Benefit Handbook

The Harvard Pilgrim HMO for *Nongroup* Members

Maine
This *Benefit Handbook* is the legal document that defines the relationship between Members and Harvard Pilgrim Health Care (HPHC). It describes benefits, limitations, conditions, exclusions, and other important information relevant to Members enrolled in HPHC.

In exchange for premiums paid in advance, HPHC agrees to provide or arrange for health care services to enrolled Members, subject to all the terms of this Handbook for the period the premium covers. By signing and returning the membership application, and/or by paying any applicable premiums, the Subscriber applies for membership in HPHC and agrees to all the terms of this Handbook.
Thank you for choosing the Harvard Pilgrim HMO for Nongroup Members Standard HMO (the Plan) in Maine offered by Harvard Pilgrim Health Care (HPHC) to help you meet your health care needs. Harvard Pilgrim Health Care (HPHC) offers two different Nongroup HMO plans for members living in Maine. These plans are referred to as “Standard A” and “Standard B”. This Benefit Handbook provides a general description of the benefits covered under both the Standard A and Standard B HMO plans. For specific benefit coverage including any member cost sharing responsibilities, please refer to the Schedule of Benefits for the specific HMO plan you selected (Standard A or Standard B).

Under the Plan your health care is provided or arranged through Harvard Pilgrim Health Care’s (HPHC) network of primary care physicians, specialists and other providers. You must choose a Primary Care Physician (PCP) for yourself and each of your family members when you enroll in the Plan.

The Plan provides benefits for the health care services described in this Handbook, the Schedule of Benefits brochure and the Prescription Drug Brochure. Such services must be provided or arranged by your Primary Care Physician, except in a Medical Emergency or when you are temporarily outside the HPHC Service Area. When your PCP arranges specialty care, it usually will be by referral to a provider in HPHC’s network. HPHC reserves the right to direct or redirect your health care to specific HPHC Providers or facilities.

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

- Selecting a Primary Care Physician
- Your Benefit Handbook
- Your Benefits
- Enrollment
- Claims
- Provider Information
- Requesting a Provider Directory
- Requesting a Member kit
- Requesting ID cards
- Registering a concern

Non-English speaking Members may call our Member Services Department at 1-888-333-4742 to have their questions answered. HPHC offers free language interpretation services in more than 120 languages.

Deaf and hard-of-hearing Members who own, or have access to, a Teletypewriter (TTY) may communicate directly with the Member Services Department by calling our TTY machine at 1-800-637-8257.

We value your input, so we would appreciate hearing from you with any comments or suggestions you may have.

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

1-888-333-4742
Internet: www.harvardpilgrim.org
TABLE OF CONTENTS

I. BENEFIT HANDBOOK......................................................................................................................................................... 4

A. ABOUT THE HARVARD PILGRIM HMO .......................................................................................................................... 4
   1. HOW TO USE THIS BENEFIT HANDBOOK .......................................................................................................................... 4
   2. HOW THE HARVARD PILGRIM HMO WORKS ................................................................................................................... 5

B. COVERED BENEFITS ............................................................................................................................................................. 8
   (See the Schedule of Benefits for a listing of the covered benefits selected by your Employer Group and the applicable benefit limitations, Copayments and Deductibles.)
   1. BASIC REQUIREMENTS FOR COVERAGE .......................................................................................................................... 8
   2. INPATIENT CARE ................................................................................................................................................................. 8
   3. OUTPATIENT CARE ............................................................................................................................................................... 9
   4. FAMILY PLANNING SERVICES .......................................................................................................................................... 10
   5. MATERNITY AND ROUTINE NEWBORN CARE .................................................................................................................... 10
   6. MENTAL HEALTH AND DRUG AND ALCOHOL REHABILITATION SERVICES ................................................................. 11
   7. DENTAL SERVICES ............................................................................................................................................................... 12
   8. AUTISM SPECTRUM DISORDERS TREATMENT .................................................................................................................... 12
   9. EARLY INTERVENTION SERVICES ..................................................................................................................................... 13
  10. OTHER SERVICES ............................................................................................................................................................. 13
  11. GENERAL EXCLUSIONS .................................................................................................................................................. 18

C. STUDENT DEPENDENT COVERAGE ................................................................................................................................. 19
   1. STUDENTS INSIDE THE HPHC ENROLLMENT AREA ...................................................................................................... 19
   2. STUDENTS OUTSIDE THE HPHC ENROLLMENT AREA ..................................................................................................... 19

D. REIMBURSEMENT AND CLAIMS PROCEDURES .................................................................................................................. 20
   1. BILLING BY PROVIDERS ..................................................................................................................................................... 20
   2. REIMBURSEMENT FOR BILLS YOU PAY .......................................................................................................................... 20
   3. LIMITS ON CLAIMS ........................................................................................................................................................... 20

E. HPHC UTILIZATION AND CASE MANAGEMENT SERVICES .................................................................................................. 21

F. APPEALS AND COMPLAINTS .................................................................................................................................................. 22
   1. BEFORE YOU FILE AN APPEAL .......................................................................................................................................... 22
   2. HPHC MEMBER APPEAL PROCEDURES ............................................................................................................................ 22
   3. INDEPENDENT EXTERNAL REVIEW OF APPEALS ............................................................................................................ 23
   4. MEMBER COMPLAINTS ..................................................................................................................................................... 24

G. ELIGIBILITY ........................................................................................................................................................................... 25
   1. MEMBER ELIGIBILITY ....................................................................................................................................................... 25
   2. EFFECTIVE DATE – NEW DEPENDENTS ............................................................................................................................ 25
   3. EFFECTIVE DATE – EXISTING DEPENDENTS ................................................................................................................... 25
   4. EFFECTIVE DATE – OFF-CYCLE ENROLLMENT .................................................................................................................. 26
   5. EFFECTIVE DATE – ADOPTIVE DEPENDENTS .................................................................................................................. 26
   6. CHANGE IN STATUS ........................................................................................................................................................ 26
   7. PERIODIC PREMIUM PAYMENTS ...................................................................................................................................... 26

H. TERMINATION AND CONVERSION .................................................................................................................................... 27
   1. TERMINATION BY THE SUBSCRIBER ................................................................................................................................. 27
   2. TERMINATION FOR LOSS OF ELIGIBILITY ........................................................................................................................ 27
   3. MEMBERSHIP TERMINATION FOR CAUSE ........................................................................................................................ 27
   4. DEPENDENT CONVERSION TO NON-GROUP COVERAGE ............................................................................................. 27
I. BENEFIT HANDBOOK

A. ABOUT THE HARVARD PILGRIM HMO
1. HOW TO USE THIS BENEFIT HANDBOOK

a. Why This Benefit Handbook Is Important
This Benefit Handbook, including the Schedule of Benefits and Prescription Drug Brochure and any applicable Riders (hereinafter collectively referred to as the Benefit Handbook or Handbook) make up the legal agreement stating the terms and conditions the Plan.

This document explains how your membership works. It outlines what you must do to obtain coverage for services and what you can expect from Harvard Pilgrim Health Care (HPHC) and the Plan is your guide to the most important things you need to know. These include:

- The requirement that you go to your Primary Care Physician (PCP) for most services
- What is covered, which includes most medical care you may need
- What is not covered
- Any limits on or special rules for coverage
- Any Copayments you must pay which are listed in the Schedule of Benefits
- Prescription drug benefits will be listed in the Prescription Drug Brochure

b. Words With Special Meaning
Some words in this Handbook have special meanings. When we use one of these words, we start it with a capital letter. We list all these words and what they mean in the Glossary at the end of this Benefit Handbook.

c. How To Find What You Need To Know
The Table of Contents will help you find what you need to know.

Within each section, we put the most important information about benefits first. For example, we list benefits and describe how coverage works first. Most limitations on services appear after the corresponding benefit on the Schedule of Benefits. Finally, any Copayment you have to pay is listed in the Schedule of Benefits.

d. Your Schedule of Benefits
Your Schedule of Benefits lists your Copayments and the particular benefits covered under your Plan. It also contains a summary of all your benefits. You should refer to this Handbook for detailed information.

e. Your Provider Directory
The Provider Directory lists our Primary Care Physicians (PCPs), specialists and other Participating Providers. Member Services can answer any questions about HPHC doctors and their qualifications. The Provider Directory is provided to you before you enroll. You can, also, obtain a copy of the Provider Directory from:

- HPHC’s Member Services Department by calling 1-888-333-4742,

The online Provider Directory at the Harvard Pilgrim Internet site, www.harvardpilgrim.org, provides links to several physician profiling sites that may be of interest.

Although the Provider Directory lists all Participating Providers, your PCP may refer you only to those Participating Providers with whom the PCP has a working relationship. (See Section I.A.2. for further information.)

Please note: The physicians and other medical professionals in the HPHC’s provider network participate through contractual arrangements that can be terminated either by a provider or by HPHC. In addition, a provider may leave the network because of retirement, relocation or other reasons. This means that HPHC cannot guarantee that the physician you choose will continue to participate in the network for the duration of your membership. If your Primary Care Physician leaves the network for any reason, the Plan will make every effort to notify you at least 60 days in advance, and will help you find a new physician to meet your health care needs. Please call the Member Services Department at 1-888-333-4742 so that HPHC can help you find a new PCP.
2. HOW THE HARVARD PILGRIM HMO WORKS
   a. Choose a Primary Care Physician (PCP)

When you enroll you must choose a Primary Care Physician (PCP). You select a PCP for yourself and each covered person in your family. You may choose a different PCP for each family member. If you do not choose a PCP when you first enroll, or if the PCP you select is not available, we will assign a PCP to you.

A PCP is generally a doctor of Internal Medicine, Pediatrics or OB/GYN. PCPs are listed in the Provider Directory. You may call Member Services to confirm that the PCP you select is available.

If you have not seen your PCP before, we suggest you do the following:

• Call your PCP's office as soon as possible and tell them you are a new Plan Member.

• Make an appointment to see your new PCP so he or she can get to know you and begin taking care of any medical needs you have.

• Ask your previous doctor to send your medical records to your new PCP.

Please do not wait until you are sick to call your PCP. You should get to know your doctor as soon as possible. Your PCP can take better care of you when he or she is familiar with your health status.

You may change your PCP at any time by calling the Member Services Department. Just choose a new PCP from the Provider Directory. We can make the change effective on the date that you call or on a future date. If you choose a new PCP, all referrals from your prior PCP become invalid. You will need to get new referrals from your new PCP.

If your PCP stops being a HPHC Provider, you will be notified in writing. You will then need to select a new PCP.

b. Your PCP Manages Your Health Care

1) Call Your PCP for Care

When you need care, call your PCP. Except as stated below, all care must be provided or arranged by your PCP. The only exceptions are:

• Care in a Medical Emergency.

• Care when you are temporarily outside the HPHC Service Area. (The HPHC Service Area is the state in which you live.)

• Special services that do not require a referral. (These services are listed on page 6.)

• Mental health, alcohol and drug rehabilitation services. For these services you must call the Plan’s Behavioral Health Access Center at 1-888-777-4742 (see Section B.6.)

Detailed information on each of these exceptions is provided below.

Either your PCP or a covering HPHC Provider is available to direct your care 24 hours a day. Talk to your PCP and find out what arrangements are available for care after normal business hours. Some PCPs have covering physicians after hours, and others have extended office/clinic hours. In the event you are unable to reach your PCP or the covering doctor, you may call the HPHC for help during normal business hours at 1-888-333-4742.

2) Hospital and Specialty Care

Your PCP generally uses one hospital for inpatient care. This is where you will need to go for coverage, unless it is Medically Necessary for you to get care at a different hospital. In some cases, prior authorization by HPHC is required.

When you need specialty care, your PCP will refer you to providers who are affiliated with the hospital your PCP uses. This helps your PCP coordinate and maintain the quality of your care. Participating Providers with recognized expertise in specialty pediatrics, including mental health care, are also covered when Medically Necessary with a referral from your PCP.

Your PCP may authorize a standing referral with a specialty care provider when: 1) the PCP determines that such referral is appropriate, 2) the specialty care provider agrees to a treatment plan for the Member and provides the PCP with all necessary clinical and administrative information on a regular basis, and 3) the services provided are covered benefits as described in this Handbook and your Schedule of Benefits.

Certain specialty services do not require a referral from your PCP. Please see “Services That Do Not Require a Referral” for a list of these specialty services.

If you select a new PCP, all referrals from your prior PCP become invalid. Your new PCP will need to assess your condition and provide new referrals. Please note although the Provider
Directory lists all HPHC Providers, your PCP may refer you only to those HPHC Providers with whom he or she is affiliated. The only exception will be for services that cannot be provided by an affiliated provider. In addition, HPHC may direct or redirect your care to specific HPHC Providers or facilities.

When you are in the Service Area, you must call your PCP's office before going to a hospital or specialist, unless you are having a Medical Emergency or are seeking the special services that do not require a referral.

c. Provider Fees for Special Services

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

In considering arrangements with physicians for special services, Members should understand exactly what services are to be provided and whether those services are worth the fee the Member must pay. For example, the Plan does not require participating providers to be available by telephone 24-hours a day. However, the Plan does require PCPs to provide both an answering service that can be contacted 24-hours a day and prompt appointments when Medically Necessary. The Plan also covers emergency room care for Medical Emergencies.

d. Medical Emergency Services

You always have coverage for care in a Medical Emergency. A referral from your PCP is not needed. In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. Your emergency room Copayment is listed on the Schedule of Benefits.

A Medical Emergency means a sudden and unexpected onset of a condition with symptoms so severe, including severe pain, that a person, possessing average knowledge of health and medicine, would expect that without immediate medical attention,

- his or her health (physical or mental) would be in serious jeopardy; or
- his or her health, body organs or parts, or some bodily function, would be seriously impaired.

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.

In the event of a Medical Emergency, HPHC will also cover services necessary to screen and stabilize your condition without requiring prior authorization.

Please remember that if you are hospitalized, you or your designee should call your PCP and HPHC within 48 hours of receiving emergency services, or as soon as possible after emergency screening and stabilization has taken place. Your PCP will arrange for any follow-up care you may need.

e. Coverage for Services When You Are Temporarily Outside the HPHC Service Area

If you are temporarily outside the HPHC Service Area and you get hurt or sick, don't worry. You do not have to call your PCP before getting care. We will cover any Medically Necessary services for sickness or injury except the following:

- Care you could have foreseen before leaving the HPHC Service Area;
- Routine care;
- Childbirth and problems with pregnancy beyond the 37th week of pregnancy, or after being told that you were at risk for early delivery; and
- Follow-up care that can wait until your return to the HPHC Service Area.

If you are hospitalized, you or your designee must call both your PCP and HPHC within 48 hours, or as soon as you can. Your PCP will help to arrange for any follow-up care you may need.

Please note that HPHC must have your current address on file in order to correctly process claims for care outside the HPHC Service Area. To change your address, please call our Member Services Department.

f. Services That Do Not Require a Referral

While in most cases you will need a referral from your PCP to get covered care from any other provider, you do not need a referral for the services listed below.
However, you must get these services from an HPHC Provider. HPHC Providers are listed in the Provider Directory. We urge you to keep your PCP informed about such care so that your medical records are current and up-to-date. Your PCP should be aware of your entire medical situation. Please note, although these services do not require a referral, any inpatient care or Day Surgery requires HPHC approval.

Family Planning Services:
• Family planning consultation
• Contraceptive monitoring
• Evaluation for pregnancy
• Voluntary sterilization, including tubal ligation
• Voluntary termination of pregnancy

Prenatal Services:
• Consultation for expectant parents
• Prenatal care

Gynecological Services:
• Annual gynecological exam, including routine pelvic and clinical breast examinations
• Cervical cryosurgery
• Colposcopy with biopsy
• Excision of labial lesions
• Laser cone vaporization of the cervix
• Loop electrosurgical excisions of the cervix (LEEP)
• Treatment of amenorrhea
• Treatment of condyloma

Dental Services:
• Extraction of impacted teeth. (Please see the end of this section for coverage rules when your PCP is a Harvard Vanguard provider.)
• Emergency dental care

(Please note that only limited coverage is provided for dental care. Please see the Covered Benefits Section and your Schedule of Benefits, before seeking such services.)

Other Services:
• Routine eye exams
• Acute chiropractic care

If coverage is provided for the extraction of impacted teeth, the HPHC Provider you can select depends upon where your PCP is located. If your PCP is located at Harvard Vanguard Medical Associates in Massachusetts; you must get your impacted tooth extraction at the Dental Department of one of the following Harvard Vanguard Medical Associates locations:

- Braintree
- Burlington
- Cambridge
- Chelmsford
- Copley
- Kenmore
- Medford
- Peabody
- Post Office Square
- Quincy
- Somerville
- Watertown
- Wellesley
- West Roxbury

If your PCP is located at any other Health Center, Medical Group or Individual Physician Practice, you can choose any HPHC Provider for extraction of impacted teeth, if a covered benefit. HPHC Providers are listed in your Provider Directory.
B. COVERED BENEFITS

It is important for you to note that some of the benefits listed in this section may not be offered by the nongroup plan you selected. Your specific benefits and Copayments will be listed on the Schedule of Benefits and the Prescription Drug Brochure.

Please remember that Standard Plan A and Standard Plan B do not have the same benefits, if the benefits listed below are part of your specific benefit package, the benefit will be listed as covered in your Schedule of Benefits and described either in a separate brochure or in this Benefit Handbook as a separate benefit.

1. BASIC REQUIREMENTS FOR COVERAGE
To be covered, all services and supplies must be:

- Medically Necessary;
- Received while an active Member of the Plan (or for disabled persons hospitalized at the time the group terminates); and
- Provided or arranged through referral in advance by your PCP to a HPHC contracted network Provider. The only exceptions are care needed in a Medical Emergency, care needed while temporarily outside the HPHC Service Area, and the special services that do not require a referral listed in Section I.A.2.f.

Please see specific benefits descriptions for any special limits or exclusions from coverage.

2. INPATIENT CARE
When you need inpatient care, your PCP will make all the necessary arrangements. He or she will coordinate any diagnostic or pre-admission work-ups. HPHC, at its option, reserves the right to direct or redirect your care to specific HPHC Providers or facilities. Your PCP is responsible for getting HPHC approval for an admission. All you need to do is follow your PCP's instructions. The Plan covers the following inpatient services:

- Semi-private room and board or private room when Medically Necessary
- Doctor visits, including consultation with specialists
- Medications
- Lab and x-ray services
- Intensive care
- Surgery, including related services
- Anesthesia, including the services of a nurse-anesthetist
- Radiation therapy
- Physical therapy, occupational therapy and speech therapy
- Private duty nursing
- Medically Necessary breast reduction surgery and symptomatic varicose vein surgery, as required by Maine law

Specific inpatient care benefits are described below.

a. Inpatient Hospital Care
The Plan covers acute hospital care, including emergency admissions, to the extent Medically Necessary. The number of days covered is listed in your Schedule of Benefits.

b. Rehabilitation Hospital Care
The Plan covers care in a facility licensed to provide rehabilitative care on an inpatient basis. Rehabilitative care includes physical, speech and occupational therapies. The number of days covered is listed in your Schedule of Benefits.

NONGROUP STANDARD “A” PLAN COVERAGE ONLY

You DO NOT have this coverage unless listed on the Schedule of Benefits.

c. Skilled Nursing Facility Care
The Standard A Plan covers care in a licensed skilled nursing care facility or unit on an inpatient basis. Admission to a skilled nursing facility must be within 30 days after a hospital confinement for the same sickness or injury that was the cause of the hospital confinement. Such coverage is provided only when you need daily skilled nursing care that must be provided in an inpatient setting. The number of days covered is listed in your Schedule of Benefits.

RELATED EXCLUSIONS FOR ALL INPATIENT CARE:

- Personal items, including telephone and television charges
- All charges over the semi-private room rate, except when a private room is Medically Necessary
- Rest or Custodial Care
- Charges after your hospital discharge
- Charges after the date on which your membership ends, unless otherwise stated in this Handbook.
3. **OUTPATIENT CARE**

The Plan covers outpatient care that you receive from your PCP. Outpatient care is also covered at a doctor's office, clinic or hospital, upon referral from your PCP to an HPHC Provider.

The only time your care does not need to be provided or arranged by your PCP is in a Medical Emergency, when you are temporarily outside the HPHC Service Area, or if it is one of the special services that do not require a referral. HPHC, at its option, reserves the right to direct or redirect your care to specific HPHC Providers or facilities.

a. **Preventive Care in the Doctor’s Office**

The Plan covers preventive care according to your individual medical needs. Your PCP generally provides these services. Covered preventive care includes: physical examinations; annual gynecological examinations; screening Pap tests, routine pelvic and clinical breast examinations; 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; vision and hearing screening; diagnostic screening and tests; health education; and nutritional counseling. If recommended by the Member’s PCP for Members between ages 50 and 72, HPHC also covers annual digital rectal and a prostate-specific antigen (PSA) test for the early detection of prostate cancer.

1) **Routine Physical Examinations**

The Plan covers routine physical examinations up to the limit described in the Schedule of Benefits. Coverage includes flu vaccinations, mammography screening for women age 40 and over, Pap tests and prostate cancer screening as required by Maine law.

**RELATED EXCLUSIONS:**

- Exams, other than those stated above, including insurance, licensing, and employment exams

2) **Routine Well-Child Physical Examinations**

The Plan covers the following routine physical examinations for Members under the age of 18, up to the limit described in the Schedule of Benefits.

- **First year:** six visits per year
- **Age 1-2:** two visits per year
- **Age 3-17:** 1 visit per year

Coverage includes periodic evaluation of child's physical and emotional status, a history, a complete physical examination, a developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests in keeping with prevailing medical standards.

3) **Eye Examinations**

The Plan covers one routine eye examination each calendar year with an HPHC ophthalmologist or optometrist. You do not need a referral. However, services must be provided by an HPHC Provider.

If you require urgent eye care services, you do not need a referral for up to 2 visits, the initial visit and one follow-up visit, per urgent event. Services must be provided by an HPHC Provider. Urgent eye care services are services provided to treat conditions, illnesses or diseases of the eye that if not treated within 24 hours present a serious risk of harm. A PCP referral is required for any visits after the second urgent eye care visit.

b. **Sick or Injured Care**

The Plan covers care when you are sick or injured. Services include, but are not limited to, injections, radiation therapy, diagnostic tests and x-rays, dressings, sutures, and casting. If you are sick or injured, call your PCP to arrange for the care you need.

c. **Emergency Room Care**

If you are sick or hurt, you must call your PCP before going to an emergency room. The only exceptions are in a Medical Emergency or when you are temporarily outside the HPHC Service Area. HPHC does not require prior authorization for screening and stabilization services for Medical Emergencies. If you need follow-up care after you are treated in an emergency room, you must call your PCP. If you are hospitalized, you must call HPHC within 48 hours of receiving emergency services, or as soon as possible after emergency screening stabilization has taken place. Your PCP will provide or arrange for the care you need.

**RELATED EXCLUSIONS:**

- Follow-up care, unless provided or arranged by your PCP

d. **Diagnostic Lab and X-Rays**

The Plan covers outpatient diagnostic laboratory and x-ray services to diagnose illness, injury, or pregnancy.
The Plan covers screening mammograms and non-routine mammograms. For the purposes of this Handbook, screening mammograms are covered once every 5 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 an HPHC provider when the initial radiologic procedure results are not definitive. Non-routine mammograms are covered when Medically Necessary. Services will be provided at your PCP's office or when directed to an HPHC Provider.

The Plan also covers screening colonoscopy or sigmoidoscopy and any other colorectal cancer examination and laboratory test recommended by an HPHC 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.

e. Physical, Speech, and Occupational Therapies
Outpatient physical, speech and occupational therapies are each covered up to the benefit limit described in the Schedule of Benefits. Services are covered only when needed to improve your ability to perform Activities of Daily Living and when, in the opinion of your PCP, there is likely to be significant improvement in your condition within that time period. Your PCP, or an HPHC Provider will order therapy for you based on your condition and needs.

f. Outpatient Surgery
The Plan covers Day Surgery or minor ambulatory surgery, including related services, provided by an HPHC Provider. Your PCP must refer you for these services. For Day Surgery your PCP must obtain HPHC approval for coverage. The only exceptions apply to the minor ambulatory services that do not require a referral listed in the front of this Handbook.

g. Second Opinions
There may be times when you want a second opinion. We will cover second opinions as long as you have a referral from your PCP, and the second opinions are given by an HPHC Provider.

h. Allergy Treatment
The Plan covers testing, antigens and allergy treatments.

i. Radiation and Chemotherapy
The Plan covers radiation and chemotherapy provided by an HPHC Provider. Your PCP must refer you for these services and obtain HPHC approval for coverage.

4. FAMILY PLANNING SERVICES
a. Family Planning Services
Family planning services are covered when provided by, or upon referral from, your PCP. The following services can be obtained from any HPHC provider without a referral:
- Annual gynecological examination, including routine pelvic and clinical breast examinations
- Family planning consultation
- Evaluation for pregnancy
- Contraceptive monitoring
- Voluntary sterilization, including tubal ligation (Please note: vasectomy requires a PCP referral.)
- Voluntary termination of pregnancy
- Birth control devices, implants and injections

Please see additional services, which do not require a referral described previously in this Handbook.

RELATED EXCLUSIONS:
- Reversal of voluntary sterilization
- Any diagnosis or treatment of infertility when infertility is the only diagnosis, including, but not limited to therapeutic donor insemination, advanced reproductive technologies, any form of surrogacy, infertility treatment related to voluntary sterilization or its reversal

5. MATERNITY AND ROUTINE NEWBORN CARE
You do not need a referral for prenatal care. However, you do need to get this care from an HPHC Provider. An HPHC Provider must make all arrangements for inpatient care. The Plan covers the following outpatient prenatal visits:
- One office visit per month during the first two trimesters or pregnancy
- Two office visits per month during the seventh and eighth month of pregnancy
- One office visit per week during the ninth month and until term. You do not need a referral for prenatal care. However, you do need to get this care from an HPHC
Provider. An HPHC Provider must make all arrangements for inpatient care.

The Plan covers the following services:

- Prenatal exams
- Diagnostic tests
- Diet regulation
- Post-partum care
- 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.);
- Charges for all routine newborn care. Routine newborn care includes, but is not limited to: routine inpatient hospital nursery care for newborns; routine inpatient hospital physician services for the newborn; vaccines and immunizations, vitamins, routine eye care and metabolic screening administered to the newborn prior to discharge. (Routine newborn services are available under either the mother’s policy or the father’s policy consistent with Maine law. Routine newborn services are provided as part of the mother’s maternity benefit without any additional deductible, coinsurance or copayment.)

6. MENTAL HEALTH AND DRUG AND ALCOHOL REHABILITATION SERVICES

If you need mental health care or drug or alcohol rehabilitation services, call the Behavioral Health Access Center at 1-888-777-4742. The phone line is staffed by licensed mental health clinicians. They will assist you in finding appropriate HPHC-contracted providers, and arranging the services you require. The Plan covers inpatient, outpatient and home health care mental health services up to the limits described in the Schedule of Benefits.

Listed below is a detailed breakdown of your coverage:

a. Inpatient Services - Mental Health

- Care in a psychiatric hospital is covered up to the limit described in your Schedule of Benefits.
- Care in a partial hospitalization program is covered up to the limit described in your Schedule of Benefits. Partial hospitalization is an intensive outpatient program that provides coordinated services in a therapeutic setting. Each partial hospitalization day counts as one-half of a psychiatric hospital day and is deducted from the limit described in your Schedule of Benefits available for inpatient services. Partial hospitalization will only be covered if you and your HPHC Provider agree that this treatment is best for you.

b. Inpatient Services - Drug and Alcohol Rehabilitation

- Inpatient rehabilitative care for drug and alcohol abuse is covered up to the limit described in your Schedule of Benefits.
- Care in a partial hospitalization program is covered up to the limit described in your Schedule of Benefits. Partial hospitalization is an intensive outpatient program that provides coordinated services in a therapeutic setting. Each partial hospitalization day counts as one-half of a drug and alcohol abuse hospital day and is deducted from the limit described in your Schedule of Benefits available for inpatient services. Partial hospitalization will only be covered if you and your doctor agree that this treatment is best for you.
- Inpatient detoxification is covered as long as it is Medically Necessary.

c. Outpatient Services - Mental Health and Drug and Alcohol Rehabilitation Services

The Plan covers outpatient mental health care up to the limit described in your Schedule of Benefits.

The Plan covers outpatient drug and alcohol rehabilitation services up to the limit described in your Schedule of Benefits.

Evaluation, diagnosis, treatment and crisis intervention is covered.

d. Outpatient Detoxification and Medication Management Services

The Plan covers outpatient detoxification and medication management services as long as they are Medically Necessary. The Behavioral Health Access Center will refer you for care, as described previously in this Handbook.

e. Home Health Care Services

The Plan covers home health care services up to the limit described in your Schedule of Benefits when the home location is determined to be Medically Necessary. These services are only covered if hospitalization or confinement in a residential treatment facility would otherwise have been required. The services must be prescribed in writing by a licensed physician or psychologist.
f. Psychological Testing
The Plan covers psychological tests when Medically Necessary. The HPHC Provider must refer you for such testing and obtain HPHC approval for coverage.

7. DENTAL SERVICES
The Plan covers only the limited dental services described below. No referral is required. However, you must go to an HPHC Provider.

a. Emergency Dental Care
The Plan covers emergency dental care needed due to an injury to sound, natural teeth. All services, except for suture removal, must be received within 6 months of injury. Only the following services are covered:
- Extraction of teeth needed to avoid infection of teeth damaged in the injury;
- Suturing and suture removal;
- Re-implanting and stabilization of dislodged teeth;
- Re-positioning and stabilization of partly dislodged teeth;
- Medication received from the provider.

The following services are not covered:
- Fillings
- Crowns
- Gum care, including gum surgery
- Braces
- Root canals
- Bridges
- Dentures
- Bonding

b. General Anesthesia for Dentistry
The Plan covers general anesthesia and associated facility charges for dental procedures rendered in a hospital for certain conditions. Your PCP must obtain HPHC approval for coverage. The following conditions are covered:
1) Members, including infants, with physical, intellectual or medically compromising conditions in which general anesthesia is Medically Necessary
2) Members for which local anesthesia is ineffective due to acute infection, anatomic variation or allergy.

3) 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.

4) Members with extensive oral-facial or dental trauma for which local anesthesia would be ineffective or compromised.

Please note: HPHC does not cover the cost of any dental procedures or the dentist’s fee. HPHC covers general anesthesia for dental procedures as noted above.

The following services are not covered:
- Dental services, except the specific dental services listed in this Handbook. Restorative, periodontal, orthodontic, endodontic, prosthodontic, and dental services for temporomandibular joint dysfunction (TMD) are not covered. Removal of impacted teeth to prepare for or support orthodontic, prosthodontic or periodontal procedures and dental fillings; crown; gum care, including gum surgery; braces; root canals; bridges; and dentures, including gum surgery; braces; and bonding.

c. Oral Surgery
The Plan covers the surgical removal of impacted teeth, unerupted teeth and tumors. Pre-operative and post-operative care, x-rays and anesthesia are covered. You do not need a referral. However, services must be provided by an HPHC Provider. The HPHC Providers you can select depend upon where your PCP is located. Please see Section I.A.2.e for more information.

The following services are not covered:
- Removal of impacted teeth to prepare for or support orthodontic, prosthodontic, or periodontal procedures

8. AUTISM SPECTRUM DISORDERS TREATMENT
The Plan covers the following services for the treatment of autism spectrum disorders to the extent required by Maine law:
- Any assessments, evaluations or tests by a licensed physician or psychologist to diagnose whether a Member has an autism spectrum disorder.
- Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain
and restore the functioning of an individual to the extent possible. To be covered by the Plan, applied behavior analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts.

- Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker.
- Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist.
- Prescription drugs in the same manner as provided for the treatment of any other illness or condition if your Plan includes outpatient prescription drug coverage.

A licensed physician or psychologist must determine that the service is Medically Necessary. Such determination must be renewed annually.

For purposes of this section the following terms have defined as follows:

“Applied behavior analysis” means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

“Autism spectrum disorders” means any of the pervasive developmental disorders. As defined by the Diagnostic and Statistical Manual of Mental Disorders, including: autistic disorder, Asperger’s disorder and pervasive developmental disorder not otherwise specified.

9. EARLY INTERVENTION SERVICES

The Plan covers early intervention services for children with an identified developmental disability or delay. Coverage is provided for children from birth up to 3 years of age. The Plan covers up to $3,200 per Member per calendar year, up to a maximum of $9,600 by the child’s third birthday.

Coverage under this benefit is only available for services rendered by the following types of providers:

- Occupational therapists
- Physical therapists

- Speech-language pathologists
- Clinical social workers

10. OTHER SERVICES

a. Home Health Care

The Plan covers home health care services when:

- You are homebound for medical reasons
- Your PCP finds that skilled nursing care or physical therapy is an essential part of active treatment
- There is a defined medical goal that your PCP expects you will meet

When you satisfy all three conditions listed above, the Plan covers the following on a short-term intermittent basis when Medically Necessary:

- Skilled nursing care
- Physical therapy
- Occupational therapy
- Speech therapy
- Durable medical equipment and supplies
- Medical social services
- Nutritional counseling
- Services of a home health aide

Care on a “short-term intermittent basis” means care that is provided (1) fewer than eight hours per day, on a less than daily basis, up to 35 hours per week, or (2) up to 8 hours per day of combined services, for up to 21 consecutive days. If you receive more than one type of skilled service in the home, these time limits apply to all services combined.

Your PCP must arrange all home health care. He or she also must obtain HPHC approval for coverage.

RELATED EXCLUSIONS:

- Continuous or long-term home health services
- Private duty nursing

b. Hospice Services

The Plan covers hospice services for terminally ill Members who need the skills of qualified technical or professional health personnel for palliative care. Care may be provided at home or on an inpatient basis. (Inpatient respite care is covered for the purpose of...
relieving the primary care giver and may be provided up to 5 days every 3 months not to exceed 14 days per calendar year. 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 which cannot be managed in a home setting.)

Covered services include: physician services; nursing care; medical and social services; counseling; care to relieve pain; home health aide services; nutritional counseling; occupational, physical, speech and respiratory therapy; medical supplies; durable medical equipment; drugs which cannot be self administered; volunteer services; bereavement services and respite care.

Your PCP must arrange for all hospice services and obtain HPHC approval for coverage.

c. House Calls
The Plan covers house calls within the HPHC Service Area when your PCP or an HPHC nurse practitioner or physician’s assistant decide that they are Medically Necessary.

d. Durable Medical and Prosthetic Equipment
The Plan covers durable medical equipment including prosthetic devices when Medically Necessary and ordered by an HPHC Provider. HPHC will rent or buy all equipment. HPHC may recover the equipment, excluding prosthetic devices, if your PCP decides you no longer need it or your membership ends. The cost of the repair and maintenance of covered equipment is also covered.

Coverage is only available for:

- The least costly equipment or prosthesis (excluding prosthetic arms and legs) adequate to allow you to do Activities of Daily Living;
- Prosthetic arms and legs which are Medically Necessary and which are the most appropriate model that adequately meets a Member’s medical needs; and
- One item of each type of equipment that meets the Member's need. No back up items or items that serve a duplicate purpose are covered. For example, the Plan covers a manual or an electric wheelchair, not both.

Durable medical equipment and prosthetic equipment is covered up to the limit described in the Schedule of Benefits. The limit does not apply to prosthetic arms and legs, breast prostheses (including replacements and mastectomy bras), respiratory equipment (including oxygen), or durable medical equipment ordered as part of an authorized home health care program. Both the benefit maximum and Copayments are based on the cost of equipment to HPHC.

When you are temporarily outside of the HPHC Service Area, coverage is provided for equipment available under this Handbook only when the need for it cannot be foreseen before leaving the HPHC Service Area. (Please see section I.A.2.d. for more information.)

In order to be covered, all equipment must be:

- Able to withstand repeated use;
- Not generally useful in the absence of disease or injury;
- Suitable for home use; and
- Normally used in the treatment of an illness or injury or for the rehabilitation of an abnormal body part (This does not apply to prostheses).

Covered equipment includes:

- Respiratory equipment
- Certain types of braces
- Oxygen and oxygen equipment
- Hospital beds
- Wheelchairs
- Walkers
- Crutches
- Canes

Covered prostheses include:

- Prosthetic arms and legs, including electronic and myoelectric devices that contain a microprocessor
- Artificial eyes
- Breast prostheses (including replacements and mastectomy bras)
- Ostomy supplies
- Wigs up to the benefit limit described in your Schedule of Benefits for the treatment of alopecia areata, alopecia totalis, hair loss due to the treatment of cancer or leukemia and permanent loss of scalp hair due to injury
The following items are *not* covered:

- Exercise equipment
- Foot orthotics, except when needed to prevent or treat complications of diabetes
- Dentures
- Wigs, except for alopecia areata, alopecia totalis, hair loss due to the treatment of cancer or leukemia and permanent loss of scalp hair due to injury
- Repair or replacement of equipment or devices as a result of loss, negligence, willful damage, or theft
- Any devices or special equipment needed for sports or occupational purposes, except for prosthetic arms and legs
- Prosthetic arms and legs designed exclusively for athletic purposes
- Any home adaptations, including, but not limited to home improvements and home adaptation equipment

**e. Ambulance Transport**

Except in a Medical Emergency, ambulance transport is covered only when arranged by an HPHC Provider. The Plan covers such ambulance transport to the nearest hospital that can provide the care you need. We also cover transfer from one health care facility to another.

**f. Cosmetic Surgery**

For purposes of this Handbook, cosmetic surgery is any procedure to change or restore appearance. Your PCP will refer you to an HPHC Provider for such surgery. Your PCP must also obtain HPHC approval for coverage. The Plan covers cosmetic surgery only to repair severe disfigurement due to an injury or disease or birth defect.

**g. Kidney Dialysis**

The Plan covers kidney dialysis on an inpatient or outpatient basis, or at home. You must apply for Medicare when federal law permits Medicare to be the primary payer for dialysis. You must also pay any Medicare premium. When Medicare is primary (or would be primary if the Member were timely enrolled) the Plan will cover services only to the extent payments would exceed what would be payable by Medicare.

Your PCP must make all arrangements for dialysis care. Coverage for dialysis in the home includes nondurable medical supplies, drugs and equipment necessary for dialysis. Installation of home equipment is covered up to $300 per calendar year.

If you are temporarily outside the Service Area, the Plan covers dialysis services when approved by HPHC for up to one month per calendar year. You must make prior arrangements with your PCP.

**h. Human Organ Transplants**

The Plan covers Medically Necessary human organ transplants, including bone marrow transplants. Your PCP will refer you to an HPHC Provider for such care. Your PCP must obtain HPHC approval for coverage.

The Plan covers the following services when the recipient is a Member of the Plan:

- Care for the recipient
- Donor search costs through established organ donor registries
- Donor costs that are not covered by the donor's health plan

If a Member is a donor for a recipient who is not a Member, then the Plan will cover the donor costs for the Member, when they are not covered by the recipient's health plan.

**i. Special Formulas and Low Protein Foods**

The Plan covers the following to the extent required by Maine law:

1) Metabolic formulas prescribed by a licensed physician for a person with an inborn error of metabolism

2) Amino acid-based elemental infant formula for children two years of age and under without regard to the method of delivery of the formula to the extent Medically Necessary as defined below. Coverage will be provided when a licensed physician has diagnosed, and through medical evaluation has documented, one of the following conditions:

- Symptomatic allergic colitis or proctitis
- Laboratory or biopsy-proven allergic or eosinophilic gastroenteritis
- A history of anaphylaxis
- Gastroesophageal reflux disease that is non-responsive to standard medical therapies
- Severe vomiting or diarrhea resulting in clinically significant dehydration requiring medical treatment
• Cystic fibrosis
• Mal absorption of cow milk-based or soy milk-based infant formula

In addition to meeting the conditions stated in the definition of Medically Necessary, amino acid-based elemental infant formula will be considered Medically Necessary when the following conditions are met:
• The amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater; and
• Other commercial infant formulas including cow milk-based and soy milk-based formulas have been tried and have failed or are contraindicated

HPHC may require that a licensed physician confirm and document at least annually that the formula remains Medically Necessary.

3) Special modified low protein food products prescribed by a licensed physician for a person with an inborn error of metabolism. The coverage is limited to the amount described in the Schedule of Benefits.

The following services are not covered:
• Non-prescription enteral formulas, except as required by Maine law

j. Diabetes Treatment
The Plan covers the following:
• insulin
• oral agents for controlling blood sugar
• blood and urine test strips
• needles and syringes
• lancets
• blood glucose monitors
• insulin pumps and infusion devices
• therapeutic and molded shoes and inserts when needed to prevent or treat complications of diabetes
• dosage gauges, injectors, voice synthesizers and visual magnifying aids

You must get a prescription from your PCP and present it at an HPHC participating pharmacy for insulin, oral agents, test strips, needles, standard syringes, and lancets. A list of HPHC participating pharmacies is available from the Member Services Department. Your PCP will order other equipment through a medical supply vendor.

The Plan also covers outpatient diabetes self-management training and education programs provided by the ambulatory diabetes education facilities authorized by the Diabetes Control Project within the Bureau of Health.

k. Breast Cancer Treatment
The Plan covers breast cancer treatment, including prostheses and the following services.
• Inpatient care for a mastectomy, a lumpectomy or a lymph node dissection is covered for a period of time determined to be medically appropriate by the attending physician, in consultation with the Member.
• If the Member elects breast reconstruction following mastectomy surgery, the Plan covers reconstruction in the manner chosen by the Member and the physician. Coverage includes reconstruction of the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance.
• Physical complications for all stages of mastectomy, including lymphedemas are covered in a manner determined in consultation with the attending physician and the Member.

l. Cardiac Rehabilitation
The Plan covers cardiac rehabilitation. Coverage includes only Medically Necessary services for Members with established coronary artery disease or unusual and serious risk factors for such disease.

m. Chiropractic Care/Treatment by Adjustment or Manipulation
The Plan covers Medically Necessary chiropractic services for musculoskeletal conditions. The following services are covered:
• Initial diagnostic x-ray
• Care within the scope of standard chiropractic practice

In the event you require immediate treatment for sudden, severe pain or accidental injury that affects your ability to engage in activities of normal daily
living, you may consult with an HPHC-contracted chiropractic provider without a referral from your PCP. HPHC's contracted chiropractors are listed in the provider directory. The coverage provided is as follows:

- Treatment is covered for up to 3 weeks after the injury or onset of pain, or up to 12 visits, whichever comes first. If no improvement occurs after 3 weeks or 12 visits, treatment should be stopped and you should contact your PCP.

- If your condition has improved and if recommended by the chiropractor, treatment is covered for up to 5 additional weeks or up to 12 additional visits, whichever comes first.

- If pain recurs and subsequent treatment is necessary, no more than 36 visits will be covered for chiropractic care in a 12-month period without prior authorization from HPHC. For such extended chiropractic care, HPHC, at its option, may direct or redirect your care.

If the chiropractor fails to send a report to the Member's PCP as required by Maine law, neither HPHC nor the Member are liable for payment of the provider's fees.

The following services are not covered:

- Care outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, treatment of infectious disease

- Diagnostic testing after the initial X-ray, unless Medically Necessary

n. Coverage During Approved Clinical Trials

HPHC provides coverage for Medically Necessary care provided to a Member who is participating in an approved clinical trial. Coverage includes Medically Necessary services or devices that are not covered by the sponsors of the clinical trial. Your PCP must provide you with a referral for these services.

The above coverage is will be provided if:

1) the clinical trial is approved by the National Institute of Health (NIH) or an NIH cooperative group or center, or the federal Department of Health and Human Services.

2) the Member’s PCP determines that the Member’s participation in the clinical trial is appropriate based upon the following conditions:

a. the Member has a life-threatening illness for which no standard treatment is effective,

b. the Member is eligible to participate according to the clinical trial protocol with respect to treatment of such illness, and

c. the Member’s participation in the trial offers meaningful potential for significant clinical benefit to the Member.

The following services are not covered:

- Transportation other than by ambulance.

- Any services not specified in this Handbook and Schedule of Benefits.

- Any services or devices reasonably expected to be paid for by the sponsors of the approved clinical trial.

- Costs of tests or measurements conducted primarily for the purpose of the clinical trial.

o. Hearing Aids

The Plan covers the purchase of hearing aids for each hearing impaired ear for Members through the age limit required by Maine Law*, in accordance with the following conditions:

- The Member’s hearing loss must be documented by a physician or state-licensed audiologist.

- The hearing aid must be purchased from a state licensed audiologist or hearing aid dealer.

*Effective January 1, 2008, hearing aid coverage is provided for Members from birth through age 5. Effective January 1, 2009, hearing aid coverage is provided for Members from birth through age 13. Effective January 1, 2010 and thereafter, hearing aid coverage is provided for Members from birth through age 18.

Coverage of hearing aids is provided up to the benefit limit stated in your Schedule of Benefits. Please see your Schedule of Benefits for benefit details.

p. Telemedicine Services

The Plan covers Medically Necessary telemedicine services for the purpose of diagnosis, consultation or treatment in the same manner as an in-person consultation between you and your HPHC 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 HPHC Providers.
Cost sharing for telemedicine services is the same as the cost sharing for the same type of service if it had been provided through an in-person consultation. Please refer to your Schedule of Benefits for specific information on cost sharing you may be required to pay.

**The Plan does not cover the following:**

- 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

11. **GENERAL EXCLUSIONS**

**The Plan does not cover the following:**

- A Member's Pre-Existing Condition for the first 12 months following the membership effective date, except to the extent the condition was covered under the Member’s previous health coverage, or would have been covered under the Member’s previous health coverage if not for the operation of a lifetime benefit limit on all benefits, and coverage was in effect within the 90 days prior to the effective date of coverage under this Handbook.

- Cosmetic surgery, except as specified in Section I.B.8.f. in this Handbook.

- Sex change surgery.

- Dental services or supplies, except the specific dental services listed in this Handbook.

- Treatment for temporomandibular joint dysfunction (TMD).

- Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests, which are Experimental, Unproven, or Investigational

- Eyeglasses, contact lenses, radial keratotomy, and eye refraction, or any examination or fitting related to these devices.

- Routine foot care services.

- Custodial Care.

- Services for which no charge would be made in the absence of insurance.

- Services and supplies not administered or ordered by a physician or other covered professional.

- Diagnosis or treatment of infertility when infertility is the only diagnosis.

- Work-related injuries or illness, 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.

- Services or supplies furnished by any institution owned or operated by any federal, state, county, or municipal government.

- Expenses that are or could be recovered through any federal, state, county, or municipal law, other than Medicaid.

- Services that are provided by immediate family members.

- Losses which are due to war or any act of war, whether declared or undeclared.

- Services related to intentionally self-inflicted injury or illness.

- Telemonitoring, telemedicine services involving e-mail, fax, or audio-only telephone, telemedicine services involving stored images forwarded for future consultation, i.e. “store and forward” telecommunication

- Services provided to a Member with autism spectrum disorders under an individualized education plan or an individualized family service plan.

**The Nongroup Standard B Plan also excludes coverage for the following additional service unless otherwise stated on your Schedule of Benefits:**

- Skilled Nursing Facility Care.
C. STUDENT DEPENDENT COVERAGE

When your Dependent child goes to school away from home he or she may continue to receive Plan benefits. The Plan coverage works one of two ways for student Dependents, depending on where they go to school.

Your Dependent child must meet the eligibility criteria set forth in Section I.G.1.c.3 in order to continue his or her coverage as a student Dependent. HPHC may require reasonable evidence that a Member meets the requirements in Section I.G.1.c.3.

1. STUDENTS INSIDE THE HPHC ENROLLMENT AREA

If your Dependent child goes to school inside the HPHC Enrollment Area, then he or she can choose an HPHC PCP near school. This PCP manages your child’s care just as your PCP does for you.

The HPHC Enrollment Area is where Members, except for a child going to school, must live to be eligible for enrollment. The Enrollment Area includes all the places where HPHC Providers are available to care for Members. You may obtain a list of the cities and towns along with a map of the current Enrollment Area from Member Services. HPHC may revise the Enrollment Area from time to time.

2. STUDENTS OUTSIDE THE HPHC ENROLLMENT AREA

If your child goes to school outside the HPHC Enrollment Area, the Plan provides special coverage. This is because there are no nearby HPHC PCPs who can manage your child’s care while he or she is going to school.

This special coverage allows benefits for care that could have been foreseen before your child left the HPHC Service Area. It also provides different benefits for outpatient mental health services. All the rules and limits on coverage listed in this Benefit Handbook apply to these benefits, except that your Dependent child does not need to get care through his or her PCP.

PLEASE NOTE: YOUR DEPENDENT CHILD IS ENTITLED TO ALL THE BENEFITS IN THIS HANDBOOK WHEN HE OR SHE RETURNS TO THE ENROLLMENT AREA AND RECEIVES CARE FROM HPHC PROVIDERS.

a. Benefits for Out-of-Area Student Coverage

For student Dependents who attend school outside the Enrollment Area, the Plan covers the following services when Medically Necessary and related to a specific illness or condition. Copayments and Coinsurance (if any) will be applied as listed in the Schedule of Benefits.

1. Outpatient Services

The Plan covers all outpatient services listed in this Handbook and the Schedule of Benefits, other than mental health care that is described below, except the following:

a) Routine examinations and preventive care, including immunizations;

b) Preventive dental care and the extraction of impacted teeth, if covered benefits;

c) Home health care, including maternity home care programs and house calls;

d) Maintenance or replacement of prosthetic devices or durable medical equipment;

e) Cosmetic surgery;

f) Elective outpatient surgical procedures; and

g) Second opinions.

2. Inpatient Services

The Plan covers inpatient services listed in this Handbook and the Schedule of Benefits, except for elective procedures. Elective procedures are services that can be delayed until your child’s return to the Enrollment Area without permanent damage to his or her health. The Member must call his/her PCP and HPHC within 48 hours of hospitalization. The telephone numbers are on your ID card.

3. Mental Health and Drug and Alcohol Abuse Services

Student Dependents who attend school out-of-area may be covered for up to 8 outpatient mental health visits to non-participating providers outside the Service Area. These eight visits count against the in-area 40-visit outpatient mental health limit. These visits are in addition to, and do not limit, coverage inside the Enrollment Area for biologically based mental illnesses (if the Rider is purchased) and coverage outside the Enrollment Area for emergency and urgent care.
D. REIMBURSEMENT AND CLAIMS PROCEDURES

The information in this section applies when you receive services from a non-HPHC Provider. Generally, this would happen only when you get care:

• In a Medical Emergency; or

• When you are temporarily outside the HPHC Service Area.

In most cases, you should not receive bills from an HPHC Provider.

1. BILLING BY PROVIDERS

If you get a bill for a covered service you may ask the provider to:

1) Bill us on standard health care claim forms (such as the CMS 1500 or the UB-82/92 form); and

2) Send it to us at the address listed on the back of your HPHC ID card.

2. REIMBURSEMENT FOR BILLS YOU PAY

If you pay a provider for a covered service, send receipts from the provider, which show proof of payment.

Here is the information we need to process your claim:

1) The Member's full name;

2) The Member's date of birth;

3) The Member's Plan ID number (on the front of the patient's HPHC ID card);

4) The date the service was rendered;

5) A brief description of the illness or injury; and

6) For pharmacy items, a drug receipt stating: the Member’s name and Plan ID number, the name of the drug or medical supply, the drug NDC number, the quantity, the number of day’s supply, the date the prescription was filled, the prescribing physician’s name, the pharmacy name and address, and the amount paid. Pharmacy reimbursements should be sent to:

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

Members may contact the MedImpact help desk at 1-800-788-2949 for assistance with pharmacy claims.

Please note that we may need more information for some claims. If you have any questions about claims, please call our Member Services Department.

3. LIMITS ON CLAIMS

To be eligible for payment, we must get 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.

We limit the amount we will pay for covered services that are not rendered by HPHC Providers. The most we will pay for such services is the Usual, Customary and Reasonable Charge. You will have to pay the balance if the claim is for more than the Usual, Customary and Reasonable Charge. Please contact the HPHC Member Services Department at 1-888-333-4742 if you have questions concerning coverage.
E. HPHC UTILIZATION AND CASE MANAGEMENT SERVICES

HPHC provides utilization and case management services, to assure quality care in the hospital and other health care settings. The utilization management program uses a clinical review staff, who works with your physicians, to evaluate the medical appropriateness of admissions and to determine how long you should stay in the hospital. Additionally, HPHC nurse case managers evaluate the appropriateness of care and assist your PCP to coordinate needed services for continued care at home or on an outpatient basis.

The case management program identifies those Members who are likely to benefit from focused medical planning because they need complex, costly or long-term health care services. The nurse case managers may identify Members with these special needs when they first learn of a scheduled hospitalization or while a Member is hospitalized. A PCP may also request case management services for a Member at other times. The nurse case managers will assist your PCP in managing your short and long-term health care needs throughout the different health care settings.

During the pre-authorization period or upon admission to the hospital, a nurse case manager determines if you are a likely candidate for discharge planning or if you have special case management needs. While you are in the hospital, the nurse continues to review the care you receive for quality and medical appropriateness. The nurse case managers use medical records, progress notes, hospital discharge planning services, as well as patient and physician interaction to help plan your discharge and make the best use of all available medical resources.

Your PCP remains responsible for coordinating all aspects of your medical and health care needs. He or she will coordinate all necessary referrals to specialists and obtain HPHC authorization when required.

If the pre-authorization requirements are not followed and services are rendered, the care given will be reviewed after your discharge from the health care provider by clinical staff. The reviewer will verify that your PCP, attending physician and other health care providers had the intention to have the service authorized, as well as evaluate the medical appropriateness and the quality of care.

Determination of Medical Necessity is made by HPHC clinical staff and is based on the Member’s medical condition, accepted medical practice and appropriateness of care. (Please see definition in Glossary.) All denial of coverage determinations based on Medical Necessity are initially communicated verbally to the health care provider, then followed up in writing to the member and health care provider(s). The letter 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. Additionally, Members will receive written notification of any denial of coverage that is based on non-covered benefits or benefit limits, which have been reached.

For more information on the process for appealing an Adverse Utilization Determination, please see Section F, Appeals and Complaints.
F. APPEALS AND COMPLAINTS

1. BEFORE YOU FILE AN APPEAL

From time to time, claim denials result from a misunderstanding with a provider, incorrect information on the claim form or a claim processing error. Since these problems can be easy to resolve, we recommend that you contact an HPHC 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.

2. HPHC MEMBER APPEAL PROCEDURES

If you are dissatisfied with a decision on the Plan’s coverage of services, you may appeal to HPHC. We have established the following steps to ensure that you receive a timely and fair review of your appeal. If you are deaf or hard of hearing or visually impaired, you may request grievance 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.

a. 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:

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

Telephone: 1-888-333-4742
FAX: 1-617-509-3085

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

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, HPHC utilizes mediation to resolve some coverage disputes. Both HPHC and you must agree to mediation. Your Appeal Coordinator will inform you if we feel that your appeal is appropriate for mediation.

b. 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 20 working days. If we cannot reasonably meet the 20 day time frame due to an inability to obtain necessary information from non-participating 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 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 of such telephone call.

If HPHC denies 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) the reviewers’ decision and the basis for that decision; (4) a reference to the evidence or documentation used as the basis for the decision; (5) 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; (6) a description of the process to obtain a second level review; and (7) a description of the process to obtain an independent external review.

3. INDEPENDENT EXTERNAL REVIEW OF APPEALS

Appeal decisions involving an Adverse Utilization Determination by HPHC are eligible for review by an independent review organization designated by the Maine Bureau of Insurance. In most cases you are required to complete HPHC’s first and second level appeals process to be eligible for external review. However, this requirement does not apply if (1) HPHC has failed to make a decision on your first or second level appeal in the timeframes noted above; (2) you and HPHC mutually agree to bypass the HPHC Member appeals process; (3) your life or health is in jeopardy; or (4) the Member for whom external review is requested has died.

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 HPHC’s 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 HPHC. 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 any HPHC 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. Such 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.

HPHC will pay the fees of the independent review organization for conducting the review. If the independent review organization decides in your favor, HPHC will cover the services approved.

4. MEMBER COMPLAINTS

If you have any complaints about your care under the Plan or about HPHC’s 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:

Member Services Department  
HPHC Insurance Company  
1600 Crown Colony Drive  
Quincy, MA 02169  
Telephone: 1-888-333-4742

For a complaint involving mental health and drug and alcohol rehabilitation services, please call or write to us at:

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)
G. ELIGIBILITY

1. MEMBER ELIGIBILITY

a. Residence Requirement

To be eligible for coverage under this Plan, you must live, and maintain a permanent residence, within the State of Maine at least six months of a year. (A dependent child satisfies the residency requirements if at least one of the parents or legal guardian is domiciled in the State of Maine.)

This does not apply to a Dependent child who is enrolled as a Dependent child under a Qualified Medical Support Order.

If you have any questions about these requirements, you may call the HPHC’s Member Services Department. They can give you a current list of the cities and towns in the Enrollment Area. For further information, please see section I.l.c.

b. Member Eligibility

To be a Member under this Plan you must:

1) (a) be eligible for enrollment in accordance with the requirements for conversion from HPHC membership through an employer group; or (b) be a dependent of an eligible Subscriber as defined in this document; or (c) be accepted through direct application to HPHC; or (d) be a Federally Eligible Individual as required by Maine law

2) be up-to-date in the payment of the applicable premium for coverage

c. Dependent Eligibility

A Dependent must meet one of the requirements for coverage listed below to be eligible for coverage under the Plan:

1. The legal spouse of the Subscriber.

2. A child (including an adopted child or stepchild) of the Subscriber or spouse of the Subscriber until the child’s 26th birthday.

3. An unmarried 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. An unmarried 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.

d. Dependent of a Non-Subscriber

A “Non-Subscriber” is a person eligible to enroll as a Subscriber who has chosen not to do so. As required by Maine law, a Dependent (as defined by Section G.1.c) of a Non-Subscriber is eligible for coverage when:

1.) The non-Subscriber satisfies the eligibility requirements in Section G.1.b; and

2.) The Non-Subscriber accepts financial responsibility for required payments under this Benefit Handbook.

HPHC may require provision of reasonable evidence of eligibility from time to time.

2. EFFECTIVE DATE – NEW DEPENDENTS

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

1) Marriage;

2) Birth;

3) Adoption;

4) Legal guardianship; or

5) The Subscriber becoming legally responsible for a Dependent's health care coverage.

HPHC must receive notice of the addition within 60 days of the effective date. The addition of new Dependents may change the Subscriber's membership from Individual Coverage to Family Coverage. If HPHC is not notified within 60 days of the effective date, Dependents may be added only on the Anniversary Date.

3. EFFECTIVE DATE – EXISTING DEPENDENTS

You may add existing Dependents: (a) on the Anniversary Date; (b) when you change from Individual to Family Coverage to add a new Dependent; or (c) within 30 days of when such existing Dependent involuntarily loses coverage under a previous health insurance due to termination of
employment, the termination of the previous health insurance, or the death of spouse or divorce, or when a court has ordered coverage to be provided for your health plan.

4. **EFFECTIVE DATE – OFF-CYCLE ENROLLMENT**

Under the Health Insurance Portability and Accountability Act or Maine law, individuals may enroll in the Plan at any time if: 1) the employee’s spouse or eligible dependent has lost other insurance; 2) the employee marries; 3) the employer contribution toward their coverage were terminated; 4) the employee has a newborn or adoptive child; or 5) a court order is issued changing custody of a child. The employee must make written request for enrollment within thirty (30) days of one of these qualifying events. For reason 1, the effective date must be no later than the date of HPHC’s receipt of the completed enrollment application. For reasons 2 and 3, the effective date must be no later than the first day of the month following HPHC’s receipt of the enrollment request. For reason 4, the new child’s effective date must be the date of birth in the care of a newborn Dependent, or in the case of adoptive Dependent, the effective date must be the date of adoption or placement for adoption. For reason 5, the effective date must be the date specified in the court order.

5. **EFFECTIVE DATE – ADOPTIVE DEPENDENTS**

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

6. **CHANGE IN STATUS**

It is your responsibility to inform your HPHC of all changes that affect Member eligibility. These changes include address changes; marriage of a Dependent; death of a Member; and when a Dependent is no longer enrolled in an accredited educational institution on a full-time basis. Please note that HPHC must have your current address on file in order to correctly process claims for care outside the HPHC Service Area.

7. **PERIODIC PREMIUM PAYMENTS**

a. When converting from HPHC employer group coverage, the Subscriber must pay the appropriate premium. Payment must be received by HPHC within 30 days of the last date of employer group coverage. The Subscriber must pay each subsequent bill by the due date.

b. When enrolling directly into The Harvard Pilgrim HMO for Non-group Members, the Subscriber must pay the appropriate premium. Payment must be received by HPHC by the date specified. The Subscriber must pay each subsequent bill by the due date.

c. Only the Members for whom HPHC received payment are entitled to covered benefits. Coverage is only for the period to which the payment applies.

d. Termination of membership under this subsection shall not take place until a premium payment is 31 days overdue, unless it is the first payment or the Member has given notice of termination of the Handbook. If HPHC does not receive the required payment by the due date coverage for the Subscriber and Family Dependents will be terminated as of the last day of the period for which payment was received.
H. TERMINATION AND CONVERSION

1. TERMINATION BY THE SUBSCRIBER
   You may end your membership under this Handbook at any time. We must receive notification in writing within 15 days of the date you want your membership to end. HPHC will refund you any premiums paid for coverage beyond the termination date.

2. TERMINATION FOR LOSS OF ELIGIBILITY
   HPHC may end a Member's coverage under this Handbook for failing to meet any of the specified eligibility requirements.

   You will be notified if non-group coverage is ending for loss of eligibility. We will inform you in writing.

3. MEMBERSHIP TERMINATION FOR CAUSE
   HPHC may end this Handbook and a Member's coverage for any of the following causes:

   • Providing false or misleading information on an application for membership;

   • The failure to make the required Copayments or Coinsurance payments;

   • Committing or attempting to commit fraud to obtain benefits for which the Member is not eligible under this Handbook;

   • Obtaining or attempting to obtain benefits under this Handbook for a person who is not a Member; or

   Notice of termination of membership for providing false information shall be effective immediately upon notice to a Member. Notice of termination of membership for the other causes will be effective 15 days after notice. Premium paid for periods after the effective date of termination will be refunded.

4. DEPENDENT CONVERSION TO NON-GROUP COVERAGE
   Dependents who are no longer eligible for coverage under this Handbook due to age, marriage, or loss of dependency status are eligible to convert to a separate non-group plan as long as you:

   a. Send us notice that you are applying to convert within 30 days of the last day of eligibility as a Dependent;

   b. Maintain residence within the State of Maine and live there at least 6 months of the year;

   c. Were not terminated from membership in HPHC for cause, as listed in this Handbook; and

   d. Pay the non-group premium for the period starting with the date Dependent coverage ends.

   The non-group premium must be received by HPHC within 14 days after the HPHC acceptance letter is received by the new Member.
I. WHEN YOU HAVE OTHER COVERAGE

This section explains how benefits under this Benefit Handbook will be coordinated with other insurance benefits available to pay for health services that a member has received. Benefits are coordinated among insurance carriers to prevent duplicate recovery for the same service. Nothing in this section should be interpreted to provide coverage for any service or supply that is not expressly covered under this Handbook or to increase the level of coverage provided.

1. BENEFITS IN THE EVENT OF OTHER INSURANCE

Benefits under this Handbook and Schedule of Benefits will be coordinated to the extent permitted by law with other plans covering health benefits, including: motor vehicle insurance, medical payment policies, home owners insurance, governmental benefits (including Medicare), and all Health Benefit Plans. The term "Health Benefit Plan" means all HMO and other prepaid health plans, medical or hospital service corporation plans, commercial health insurance, self-insured health plans, and other insurance plans with coverage for health care or services. There is no coordination of benefits with Medicaid plans or with hospital indemnity benefits amounting to less than $100 per day.

Coordination of benefits will be based upon the Usual, Customary and Reasonable Charges 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 such services will be used as the basis for coordination. No duplication in coverage of services shall occur among plans.

When a Member is covered by two or more Health Benefit Plans, one plan 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 shall decide which Health Benefit Plans are primary or secondary:

a. 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.

b. 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 rule in this plan (the "birthday rule") will determine the order of benefits.

c. Dependent Child/Separated or Divorced Parents

Unless a court order, of which HPHC has knowledge, 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; and

3) Finally, the plan of the parent not having custody of the child.

d. 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.

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

If a Member is 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.

2. PROVIDER PAYMENT WHEN THE PLAN COVERAGE IS SECONDARY

When a Member's Plan coverage is secondary to a Member's coverage under another Health Benefit Plan, HPHC may suspend payment to a provider of services
4.  SUBROGATION

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 up to 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 will also be entitled to recover from a Member up to 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. All subrogation payments made under this Section shall be made on a just and equitable basis meaning 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.

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 under this Handbook.

5.  MEDICAL PAYMENT POLICIES

For Members who are entitled to benefits under the medical payment benefit of a motor vehicle, motorcycle, boat, homeowners, hotel, restaurant or other insurance policy, such coverage shall become primary to the coverage under this Handbook for services rendered in connection with a covered loss under that policy. 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.

6.  MEMBER COOPERATION

The Member agrees to cooperate with HPHC in exercising its rights of subrogation and coordination of benefits under this Handbook. HPHC agrees that subrogation payments will be made on a just and equitable basis. Member 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 and 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. The Member further agrees to do nothing to prejudice or interfere with HPHC's rights to subrogation or coordination of benefits.

Failure of the Member to perform the obligations stated in this Subsection shall render the Member liable to HPHC for any expenses HPHC may incur, including reasonable attorney’s fees, in enforcing its rights under this Handbook.

7.  HPHC'S RIGHTS

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

8.  MEMBERS ELIGIBLE FOR MEDICARE

For a Member who is eligible for Medicare by reason of End Stage Renal Disease, HPHC will be the primary payer for covered services during the "coordination period" specified by federal regulations at 42 CFR Section 411.62. Thereafter, Medicare will be the primary payer. When Medicare is primary (or would be primary if the Member were timely enrolled) HPHC will pay for services only to the extent payments would exceed what would be payable by Medicare.
J. ADMINISTRATION OF BENEFIT HANDBOOK

1. COVERAGE WHEN MEMBERSHIP BEGINS WHILE HOSPITALIZED

   a. General Coverage Rules

      There are times when Plan membership begins when the Member is already hospitalized. This can happen when:

      • Your Employer Group terminates your coverage and you select HPHC non-group conversion coverage;

      • The Subscriber selects the Plan coverage; or

      • Your child is born.

      We cover such hospitalization from the time membership is effective. However, to obtain coverage, you must call both your PCP and HPHC and allow us to manage your care. (This may include transfer to a Plan-affiliated hospital, if medically appropriate.)

   b. Newborn Coverage

      1) Coverage for a newborn child is effective from the moment of birth for up to 31 days. Coverage includes the covered benefits in this Handbook, including Medical Emergency services and covered services when the child is temporarily outside of the HPHC Service Area. No coverage is provided after the 31-day period, unless the Subscriber obtains Family Coverage within 60 days of the date of birth.

      2) When a newborn child is a Member, but either the mother is not a Member or an HPHC Provider did not perform the delivery, newborn services are covered only if:

         • The child is born in the Enrollment Area; and

         • HPHC is called within 48 hours of delivery to allow an HPHC PCP to manage the baby's care.

      <Note: Generally newborn coverage is bundled with the mother’s maternity coverage. When the mother is not an HPHC member, HPHC needs to be put on notice of the 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.>

   c. Coverage for Dependents Enrolled Under a Qualified Medical Support Order (QMSO) Who Live Outside the Enrollment Area

      Dependents enrolled under a Qualified Medical Support Order (QMSO) who live outside of the HPHC Enrollment Area are eligible for coverage only for services required in a Medical Emergency as described in Section I.A.2.d., above. The benefits available to Members temporarily traveling outside the Service Area, described in Section I.A.2.e., above, are not available to Members who live outside of the Enrollment Area. However, Members who live outside the Enrollment Area may obtain full coverage for the benefits provided under this Handbook from HPHC Providers within the Enrollment Area.

2. MISSED APPOINTMENTS

   Providers may charge you the Copayment for appointments you miss, if you do not cancel before the scheduled appointment, unless it was not physically possible for you to do so. You can call the provider to find out how much advance notice is needed to cancel an appointment. The Plan will not count missed appointments toward any benefit limits.

3. DISAGREEMENT WITH RECOMMENDED TREATMENT

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

4. LIMITATION ON LEGAL ACTIONS

   Any legal action against HPHC for failing to provide covered services must be brought within 2 years of the denial of any benefit. This does not apply to actions for medical malpractice.

5. LIMITS FOR PRE-EXISTING CONDITIONS

   A Copayment of 100% of the costs may be applied to all covered services for a Member's Pre-Existing Condition, as defined below. The Copayment may apply to covered services for the Pre-Existing Condition for the first 12 months of a Member's coverage. The Pre-Existing condition limit does not apply to federally eligible individuals as defined under Maine law.
A Pre-Existing Condition is any physical or mental condition for which medical advice was received or recommended or which caused, or would cause, an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the twelve months immediately preceding the effective date of coverage. Medical advice is considered to be given if a mental or physical condition is identified or recognized by a physician or other health care provider. A mental or physical condition is considered to have been treated if any services of a physician or other health care provider have been received, or a pregnancy exists on the effective date of coverage. However, if the condition was covered under the Member’s previous health coverage, or would have been covered under the Member’s previous health coverage if not for the operation of a lifetime benefit limit on all benefits, and coverage was in effect within the 90 days prior to the effective date of coverage under this Handbook, then the medical condition will not be subject to the limits of this section.

6. LIMIT ON COPAYMENTS

There may be limits on the Copayments that you must pay under this Benefit Handbook for certain combinations of services. Please see the Schedule of Benefits for limits on inpatient or office visit copayments.

7. ACCESS TO INFORMATION

The Member agrees that, except where restricted by law, HPHC may have access to (1) all health records and medical data from health care providers covered under this Handbook and (2) information concerning health coverage or claims from all providers of motor vehicle insurance, medical payment policies, home-owners insurance and all types of health benefit plans. HPHC 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 services.

8. CONFIDENTIALITY

HPHC is committed to ensuring and safeguarding the confidentiality of its members’ personal and medical information. HPHC staff access, use and disclose members’ personal information only in connection with providing services and benefits and in accordance with HPHC’s confidentiality policies. HPHC permits only designated employees, who are trained in the proper handling of member information, to have access to and use of your information. HPHC sometimes contracts with other organizations or entities to assist with the delivery of care or administration of benefits. Any such entity must agree to adhere to HPHC’s confidentiality and privacy standards.

When you enrolled with HPHC, you consented to disclosures which are necessary for the provision and administration of 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. When HPHC uses or discloses your personal information, it does so using the minimum amount of information necessary to accomplish the specific activity.

HPHC discloses its members’ personal information only: (1) in connection with the delivery of care or administration of benefits, such as utilization review, quality assurance activities and third-party reimbursement by other payers, including self-insured employer groups; (2) when you specifically authorize the disclosure; (3) in connection with certain activities allowed under law, such as research and fraud detection; (4) when required by law; or (5) as otherwise allowed under the terms of your Benefit Handbook. Whenever possible, HPHC discloses member information without member identifiers and in all cases only discloses the amount of information necessary to achieve the purpose for which it was disclosed. HPHC 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, HPHC and all of its contacted health care providers agree to provide members’ access to, and a copy of, their medical records upon a member’s request. In addition, your medical records cannot be released to a third party without your consent or unless permitted by law.

9. NOTICE

Any notice to a Member will be sent to the last address of the Member on file with HPHC. Notice to HPHC should be sent to 1600 Crown Colony Drive, Quincy, MA 02169.

Premium rate information is available from your Harvard Pilgrim Health Care by calling Member Services.

10. MODIFICATION OF THIS HANDBOOK

This Benefit Handbook, Schedule of Benefits, Prescription Drug Brochure and applicable Riders, may be amended by HPHC upon thirty (30) days written notice to you. Amendments do not require the consent of Members.
This Benefit Handbook, including the Schedule of Benefits, Prescription Drug Brochure and applicable Riders, is the entire contract between you and HPHC. It can only be modified in writing by an authorized officer of HPHC. No other action by HPHC, including the deliberate non-enforcement of any benefit limit shall be deemed to waive or alter any part of this Handbook.

11. RELATIONSHIP OF HPHC PROVIDERS AND HPHC

The relationship of HPHC to providers, other than Plan employees, is governed by separate agreements. They are independent contractors. Such providers may not modify this Handbook or Schedule of Benefits brochure, Prescription Drug Brochure, or any applicable Riders, or create any obligation for HPHC. HPHC is not liable for statements about this Handbook by them, their employees or agents. HPHC may change its arrangements with service providers, including the addition or removal of providers, without notice to Members.

For any questions regarding this Handbook, Members may contact HPHC at 1-888-333-4742.

12. MAJOR DISASTERS

HPHC will try to provide or arrange for services in the case of major disasters. However, if HPHC cannot provide or arrange services due to a major disaster, HPHC is not responsible for the costs or outcome of its inability. For purposes of this Handbook, major disasters may include acts of war, riot, epidemic, public emergency or natural disaster. Other causes include the partial or complete destruction of HPHC Facility(ies) or the disability of service providers.

13. EVALUATION OF NEW TECHNOLOGY

The Plan covers medical devices; diagnostic, medical and surgical procedures and drugs as described in your Benefit Handbook, Schedule of Benefits, and if applicable, your Prescription Drug Brochure. This includes new devices, procedures and drugs, as well as those with new applications, as long as they are not Experimental, Unproven, or Investigational.

HPHC has a dedicated team of corporate staff that evaluates diagnostics, medical therapies, surgical procedures, medical devices and drugs. The team manages the evidence-based evaluation process from initial inquiry to final policy recommendation. The team researches the safety and effectiveness of these new technologies by reviewing published medical reports, literature, expert consultation with 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.

14. HIPAA CERTIFICATE OF CREDITABLE COVERAGE

In compliance with the Health Insurance Portability and Accountability Act of 1997 (HIPPA), Members are entitled to a Certificate of Creditable Coverage, which verifies the most recent period of coverage under the Member’s Employer Group.

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 provide to a new 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 a new employer’s health plan must be reduced by the number of days of coverage shown on the Certificate.

HPHC will automatically send this certificate to Members upon termination of membership. Unless the Member’s Employer Group has specifically notified HPHC in writing that it will send such certificates and has instructed HPHC not to do so. However, Members may call the Member Services Department at 1-888-333-4742 at any time within two (2) years from the date coverage ended to request a free copy of their Certificate from HPHC.
K. GLOSSARY

This Section lists the words with special meaning in the Benefit Handbook.

1. Activities of Daily Living
   The normal functions of daily life, including walking, speaking, eating, transferring, bathing, dressing, continence, and using the toilet. Activities of Daily Living do not include special functions needed for occupational purposes or sports.

2. Adverse Utilization Determination
   A determination by HPHC that: (1) an admission, availability of care, continued stay or other health care service has been reviewed and does not meet HPHC’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness; and (2) payment for the requested services is therefore denied, reduced without further opportunity for additional service or terminated.

3. Anniversary Date
   The date upon which your premium rate is adjusted and benefit changes become effective. This Benefit Handbook will terminate unless renewed on the Anniversary Date.

4. Behavioral Health Access Center
   The organization, designated by HPHC, responsible for coordinating services for Members in need of mental health, or drug or alcohol abuse care. You may call the Behavioral Health Access Center at 1-888-777-4742.

5. Benefit Handbook (or Handbook)
   This legal document, including the Schedule of Benefits, and the Prescription Drug Brochure, and any applicable Riders which sets forth the services covered by the Plan, the exclusions from coverage and the conditions of coverage for Members.

6. Copayment
   Fees payable by Members for certain covered services. Copayments are payable at the time of the visit or when billed by the provider.

7. Custodial Care
   Services that are furnished mainly to assist a person in Activities of Daily Living. Examples of such services include: room and board, routine nursing care, help in personal hygiene, and supervision in daily activities.

8. Day Surgery
   Outpatient surgery that includes charges for use of anesthesia, operating room and recovery room.

9. Dependent
   A Member of the Subscriber's family who meets the eligibility requirements for coverage through a Subscriber under this Benefit Handbook.

10. Eligible Individual
    A resident of the State of Maine who meets the criteria listed in the eligibility section of this Handbook.

11. 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 HPHC under this Benefit Handbook for use in the diagnosis or treatment of a particular medical condition if either of the following is true:
    a. The service, procedure, device, or drug 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).

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

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

14. HPHC Enrollment Area/Enrollment Area
    A list of cities and towns where HPHC Providers are available to manage our Members' care. Members,
except for a Dependent child attending an accredited educational institution or a child under a Qualified Medical Support Order, must live in the Enrollment Area at least nine months of the year. HPHC may add cities and towns to HPHC Enrollment Area from time to time.

15. HPHC Provider
Licensed or certified providers of health care services who are under contract to provide care to the Plan Members. HPHC Providers include: 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, independent practice dental hygienists, chiropractors, 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). HPHC Providers are listed in the Provider Directory.

16. HPHC Service Area
The State in which the Member lives. When you are in the HPHC Service Area you must call your PCP for care unless you have a Medical Emergency or you seek the special services that do not require a referral.

17. Harvard Vanguard Medical Associates (Harvard Vanguard)
Harvard Vanguard Medical Associates is a medical group practice affiliated with HPHC. Members who are enrolled in Harvard Vanguard must obtain extractions of impacted teeth, if covered benefits, at a Harvard Vanguard office.

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

19. Individual Physician Practice
An individual doctor who is under contract to provide primary care to Members. Some Individual Practices have specialty providers at the same location.

20. 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; (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.

21. Medical Group
A group of physicians who are under contract to provide primary care to Members. Some Medical Groups also provide specialty care.

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

a. Consistent with generally accepted standards of medical practice;
b. Clinically appropriate in terms of type, frequency, extent, site and duration;
c. Demonstrated through scientific evidence to be effective in improving health outcomes;
d. Representative of best practices in the medical profession; and

e. Not primarily for the convenience of the enrollee or physician or the other health care practitioner.

23. Member
Any Subscriber or Dependent covered by this Handbook.

24. Plan
A package of health care benefits known as The Harvard Pilgrim HMO. For coverage under this Plan, covered services must be obtained from an HPHC provider.

25. Pre-Existing Condition
A Pre-Existing Condition is any physical or mental condition which would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which a provider of health care services recommended or provided medical advice or treatment to the Member during the six months prior to the effective date of coverage under this Handbook. Medical advice is considered to be given if a mental or physical condition is identified or recognized by a physician or other health care provider. A mental or
physical condition is considered to have been treated if any services of a physician or other health care provider have been received on the effective date of coverage. In accordance with Maine law, pregnancy cannot be considered a Pre-Existing Condition.

26. Primary Care Physician (PCP)
A specialist in internal medicine, family practice, general practice, or pediatrics or obstetrics and gynecology or a certified nurse practitioner licensed by the Maine Board of Nursing, who is employed by HPHC, or under contract to provide and authorize Members' care. A Member selects a Primary Care Physician at a Harvard Pilgrim Health Care of New England Health Center, Harvard Vanguard Medical Associates, Medical Group or an Individual Physician Practice. A Primary Care Physician may designate other HPHC Providers to provide or authorize a Member's care.

27. Primary Care Site
The places where PCPs provide care to our Members. A Primary Care Site may be a:
   a. Harvard Vanguard office
   b. Medical Group or Individual Practice

28. Provider Directory
A list of Plan affiliated medical facilities and professionals, including PCPs and specialists. HPHC revises the Provider Directory from time to time without notice to Members.

29. Qualified Medical Support Order (QMSO)
A court order providing for coverage of a child under a group health plan that meets the requirements of the Employee Retirement Income Security Act (ERISA). A child enrolled under a QMSO is subject to the same terms and limitations stated in this Handbook, Schedule of Benefits, Prescription Drug Brochure and any applicable Riders. QMSO does not entitle a Member to the benefits described in the Student Dependent section if these Dependents have a permanent residence outside the Enrollment Area.

30. Subscriber
The person who meets the eligibility requirements described in this Benefit Handbook.

31. Usual, Customary and Reasonable Charge
An amount that is consistent, with the normal range of charges by health care providers for the same, or similar, products or services in the geographical area where the product or service was provided to a Member. HPHC utilizes the Health Insurance Association of America (HIAA) fee schedule to determine the appropriate reimbursement for each geographic area. The member may request information regarding reimbursement for a specific service by contacting the HPHC Member Services Department at 1-888-333-4742. The Usual, Customary, and Reasonable charge is the maximum amount that HPHC will pay for covered services.
II. PATIENT RIGHTS

This section describes your rights as a patient.

As a patient you are entitled to the following patient rights from your health care provider:

1) To request and obtain the name and specialty, if any, of the physician or other person responsible for your care or the coordination of your care;

2) To have all your medical records and communications kept confidential to the extent provided by law;

3) To have all reasonable requests answered promptly and adequately within the capacity of the treating provider;

4) To obtain a copy of any rules or regulations which apply to your conduct as a patient;

5) To request and receive any information a provider has available regarding financial assistance and free health care;

6) To inspect your medical records and to receive a copy of your records for a reasonable fee;

7) To refuse to be examined, observed, or treated by students or any other staff without jeopardizing access to medical care and attention;

8) To refuse to serve as a research subject and to refuse any care or examination the primary purpose of which is educational rather than therapeutic;

9) To have privacy during medical treatment within the capacity of the provider’s office;

10) To prompt life-saving treatment in an emergency without discrimination based on economic status or source of payment; and without delaying treatment to discuss source of payment, unless delay will not cause risk to your health;

11) To informed consent to the extent provided by law;

12) To request and receive an itemized copy of your bill or statement of charges, if any, including third party payments towards the bill, regardless of the sources of payment;

13) To request and receive an explanation of the relationship, if any, of the physician to any health care facility or educational institutions if this relationship relates to your care or treatment; and

14) In the case of a patient suffering from breast cancer, to be provided with complete information on alternative treatments that are medically appropriate.

If you believe that any of your rights have been violated by a participating provider, you have the right to file a complaint with HPHC or its designee. All complaints must be submitted in writing and addressed to HPHC or one of the regulatory offices listed below:

**Member Services Department**  
Harvard Pilgrim Health Care  
1600 Crown Colony Drive  
Quincy, MA 02169

For Massachusetts Physicians:

Board of Registration in Medicine  
560 Harrison Avenue, Suite G-4  
Boston, MA 02118  
(617) 654-9800

Massachusetts Department of Public Health  
250 Washington Street  
Boston, MA 02108-4619  
(617) 624-5200

For New Hampshire Physicians:

Board of Medicine  
2 Industrial Park Drive  
Suite #8  
Concord, NH 03301-8520

State of New Hampshire Insurance Department  
56 Old Suncook Road  
Concord, NH 03301-7317

For Maine Physicians:

Board of License in Medicine  
137 State House Station  
Augusta, ME 04333

Telephone: 1-888-365-9964  
Web site: http://www.docboard.org/me/me_home.html

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

Telephone: 1-800-300-5000 (in state)  
1-207-624-8475 (out of state)  
Web site: http://www.maineinsurancereg.org
For Vermont Physicians:
Vermont Board of Medical Practice
109 State Street
Montpelier, VT 05609-1106

Director of Consumer Services
89 Main Street
Drawer 20
Montpelier, VT 05620-3101
III. MEMBER RIGHTS AND RESPONSIBILITIES:

- Members have a right to receive information about Harvard Pilgrim, 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 Harvard Pilgrim or the care provided.
- Members have a right to make recommendations regarding the organization’s member’s right and responsibilities policies.
- Members have a responsibility to provide, to the extent possible, information that Harvard Pilgrim 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.