensory integrative praxis tests.</p> <p>[#.] Services for any condition with only a "V Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder.</p> <p>[#.] Services or supplies for the diagnosis or treatment of mental health and drug and alcohol rehabilitation services that, in the reasonable judgment of the Behavioral Health Access Center, are any of the following:</p> <ul style="list-style-type: none"> <li>• Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.</li> <li>• Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.</li> <li>• Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.</li> </ul>

THE BEST BUY HSA PPO PLAN FOR INDIVIDUAL MEMBERS - MAINE

Exclusion	Description
<p><b>[#] . Physical Appearance</b></p>	<ul style="list-style-type: none"> <li>[#.] Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) reconstructive surgery to repair or restore appearance damaged by an accidental injury and (3) post-mastectomy care.</li> <li>[#.] Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy.</li> <li>[#.] Liposuction or removal of fat deposits considered undesirable.</li> <li>[#.] Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).</li> <li>[#.] Skin abrasion procedures performed as a treatment for acne.</li> <li>[#.] Treatment for skin wrinkles or any treatment to improve the appearance of the skin.</li> <li>[#.] Treatment for spider veins.</li> <li>[#.] [Wigs]</li> </ul>
<p><b>[#] . Procedures and Treatments</b></p>	<ul style="list-style-type: none"> <li>[#.] 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.</li> <li>[#.] Commercial diet plans, weight loss programs and any services in connection with such plans or programs.</li> <li>[#.] Gender reassignment surgery and all related drugs and procedures.</li> <li>[#.] 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).</li> <li>[#.] Physical examinations and testing for insurance, licensing or employment.</li> <li>[#.] Services for Members who are donors for non-members, except as described under Human Organ Transplant Services.</li> <li>[#.] Testing for central auditory processing.</li> <li>[#.] Group diabetes educational programs or camps.</li> </ul>
<p><b>[#] . Providers</b></p>	<ul style="list-style-type: none"> <li>[#.] Charges for services which were provided after the date on which your membership ends, except as required by Maine law.</li> <li>[#.] 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.</li> <li>[#.] Charges for missed appointments.</li> <li>[#.] Concierge service fees. (See section <i>H. PROVIDER FEES FOR SPECIAL SERVICES (CONCIERGE SERVICES)</i> for more information.)</li> <li>[#.] Inpatient charges after your hospital discharge.</li> </ul>

**THE BEST BUY HSA PPO PLAN FOR INDIVIDUAL MEMBERS - MAINE**

<b>Exclusion</b>	<b>Description</b>
<b>Providers (Continued)</b>	
	<ul style="list-style-type: none"> <li>[#.] Provider's charge to file a claim or to transcribe or copy your medical records.</li> <li>[#.] Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.</li> </ul>
<b>[#] . Reproduction</b>	
	<ul style="list-style-type: none"> <li>[#.] Infertility treatment and drugs.</li> <li>[#.] Any form of Surrogacy or services for a gestational carrier.</li> <li>[#.] Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal).</li> <li>[#.] Voluntary termination of pregnancy, unless the life of the mother is in danger or unless it is specifically listed as a Covered Benefit (please see your Schedule of Benefits).</li> <li>[#.] Sperm identification when not Medically Necessary (e.g., gender identification).</li> <li>[#.] The following fees: wait list fees, non-medical costs, shipping and handling charges etc.</li> </ul>
<b>[#] . Services Provided Under Another Plan</b>	
	<ul style="list-style-type: none"> <li>[#.] Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities.</li> <li>[#.] 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.</li> </ul>
<b>[#] . Telemedicine</b>	
	<ul style="list-style-type: none"> <li>[#.] Telemonitoring, telemedicine services involving e-mail, fax, or audio-only telephone, telemedicine services involving stored images forwarded for future consultation, i.e. "store and forward" telecommunication.</li> </ul>
<b>[#] . Types of Care</b>	
	<ul style="list-style-type: none"> <li>[#.] Custodial Care.</li> <li>[#.] Rest or domiciliary care.</li> <li>[#.] All institutional charges over the semi-private room rate, except when a private room is Medically Necessary.</li> <li>[#.] Pain management programs or clinics.</li> <li>[#.] Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.</li> <li>[#.] Private duty nursing.</li> <li>[#.] Sports medicine clinics.</li> <li>[#.] Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.</li> </ul>

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<b>Exclusion</b>	<b>Description</b>
<b>[#] . Vision and Hearing</b>	<p>[#.] Eyeglasses, contact lenses and fittings, except as listed in this Benefit Handbook and any associated Riders.</p> <p>[#.] Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of myopia, hyperopia and astigmatism.</p>
<b>[#] . All Other Exclusions</b>	<p>[#.] Any service or supply furnished in connection with a non-Covered Benefit.</p> <p>[#.] Beauty or barber service.</p> <p>[#.] Any drug or other product obtained at an outpatient pharmacy not included in your outpatient pharmacy benefit, except for pharmacy supplies covered under the benefit for diabetes services, Please see your associated Riders documents for more information.</p> <p>[#.] Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law.</p> <p>[#.] Guest services.</p> <p>[#.] Services for non-Members.</p> <p>[#.] Services for which no charge would be made in the absence of insurance.</p> <p>[#.] Services for which no coverage is provided in this Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure.</p> <p>[#.] Services that are not Medically Necessary.</p> <p>[#.] Taxes or governmental assessments on services or supplies.</p> <p>[#.] Transportation other than by ambulance.</p> <p>[#.] The following products and services:</p> <ul style="list-style-type: none"> <li>• Air conditioners, air purifiers and filters, dehumidifiers and humidifiers.</li> <li>• Car seats.</li> <li>• Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners.</li> <li>• Electric scooters.</li> <li>• Exercise equipment.</li> <li>• Home modifications including but not limited to elevators, handrails and ramps.</li> <li>• Hot tubs, jacuzzis, saunas or whirlpools.</li> <li>• Mattresses.</li> <li>• Medical alert systems.</li> <li>• Motorized beds.</li> <li>• Pillows.</li> <li>• Power-operated vehicles.</li> <li>• Stair lifts and stair glides.</li> <li>• Strollers.</li> </ul>

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Exclusion	Description
<b>All Other Exclusions (Continued)</b>	
	<ul style="list-style-type: none"><li>• Safety equipment.</li><li>• Vehicle modifications including but not limited to van lifts.</li><li>• Telephone.</li><li>• Television.</li></ul>

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

Proof of loss is administered under this Handbook by filing a claim on HPHC claims forms. Such forms may be obtained online at [[www.harvardpilgrim.org](http://www.harvardpilgrim.org)] or by calling HPHC's Member Services Department at [1-888-333-4742].

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

#### Claims for Mental Health Care:

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

#### Pharmacy Claims:

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

#### All Other Claims:

**[HPHC Claims]  
[P.O. Box 699183]  
[Quincy], [MA ][02269-9183]**

**Please note:** Prior Approval is required to receive full coverage for certain Out-of-Network services. Please see section *F. NOTIFICATION AND PRIOR APPROVAL* for more information on these requirements. For services that require Prior Approval from HPHC, please have your Provider call [1-800-708-4414].

### B. INFORMATION NEEDED FOR CLAIMS PROCESSING

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

- The Member's full name and address

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

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

#### 1. International Claims

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

#### 2. Pharmacy Claims

To obtain reimbursement for pharmacy bills you have paid, you must submit a Prescription Claim Form. The form can be obtained online at [[www.harvardpilgrim.org](http://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 BEST BUY HSA PPO PLAN FOR INDIVIDUAL MEMBERS - MAINE

- The number of days supply of the medication provided
- The date the prescription was filled
- The prescribing Provider's name
- The pharmacy name and address
- The amount you paid

**Important Notice:** Please see your Prescription Drug Brochure for more information about reimbursement for prescription drugs.

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

### C. TIME LIMITS ON FILING CLAIMS

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

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

### D. PAYMENT LIMITS

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

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

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

Please contact the Member Services Department at [1-888-333-4742] or at [1-800-637-8257] 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. NOTICE OF CLAIM

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The Member is not required to give notice to HPHC prior to the filing of a claim, except for the Prior

Approval requirements applicable to certain services. Please see section F. *NOTIFICATION AND PRIOR APPROVAL* for more information.

### F. MISCELLANEOUS CLAIMS PROVISIONS

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Benefits will be paid to the Member who received the services for which a claim is made unless such Member is a minor. In such case, benefits will be paid to the parent or custodian with whom the child resides. The Member may authorize HPHC to pay benefits 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 [1-888-333-4742] or at [1-800-637-8257] for TTY service. The Member Service Representative will investigate the claim and either resolve the problem or explain why the claim is being denied. If you are dissatisfied with the response of the Member Service Representative, you may file an appeal using the procedures outlined below.

### B. OUR MEMBER APPEAL PROCEDURES

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

#### 1. Initiating Your Appeal

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

Please send your appeal to the following address:

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

If you are deaf or hard of hearing or visually impaired, you may request appeal procedure materials in an appropriately accessible format by calling Member Services toll free at [1-888-333-4742] or at [1-800-637-8257] for TTY service.

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

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

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

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

#### 2. First-Level Appeal Process

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

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

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

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

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

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

### 3. Second-Level Appeal Process

If you are dissatisfied with the decision of the first level appeal process, you may ask that your appeal be reviewed by our review committee. You have a right to attend the meeting to discuss your case with the review committee. Just let your Appeals Coordinator

know if you wish to attend. You may also participate in the meeting by telephone if you wish. We will hold a review meeting within 45 days after receiving your request for a second-level appeal. You will be notified in writing at least 15 days in advance of the review meeting. You may submit supporting materials before and at the review meeting. You also may be represented by someone at the review meeting. You may also obtain your medical file and information relevant to the appeal free of charge upon request. The decision of the review committee will be sent to you in writing within 5 working days of the meeting. The decision of the review committee is the final decision.

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

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

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

### C. INDEPENDENT EXTERNAL REVIEW OF APPEALS

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

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

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

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

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

#### **D. MEMBER COMPLAINTS**

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If you have any complaints about your care under the Plan or about our service, we want to know about it. We are here to help. For all complaints, except mental

health and drug and alcohol rehabilitation complaints, please call or write to us at:

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

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

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

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

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

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

[TTY: 1-888-577-6690 ]

#### **E. INCONTESTABILITY**

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

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

## VII. Eligibility

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

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#### 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 child's 26th birthday.
- 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; (c) lives either with the Subscriber or spouse or in a licensed institution; and (d) remains financially dependent on the Subscriber. The term "Disabled" means unable to engage in any substantial gainful activity by reason of a specific medically determinable physical or mental impairment which can be expected to last, or has lasted, for at least 12 months or result in death.
- 4) A child under the age of 19 years for whom the Subscriber or Subscriber's spouse is the court appointed legal guardian. Proof of guardianship must be submitted to HPHC prior to enrollment.

- 5) The child of an eligible Dependent of the Subscriber until such time as the parent is no longer a Dependent.

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

### B. EFFECTIVE DATE - NEW DEPENDENTS AND EXISTING DEPENDENTS

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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. If HPHC is not notified within 60 days of the effective date, Dependents may only be added on the Anniversary Date of this Plan.

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

**Please Note:** Generally newborn coverage is bundled with the mother's maternity coverage. When the mother is not an HPHC member, HPHC needs to be put on 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

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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**

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

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

#### **E. SPECIAL ENROLLMENT RIGHTS**

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If an eligible Subscriber declines enrollment for his or her eligible Dependents (including his or her spouse) because of the other health insurance coverage, the Subscriber may be eligible to enroll his or her eligible Dependents in this plan if the eligible Dependents lose eligibility for that other coverage.

In addition, in order to enroll in the Plan, any eligible Dependents must be an “eligible individual” as defined by Section 2741 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Enrollment must be requested within 63 days after the other coverage ends.

#### **F. HOW YOU’RE COVERED IF MEMBERSHIP BEGINS WHILE YOU’RE HOSPITALIZED**

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If your membership happens to begin while you are hospitalized, coverage starts on the day membership is effective. All other terms and conditions of coverage under this Handbook will apply.

For In-Network coverage, you must be hospitalized in an In-Network hospital.

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

## VIII. Termination and Transfer to Other Coverage

### A. TERMINATION BY THE SUBSCRIBER

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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.

### B. TERMINATION FOR LOSS OF ELIGIBILITY

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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

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

- Providing false or misleading information to us on an application for membership;
- Failure to comply with the Plan's reasonable request for information provided in the application for coverage of this health plan;
- Failure to meet any of the specified eligibility requirements. This includes relocating outside the HPHC Enrollment Area;
- Obtaining or attempting to obtain benefits under this Handbook for a person who is not a Member; or
- The commission of acts of physical or verbal abuse by a Member, which pose a threat to providers, or other Members and which are unrelated to the Member's physical or mental condition.
- 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. 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.

### D. TERMINATIONS FOR OTHER REASONS

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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.

### E. REINSTATEMENT

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

## IX. When You Have Other Coverage

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

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

### **A. BENEFITS IN THE EVENT OF OTHER INSURANCE**

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

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

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

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

#### **1. Dependent/Non-Dependent**

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

#### **2. A Dependent Child Whose Parents Are Not Separated or Divorced**

The order of benefits is determined as follows:

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

#### **3. Dependent Child/Separated or Divorced Parents**

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

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

#### **4. Active/Inactive Employee**

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

#### **5. Longer/Shorter Length of Coverage**

If none of the above rules determines the order of benefits, the benefits of the plan that covered the employee, Member or Subscriber longer are

determined before those of the plan that covered that person for the shorter time.

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

#### **B. PAYMENT WHEN HPHC COVERAGE IS PRIMARY OR SECONDARY**

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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**

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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**

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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. HPHC will have the right to seek such recovery from, among others, the person or entity that caused the injury or illness, his/her liability carrier or the Member's own auto insurance carrier, in cases of uninsured or underinsured motorist coverage. HPHC's right to recovery shall apply even if a recovery the Member receives for the illness or injury is designated or described as being for injuries other than health care expenses. HPHC's recovery will be made from any recovery the Member receives from an insurance company or any third party. 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. 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, which means any factors that reduce the potential value of the services may likewise reduce HPHC's claim.

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 application requesting coverage under the Plan, you have authorized HPHC's right of subrogation.

#### **E. MEDICAL PAYMENT POLICIES**

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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.

primary payor. When Medicare is primary, HPHC will pay for services only to the extent payments would exceed what would be payable by Medicare.

## **F. MEMBER COOPERATION**

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

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

## **G. HPHC'S RIGHTS**

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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**

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

For a Member who is eligible for Medicare by reason of End Stage Renal Disease, HPHC will be the primary payor for Covered Benefits during the "coordination period" specified by federal regulations at 42 CFR Section 411.162. Thereafter, Medicare will be the

## X. Plan Provisions and Responsibilities

### A. LIMITATION ON LEGAL ACTIONS

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

### B. ACCESS TO INFORMATION

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

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

### C. SAFEGUARDING CONFIDENTIALITY

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

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

amount of information necessary to accomplish the specific activity.

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

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

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

### D. NOTICE

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

**[HPHC Member Services Department]  
[1600 Crown Colony Drive]  
[Quincy], [MA ][02169]  
[1-888-333-4742]**

[[www.harvardpilgrim.org](http://www.harvardpilgrim.org)]

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.

## **E. MODIFICATION OF THIS HANDBOOK**

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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.

## **F. OUR RELATIONSHIP WITH PLAN PROVIDERS**

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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.

## **G. IN THE EVENT OF A MAJOR DISASTER**

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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.

## **H. EVALUATION OF NEW TECHNOLOGY**

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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.

## **I. CERTIFICATE OF CREDITABLE COVERAGE**

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In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Members are entitled to a Certificate of Creditable Coverage, which verifies the most recent period of coverage under the Member's Plan.

The Certificate shows how many months of coverage a Member has, up to a maximum of eighteen (18) months. It also shows the date coverage ended. It may be used to prove to an employer the number of days of "credit" a person has from a prior health plan. If there has not been a gap in coverage of sixty-three (63) days or more, preexisting condition exclusion periods in an employer's health plan must be reduced by the number of days of coverage shown on the Certificate.

We will send you a Certificate of Creditable Coverage upon termination of membership. You may also call the Member Services Department at [1-888-333-4742] at any time within two years from the date coverage ended to request a free copy of the Certificate from us.

## **J. GOVERNING LAW**

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This Evidence of Coverage is governed by Maine law.

## **K. UTILIZATION REVIEW PROCEDURES**

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We use the following utilization review procedures to evaluate the medical necessity of selected health care services using clinical criteria and to facilitate clinically appropriate, cost-effective management of

your care. This process applies to guidelines for both physical and mental health services.

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

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

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

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

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

#### L. QUALITY ASSURANCE PROGRAMS

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

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

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

congestive heart failure, and the investigation and resolution of quality-of-care complaints registered by individual Members.

network, serve as the forum for the discussion of specialty-specific clinical programs and initiatives, and provide guidance on strategies and initiatives to evaluate or improve care and service.

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

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

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

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

#### **N. PROCESS TO DEVELOP CLINICAL GUIDELINES AND UTILIZATION REVIEW CRITERIA**

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

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

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

Our Clinician Advisory Committees, comprised of actively practicing physicians from throughout the

## **XI. MEMBER RIGHTS & RESPONSIBILITIES**

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

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

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

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

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

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

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

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

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

**HPHC Insurance Company, Inc.**  
**[1600 Crown Colony Drive]**  
**[Quincy, MA 02169]**  
**[1-800-333-4742]**  
**[[www.harvardpilgrim.org](http://www.harvardpilgrim.org)]**