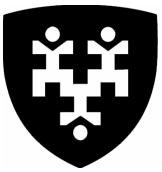


Harvard Pilgrim Health Care

DirigoChoice PPO Plan Maine

Benefit Handbook

Coverage underwritten by HPHC Insurance Company, Inc.,
an affiliate of Harvard Pilgrim Health Care, Inc.

Form No.711

Benefit Handbook

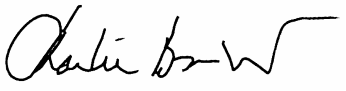
The DirigoChoice PPO Plan
Maine

This Benefit Handbook (Handbook), Summary of Benefits and Prescription Drug Brochure is the legal document that defines the relationship between your Employer Group (if applicable), you and your Dependents, and HPHC Insurance Company, Inc. It describes benefits, limitations, exclusions, requirements and other important information relevant to coverage in the DirigoChoice PPO Plan (the Plan).

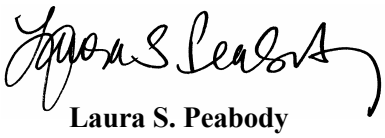
In exchange for premiums paid in advance, HPHC Insurance Company agrees to pay for Member's health care services, subject to all the terms of this Handbook, for the period the premium covers.

By submitting a complete application for enrollment or by paying the applicable premium, the Member applies for coverage under the Plan and agrees to all of its terms.

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



Charles D. Baker Jr.
President
HPHC Insurance Company



Laura S. Peabody
Clerk
HPHC Insurance Company

Introduction

Thank you for choosing the DirigoChoice PPO Plan (the Plan) offered by HPHC Insurance Company (HPIC) to help you meet your health care needs. We are committed to providing you with excellent value and quality service.

We encourage you to review this Handbook, which describes your benefits. The Plan has been designed to offer you the flexibility of obtaining Covered Benefits from HPIC's Participating Providers or the Non-Participating Provider of your choice. Benefits are covered both In-Network and Out-of-Network. In most cases, you will have a lower out-of-pocket cost for Covered Benefits received from Participating Providers.

To be covered at the In-Network level, all care, except for care received in a Medical Emergency, must be received from a Participating Provider.

If you choose to receive Covered Benefits from a Non-Participating Provider, your benefits will be covered at the Out-of-Network level.

To be eligible for coverage, a service must be Medically Necessary and a Covered Benefit under the Plan. Some benefits have limits on the amount of coverage provided in a calendar year. If a Covered Benefit has a benefit limit, your In-Network and Out-of-Network services are combined and both count towards the benefit limit. Please refer to the Summary of Benefits (Section A) for detailed information regarding your Cost Sharing and limits on Covered Benefits.

Notice: HPIC uses clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for your care. You or your practitioners may obtain a copy of any HPIC clinical review criteria that is applicable to a service or procedure for which coverage is requested. Clinical review criteria may be obtained by calling **1-877-213-5225**.

You may call the HPIC Customer Service Unit at **1-877-213-5225** if you have any questions. Member Services staff are available to help you with questions about:

- Selecting Participating Providers
- Your Benefit Handbook, including the Summary of Benefits and Prescription Drug Brochure
- Your benefits
- Your enrollment
- Your claims
- Provider information
- Requesting a Provider Directory
- Requesting a member kit
- Requesting ID cards
- Registering a complaint

Deaf and hard-of-hearing Members who own, or have access to, a Teletypewriter (TTY) may communicate directly with the Customer Service Department by calling our TTY service at **1-877-213-5556**.

Non-English speaking Members may also call our Customer Service Unit at **1-877-213-5225** with questions. HPIC offers free language interpretation services in more than 120 languages.

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

HPHC Insurance Company
Customer Service Unit
PO Box 5225
Westborough, MA 01581

1-877-213-5225
1-877-213-5556 **(TTY)**
Internet: www.healthplansinc.com

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SECTION A. Summary of Benefits

Please see your Summary of Benefits that has been included in the mailing with this Handbook.

SECTION B. About the Plan

This section describes how to use your Handbook and how your coverage works under the Plan. The Plan provides you with two payment levels of benefits known as In-Network and Out-of-Network. You receive In-Network coverage when you obtain Covered Benefits from Providers participating in the Plan. These Providers are referred to as "Participating Providers". You receive Out-of-Network coverage when you obtain Covered Benefits from Providers not participating in the Plan. These Providers are referred to as "Non-Participating Providers". Your In-Network and Out-of-Network coverage is described further below.

1. HOW TO USE THIS BENEFIT HANDBOOK

a. Why This Benefit Handbook Is Important

This Benefit Handbook, the Summary of Benefits, and the Prescription Drug Brochure hereinafter collectively referred to as the Benefit Handbook or Handbook, make up the legal agreement stating the terms of the Plan. This document incorporates by reference employer or individual applications for coverage, coverage election forms, participation agreements, group profiles and rate sheets, as applicable.

This document explains how your membership works. It outlines what you must do to obtain coverage for services and what you can expect from HPIC and the Plan. It is also your guide to the most important things you need to know. These include:

- What is covered
- What is not covered
- Any limits or special rules for coverage
- Any Deductible, Copayments, Coinsurance, or Penalties you must pay, which are listed in the Summary of Benefits
- How to obtain benefits at the In-Network level
- Your prescription drug coverage

b. Words With Special Meaning

Some words in this Handbook have a special meaning. These words are capitalized and defined in the Glossary (Section M).

c. How To Find What You Need To Know

The Table of Contents will help you find what you need to know. The following is a description of some other important sections.

The Summary of Benefits can be found in Section A. The Summary of Benefits lists the Member Cost Sharing that you are required to pay, including Deductibles, Copayments and Coinsurance. It also lists some of the important limitations on coverage.

The benefits covered by the Plan are explained in detail in Section C. You must review Section C for an understanding of your benefits.

Your benefits for outpatient prescription drugs are described in Section O.

Section G, titled "Appeals and Complaints", provides detailed information on how to appeal a denial of coverage or file a complaint.

2. HOW THE PPO PLAN WORKS

a. In-Network and Out-of-Network Benefits

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

In-Network benefits are available when you receive Covered Benefits from a Participating Provider. Your out-of-pocket cost is generally lower for In-Network benefits. Since HPIC pays Participating Providers directly, you do not have to file a claim when you use your In-Network coverage.

Out-of-Network benefits are available for Covered Benefits you receive from Non-Participating Providers. Your Out-of-Network coverage provides you greater flexibility in where you receive your health care services. Although your out-of-pocket cost is generally higher for Out-of-Network benefits, you may obtain Covered Benefits from the Provider of your choice.

Please see your Summary of Benefits (Section A) for the specific Cost Sharing amounts that apply to the In-Network and Out-of-Network benefits.

Please Note: Members are responsible for obtaining Prior Approval from HPIC for some Out-of-Network services. Please see Section B.4 for information on

the Prior Approval program, including a list of the specific services that require Prior Approval.

b. Selecting a Provider from the Provider Directory

To be covered at the In-Network level, Covered Benefits must be obtained from a Participating Provider. Participating Providers include a large number of specialists and health care institutions in Maine and surrounding states. HPIC publishes a Provider Directory that lists Participating Providers by geographic area and languages spoken.

HPIC provides copies of the Provider Directory without charge. You may also obtain a copy of the Provider Directory from HPIC's Customer Service Department by calling **1-877-213-5225**.

You may view the online Provider Directory at HPIC's Internet site at www.healthplansinc.com. The online Provider Directory allows you to search for Providers by location. The information in the online Provider Directory is updated regularly by HPIC.

Please note: The Providers in HPIC's network are under contractual arrangements that can be terminated either by a Provider or by HPIC. In addition, a Provider may leave the HPIC network because of retirement, relocation or other reasons. This means that HPIC cannot guarantee that the Provider you choose will continue to participate in HPIC's network for the duration of your HPIC membership.

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 primary care 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 the 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 In-Network physicians to provide both an answering service that can be contacted 24-hours a day and prompt appointments when Medically Necessary.

d. Medical Emergency Services

You always have coverage for care in a Medical Emergency. In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. Your emergency room Cost Sharing is listed in your Summary 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, HPIC will also cover services necessary to screen and stabilize your condition without requiring Prior Approval.

Please remember that if you are hospitalized, you or your designee should call HPIC within 48 hours of receiving emergency services, or as soon as reasonably possible after emergency screening and stabilization have taken place. If an attending emergency physician gives notice of hospitalization to the Plan, no further notice is required.

3. MEMBER COST SHARING

Below are descriptions of Member Cost Sharing that may apply when using Participating or Non-Participating Providers. See your Summary of Benefits for Cost Sharing details that are specific to your Plan.

a. Deductible

A Deductible is a specific dollar amount that you pay for most Covered Benefits each calendar year before any benefits subject to the Deductible are payable by the Plan. Your Plan may include separate Deductibles that must be met for medical services and non-Biologically Based Mental Illness services. Deductible amounts are incurred on the date of service on a calendar year basis. Deductible amounts applicable to your Plan are stated in the Summary of Benefits.

In most cases, you have an individual Deductible and a family Deductible. Unless a family Deductible applies, you are responsible for the individual Deductible for Covered Benefits each calendar year. If you are a Member with Family Coverage, your Deductible can be satisfied in one of two ways:

(1) If a Member of a covered family meets an individual Deductible, then services for that Member that are subject to that Deductible are covered by the Plan for the remainder of the calendar year.

(2) If any number of Members in a covered family collectively meets a family Deductible, then all services that are subject to that Deductible are covered by the Plan for the remainder of the calendar year.

b. One Deductible for a Common Accident

If two or more Members in a covered family are injured in the same accident, only one individual Deductible will apply for all Covered Services resulting from the accident during a calendar year.

c. Deductible Rollover

Your Plan includes a Deductible Rollover. A Deductible Rollover allows you to apply any Deductible amount incurred for Covered Benefits during the last three (3) months of a calendar year toward the Deductible for the next year. In order for the Deductible Rollover to apply, you, or your covered family, must have had continuous coverage under DirigoChoice at the time the charges for the prior year were incurred.

d. Copayment

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

e. Coinsurance

Coinsurance is a percentage of Covered Charges for certain Covered Benefits that must be paid by the Member. The Coinsurance amounts applicable to your Plan are stated in the Summary of Benefits.

Coinsurance amounts apply after any applicable Deductible has been met. When using Participating Providers, Covered Charges are based on the contracted rate between HPIC and the Provider. When using Non-Participating Providers, Covered Charges are based on the Provider's charge for the service up to the Usual, Customary and Reasonable Charge for the service. In most cases, this will be higher than HPIC's contracted rate.

f. Out-of-Pocket Maximum

An Out-of-Pocket Maximum is an annual limit on the amount of Deductible and Coinsurance that Members are required to pay per calendar year for all services covered by the Plan. If your Plan includes an Out-of-Pocket Maximum, your specific Out-of-Pocket Maximum amount is listed in your Summary of Benefits (Section A).

Certain expenses do not apply to the Out-of-Pocket Maximum. These include, but may not be limited to, Copayments, Cost Sharing payments for non-Biologically Based Mental Illness services, Cost Sharing payments for prescription drugs, any charges incurred by a Member in excess of the Usual, Customary and Reasonable Charge for a service, and any Penalty for failure to receive Prior Approval when required.

In most cases where an Out-of-Pocket Maximum is included in the Plan, you have both an individual Out-of Pocket Maximum and a family Out-of Pocket Maximum. If you are a Member with Family Coverage, your Out-of Pocket Maximum can be reached in one of two ways:

(1) If a Member of a covered family meets an individual Out-of Pocket Maximum, then that Member has no additional Cost Sharing responsibilities for Covered Benefits for the remainder of the calendar year

(2) If any number of Members in a covered family collectively meets a family Out-of Pocket Maximum, then all Members in that covered family have no additional Cost Sharing responsibilities for Covered Benefits for the remainder of the calendar year

If a Member changes to Family Coverage from Individual Coverage or to Individual Coverage from Family Coverage within a calendar year, expenses incurred for Covered Benefits toward the Out-of-Pocket Maximum under the prior coverage will apply toward the Out-of-Pocket Maximum limit under the new coverage. If the incurred Out-of-Pocket Maximum amount is greater than the new Out-of-Pocket Maximum limit, the Member will have no additional Cost Sharing for that calendar year.

g. Lifetime Benefit Maximum

The Lifetime Benefit Maximum is the total amount the Plan will pay for Covered Benefits for one Member under this Handbook. If applicable, you will find your Lifetime Benefit Maximum listed in your Summary of Benefits.

h. Charges in Excess of the Usual, Customary and Reasonable Charges

On occasion, a Non-Participating Provider may charge amounts in excess of the Usual, Customary and Reasonable Charge for a service. In those instances, you will be financially responsible for the difference between what the Provider charges and the amount of the Usual, Customary and Reasonable Charge payable by the Plan. You may contact the Customer Service Department **1-877-213-5225** or at **1-877-213-5556** for TTY service if you have questions about the maximum allowable charge that may be permitted by HPIC for a service.

4. PRIOR APPROVAL

HPIC's Prior Approval program is designed to assure that covered medical services are used appropriately and that the benefits are correctly administered. If you use a Participating Provider, he or she will obtain Prior Approval for you. If you use a Non-Participating Provider you (or someone you designate) are responsible for requesting Prior Approval for any service requiring approval.

The services for which Prior Approval is required and the telephone numbers to call to request approval are listed further in this section.

a. What Services Require Prior Approval

The following is a list of the services for which Prior Approval is required. Unless otherwise stated below, Prior Approval is required for these procedures and services irrespective of where the procedure and or service is delivered (for example, at a hospital, Surgical Day Care facility, or physician's office).

- **Home health care** – Includes home infusion and home hospice care
- **Inpatient care** – Includes all hospital care, inpatient mental health and drug and alcohol rehabilitation services, care in a skilled nursing facility (SNF) or inpatient rehabilitation facility, and all transfers between inpatient facilities.
- **Organ and Tissue transplants** - Includes bone marrow and stem cell transplants

b. How to Seek Prior Approval

To seek Prior Approval, please call the appropriate telephone number below:

- For all medical services, call **1-877-213-5225**
- For all mental health and drug and alcohol rehabilitation services, call **1-877-213-5225**

For planned admissions to an Out-of-Network medical facility, you or your designee must contact HPIC in advance. To assure that the Prior Approval process will be completed in a timely manner, you should contact HPIC at least five (5) business days in advance of an elective admission. Prior Approval is not required for hospital admissions in a Medical Emergency.

However, in the event of an emergency admission, HPIC must be contacted no more than 48 hours after admission or as soon as reasonably possible.

The following information will be required when you call:

- The Member's name
- The Member's ID number
- The treating Provider's name, address and telephone number
- The name and address of the facility where care will be received
- The diagnosis for which care is ordered and date of admission
- The treatment ordered and the date it is expected to be performed

c. Who Needs to Seek Prior Approval

If you use a Participating Provider, he or she will obtain Prior Approval for you. If you use a Non-Participating Provider, you (or someone you designate) are responsible for obtaining Prior Approval.

If either the Hospital or physician are Out-of-Network, you are responsible for contacting HPIC for Prior Approval. Please refer to the following chart to determine who is responsible for requesting Prior Approval for inpatient admissions.

Admitted by:	Admitted to:	Approval Responsibility:
Participating Provider	In-Network Hospital	Participating Provider
Participating Provider	Out-of-Network Hospital	Member
Non-Participating Provider	In-Network Hospital	Member
Non-Participating Provider	Out-of-Network Hospital	Member

d. What the Prior Approval Program Does

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

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

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

If the Prior Approval program denies a coverage request, it will send you a written notice that explains the decision and HPIC's appeal process.

e. Effect of Prior Approval on Coverage

If Prior Approval is obtained for a service, coverage will be provided at the applicable rate stated in the Summary of Benefits. If Prior Approval is not obtained for a service, the effect on coverage will be as follows:

- If HPIC later determines that the procedure or service was Medically Necessary, coverage will be provided minus the Penalty stated in the Member's Summary of Benefits. The Penalty will not apply toward any Deductible or Out-of-Pocket Maximum.
- If HPIC later determines that the service was not Medically Necessary, no coverage will be provided and the Member will be responsible for the full cost of the service.

Prior Approval does not entitle you to coverage for any procedure or service that is not covered under the Plan, including procedures or services in excess of the benefit limits stated in this Handbook.

5. PAYMENT LEVELS

The situation could occur where you utilize the services of both a Participating Provider and a Non-Participating Provider when receiving care. For example, you may receive treatment in a Participating Provider's office and receive associated blood work from an Out-of-Network laboratory. Since the payment level is dependent upon the participation status of the Provider, the Participating Provider would be paid at the In-Network coverage level and the laboratory would be paid at the Out-of-Network coverage level.

The benefit payment level that is applied to a hospital admission depends on the participation status of both the admitting physician and the hospital. If you are admitted to an In-Network hospital by a Participating Provider, both the hospital and physician are paid at the In-Network coverage level. If you are admitted to an In-Network hospital by an Out-of-Network physician, the hospital's charges are paid at the In-Network coverage level, but the physician's charges are paid at the Out-of-Network coverage level. Likewise if you are admitted to an Out-of-Network hospital by a Participating Provider, the hospital's charges are paid at the Out-of-Network coverage level, but the physician's charges are paid at the In-Network coverage level.

SECTION C. Covered Benefits

This section contains detailed information on the benefits covered under the Plan. Member Cost Sharing information, including Deductibles, Copayments or Coinsurance amounts that apply to your Plan, are listed in the Summary of Benefits, which is Section A of the Handbook. Prescription drug benefits and the applicable Member Cost Sharing are described in Section O of the Handbook.

You have one set of Covered Benefits per calendar year. If the Covered Benefit has benefit limits, you are restricted to those limits regardless of whether you choose to receive care In-Network or Out-of-Network or both. For example, if the Covered Benefit is limited to ten visits and you receive nine visits In-Network and one visit Out-of-Network, then you will have reached your benefit limit and will no longer have coverage for that benefit during that calendar year.

1. BASIC REQUIREMENTS FOR COVERAGE

To be covered, all services and supplies must be:

- Medically Necessary
- Listed as a Covered Benefit in this Section and the Summary of Benefits (Section A) and not excluded under Section D
- Received while an active Member of the Plan

In-Network services must be provided by a Participating Provider, except in a Medical Emergency. Please see specific benefits in this section and in the Summary of Benefits for any special limits on your coverage. Please see Section D for exclusions from coverage.

2. OUTPATIENT PROFESSIONAL SERVICES

a. Ambulance Transport, Non-Emergency

The Plan covers non-emergency ambulance transport between hospitals or other covered health care facilities or from a covered facility to the Member's home when Medically Necessary.

RELATED EXCLUSIONS:

- Wheelchair vans
- Transportation other than by ambulance

b. Asthma Education

The Plan covers asthma education programs for Members with asthma and their families. Coverage is provided up to $200 per Member per calendar year when a Participating Provider or professional renders services.

c. Cardiac Rehabilitation

The Plan covers cardiac rehabilitation services for Members with established coronary artery disease or unusual and serious risk factors for such disease.

d. Chiropractic Care

The Plan covers chiropractic care by adjustment or manipulation up to the benefit limit listed in the Summary of Benefits (Section A). The following services are covered:

- Initial diagnostic x-ray
- Care within the scope of standard chiropractic practice

e. Diagnostic Laboratory and X-Rays

The Plan covers outpatient diagnostic laboratory and x-ray services to diagnose illness, injury, or pregnancy. Please refer to the Summary of Benefits to determine your Cost Sharing responsibilities.

1) Diagnostic Tests, X-rays Associated with Preventive or Routine Care

The Plan also covers diagnostic tests and x-rays associated with routine or preventive medical exams. These services may have lower Cost Sharing than other preventive tests. Please refer to the Summary of Benefits to determine your Cost Sharing responsibilities.

2) Mammograms

The Plan also 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 a provider when the results of an initial radiologic procedure are not definitive. Non-routine mammograms are covered when medically necessary. Please refer to the Summary of Benefits to determine your Cost Sharing for mammograms.

f. Dialysis

The Plan covers dialysis on an inpatient, outpatient or at-home basis. When Medicare is the primary payor under federal law, the Plan will cover services only to the extent payments would exceed what would be payable by Medicare. Coverage for dialysis in the home includes non-durable medical supplies, drugs and equipment necessary for dialysis. Installation of home dialysis equipment is covered up to $300 in a Member's lifetime.

Prior Approval is required for any inpatient admission and any services provided in the home. If you use a Participating Provider, he or she will obtain Prior Approval for you. If you use a Non-Participating Provider, you are responsible for obtaining Prior Approval. The Prior Approval process is initiated by calling: **1-877-213-5225**. Further information about Prior Approval may be found in section B.4.

g. 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) Special modified low protein food products prescribed by a licensed physician for a person with an inborn error of metabolism. This coverage of low protein foods is limited to $3,000 per Member per calendar year.

RELATED EXCLUSIONS:

- Non-prescription formulas, except as required by Maine law

h. Home Health Care

When you are homebound for medical reasons, the Plan covers the home health care services stated below on a short-term intermittent basis. To be eligible for home health care, your Provider must find that skilled nursing care or physical therapy is an essential part of active treatment. There must also be a defined medical goal that your Provider expects you will meet in a reasonable period of time.

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.

When you qualify for home health care services as stated above, the Plan also covers the following services on a short-term intermittent basis when Medically Necessary:

- Skilled nursing care
- Physician home visits
- Physical therapy
- Occupational therapy
- Speech therapy
- Inhalation therapy
- Medical social services
- Nutritional counseling
- Services of a home health aide

Durable medical equipment and supplies are also covered to the extent that they are a Medically Necessary component of the home health care services being provided.

Prior Approval is required for any services provided in the home. If you use a Participating Provider, he or she will obtain Prior Approval for you. If you use a Non-Participating Provider, you are responsible for obtaining Prior Approval. The Prior Approval process is initiated by calling: **1-877-213-5225.** Further information about Prior Approval may be found in section B.4.

RELATED EXCLUSIONS:

- Home health care extending beyond a short-term intermittent basis as described above
- Private duty nursing at home

i. 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 that cannot be managed in a home setting.

Covered Benefits 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 appliances
- Drugs that cannot be self administered
- Volunteer services
- Bereavement services and respite care

j. Physical, Speech and Occupational Therapies

Outpatient physical, speech and occupational therapies are covered up to the benefit limit described in the Summary of Benefits (Section A). Services are covered only when needed to improve your ability to perform Activities of Daily Living and when, in the opinion of your Provider, there is likely to be significant improvement in your condition within the period of time benefits are covered.

Please note that outpatient physical, speech and occupational therapies for children under the age of 3 are covered to the extent Medically Necessary.

If you are in an approved course of pulmonary rehabilitation, physical and occupational therapies are covered to the extent that they are a Medically Necessary component of the pulmonary rehabilitation. Services must be approved by HPIC. Physical, speech and occupational therapies are also covered under your inpatient hospital and home health benefits. When such therapies are part of an approved home care treatment plan they are available on a short-term intermittent basis as described in section C.2.h (Home Health Care).

RELATED EXCLUSIONS:

- Educational services or testing, except such services covered under the Outpatient Mental Health and Drug and Alcohol Rehabilitation benefits. No benefits are provided for educational services intended to enhance educational achievement (e.g. subject achievement testing), or to resolve problems regarding school performance; or services to treat learning disabilities in a school based setting.
- Sensory integrative praxis tests
- Testing of central auditory processing
- Vocational rehabilitation, or vocational evaluations focused on job adaptability, job placement, or therapy to restore function for a specific occupation
- Massage therapy when performed by anyone other than a licensed physical therapist/physical therapy assistant or occupational therapist/certified occupational therapy assistant.
- Myotherapy

k. Physician Services

Your Plan provides coverage for the physician services described below. Physician services include the services of a nurse practitioner, physician assistant, certified nurse midwife, and certified registered nurse anesthetist working under the supervision of a licensed physician.

1) Preventive/Routine Care in the Physician's Office

The Plan covers preventive care according to your individual medical needs. Covered preventive care includes:

- Routine physical examinations,
- Annual gynecological examinations
- Annual digital rectal exams for the early detection of prostate cancer for Members between ages 50 and 72

- Routine pelvic and clinical breast examinations
- Vision and hearing screening
- Health education
- Nutritional counseling
- Medication management services

RELATED EXCLUSIONS:

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

2) Sick or Injured Care

The Plan covers care when you are sick or injured. Services include, but are not limited to:

- Office visits
- Diagnostic tests and x-rays
- Dressings, sutures, and casting
- Injections
- Radiation therapy

3) Second Opinion

There may be times when you want a second opinion. The Plan provides coverage for second opinions.

4) Family Planning Services

The Plan covers family planning services. These services include, but are not limited to:

- Annual gynecological examination
- Follow-up care provided by an obstetrician or gynecologist for obstetrical or gynecological conditions identified during maternity care or annual gynecological visits
- Family planning consultation
- Pregnancy testing
- Contraceptive monitoring
- Voluntary sterilization
- Voluntary termination of pregnancy
- Injection of birth control medication and the insertion or removal of birth control implants or devices is covered.

5) Coverage During Approved Clinical Trials

HPIC provides coverage for Medically Necessary care provided to a Member who is participating in an approved clinical trial. Coverage includes Medically Necessary services, drugs and devices, which are not the subject of the clinical trial and its administration. All such services, drugs and devices must be otherwise covered under the Plan.

The above coverage will be provided if:

- the clinical trial is approved and funded by the National Institute of Health (NIH), an NIH cooperative group or center or the federal Department of Health and Human Services;
- the Member has a life-threatening illness for which no standard treatment is effective;
- the Member is eligible to participate according to the clinical trial protocol with respect to treatment of such illness; and
- the Member's participation in the trial offers meaningful potential for significant clinical benefit to the Member.

If you are participating in a qualified clinical trial, please notify our Care Management Team. You can do this by calling the Care Management Team at **1-877-747-1333**. The Care Management Team can provide you with assistance concerning your clinical trial participation.

6) Prenatal and Postpartum Care

The Plan covers the following prenatal and postpartum care:

- 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 cesarean 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

7) Allergy Treatment

The Plan covers testing, antigens and allergy treatments.

8) Annual Eye Examinations

The Plan covers routine eye examinations by an ophthalmologist or optometrist. Coverage is limited to one examination every two calendar years.

9) Extraction of Impacted Teeth

The Plan covers extraction of impacted and/or unerupted teeth, including pre-operative and post-operative care, x-rays, and anesthesia.

10) Diabetes Treatment

The Plan covers the following:

a) Outpatient Care

- Medically Necessary laboratory tests
- Diabetes self-management training and education programs provided by the ambulatory diabetes education facilities authorized by the Diabetes Control Project within the Maine Bureau of Health.

b) Durable Medical Equipment, as described in Section C.6.

c) Pharmacy supplies, including:

- Insulin
- Oral agents for controlling blood sugar
- Blood glucose, urine and ketone test strips
- Lancets
- Insulin needles and syringes

For coverage of pharmacy items listed above, you must get a prescription from your Provider. For In-Network coverage, you must go to a HPIC network pharmacy. A list of HPIC In-Network pharmacies is available from the Customer Service Unit.

Pharmacy supplies for the treatment of diabetes are subject to the applicable pharmacy Copayments listed on your ID card.

l. Smoking Cessation

The Plan covers nicotine replacement therapy products and any other medication specifically approved by the Food and Drug Administration (FDA) for smoking cessation. To be eligible for coverage, these products and medications must be prescribed by your Provider.

The Plan covers the following:

- Up to two office visits per calendar year for smoking cessation education and counseling
- Nicotine replacement therapy products, including but not limited to: nicotine patches, gum, and nasal spray
- Approved smoking cessation programs

Please refer to the Summary of Benefits to determine your Cost Sharing.

m. Surgical Day Care

The Plan covers outpatient Surgical Day Care (SDC). Surgical Day Care is a surgery or procedure performed in a day surgery department, ambulatory surgery department or outpatient surgery center that requires operating room, anesthesia and recovery room services.

1) General Anesthesia in a Hospital or Surgical Day Care Setting for Dentistry

The Plan also covers general anesthesia and associated facility charges for dental procedures rendered in a hospital or Surgical Day Care setting in certain circumstances. Services are covered in the following conditions:

a) Members, including infants, with physical, intellectual or medically compromising conditions in which general anesthesia is Medically Necessary;

b) Members for whom local anesthesia is ineffective due to acute infection, anatomic variation or allergy;

c) Extremely uncooperative, fearful, anxious, or uncommunicative children or adolescents with dental needs that cannot be postponed

and for whom lack of treatment might result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; or

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

Please note: HPIC's dental coverage is very limited. HPIC covers general anesthesia for dental procedures only as noted above. However, HPIC does not cover the cost of any Dental Care or the dentist's fee.

Prior Approval is required for general anesthesia for dentistry in an inpatient or Surgical Day Care setting. If you use a Participating Provider, he or she will obtain Prior Approval for you. If you use a Non-Participating Provider, you are responsible for obtaining Prior Approval. The Prior Approval process is initiated by calling: **1-877-213-5225**. Further information about Prior Approval may be found in section B.4.

n. Vision Hardware for Special Conditions

The Plan provides limited coverage for contact lenses or eyeglasses needed for certain eye conditions. The coverage provided for these conditions is as follows:

1) Post cataract surgery with an intraocular lens implant (pseudophakes). Coverage is available for the purchase of eyeglass frames and lenses. The replacement of lenses due to a change in the Member's prescription of .50 diopters or more within 90 days of the surgery is also covered.

2) Post cataract surgery without lens implant (aphakes). One pair of eyeglass lenses or contact lenses is covered per year. Coverage is also provided for the purchase of eyeglass frames. The replacement of lenses due to a change in the Member's condition is also covered. Replacement of lenses due to wear, damage, or loss, is also covered.

3) Accommodative Strabismus. One pair of eyeglass lenses or contact lenses is covered per year. Coverage is also provided for the purchase of eyeglass frames. The replacement of lenses due to a change in the Member's condition is also covered. Replacement of lenses due to wear, damage, or loss, is also covered.

3. EMERGENCY SERVICES

a. Ambulance Transport, Emergency

In the event of a Medical Emergency, the Plan covers ambulance transport to the nearest hospital that can render Medically Necessary care to a Member.

b. Emergency Dental Care

The Plan covers the emergency Dental Care indicated below needed due to an injury to sound, natural teeth. All services, except for suture removal, must be received within 12 months of injury.

Only the following services are covered:

- Treatment to replace or repair natural teeth
- Extraction of teeth needed to avoid infection of teeth damaged in the injury
- Suturing and suture removal
- Reimplantion and stabilization of dislodged teeth
- Repositioning and stabilization of partly dislodged teeth
- Medication received from the Provider
- Replacement or repair of a dental prostheses caused by accidental bodily injury

RELATED EXCLUSIONS:

- All other Dental Care, unless your Plan includes coverage for the extraction of impacted teeth (see Section C.2.k.9.)

c. Emergency Room Care

In the event of a Medical Emergency, the Plan covers emergency room care. You are always covered for care in a hospital emergency room at the In-Network benefit level.

Please remember, if you need follow-up care after you are treated in an emergency room, you must get your care from Participating Providers for coverage to be at the In-Network benefit level. If you are hospitalized, you must call HPIC within 48 hours of receiving emergency services, or as soon as possible after emergency screening and stabilization has taken place.

4. INPATIENT SERVICES

The Plan covers the following inpatient services:

- Semi-private room and board (or private room and board when Medically Necessary)
- Physician visits, including consultation with specialists
- Medications
- Laboratory and x-ray services
- Intensive care
- Surgery, including related services
- Anesthesia, including the services of a nurse-anesthetist
- Radiation therapy
- Physical therapy, occupational therapy and speech therapy
- Reconstructive surgery related to (1) surgery that is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved body part, or (2) congenital disease or anomaly of a covered child which has resulted in a functional defect
- Medically Necessary breast reduction surgery and symptomatic varicose vein surgery, as required by Maine law

Prior Approval is required for all inpatient services. If you use a Participating Provider, he or she will obtain Prior Approval for you. If you use a Non-Participating Provider, you are responsible for obtaining Prior Approval. The Prior Approval process is initiated by calling: **1-877-213-5225**. Further information about Prior Approval may be found in section B.4.

Specific inpatient care benefits are described below.

a. Acute Hospital Care

The Plan covers acute hospital care, including emergency admissions, to the extent Medically Necessary. There is no limit on the number of days covered.

As part of Acute Hospital care, the following additional services are also covered.

1) Cosmetic Surgery

For purposes of this Handbook, cosmetic surgery is any procedure to change or restore appearance. The Plan covers cosmetic surgery only to repair severe disfigurement due to an injury or disease or birth defect.

Prior Approval is required for cosmetic surgery. If you use a Participating Provider, he or she will obtain Prior Approval for you. If you use a Non-Participating Provider, you are responsible for obtaining Prior Approval. The Prior Approval process is initiated by calling: **1-877-213-5225.** Further information about Prior Approval may be found in section B.4.

2) Breast Cancer Treatment

The Plan covers inpatient care for 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 by the attending physician in consultation with the Member.

Prior Approval is required for inpatient admissions. If you use a Participating Provider, he or she will obtain Prior Approval for you. If you use a Non-Participating Provider, you are responsible for obtaining Prior Approval. The Prior Approval process is initiated by calling: **1-877-213-5225.** Further information about Prior Approval may be found in section B.4.

3) Human Organ and Tissue Transplant Services

The Plan covers Medically Necessary human organ and tissue transplants, including bone marrow transplants. 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, the Plan will cover the donor costs for the Member when they are not covered by the recipient's health plan.

Prior Approval is required for human organ transplants. If you use a Participating Provider, he or she will obtain Prior Approval for you. If you use a Non-Participating Provider, you are responsible for obtaining Prior Approval. The Prior Approval process is initiated by calling: **1-877-213-5225**. Further information about Prior Approval may be found in section B.4.

b. Maternity Care

The Plan covers the following inpatient maternity 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.

Prior Approval is required for any inpatient admission for maternity care. If you use a Participating Provider, he or she will obtain Prior Approval for you. If you use a Non-Participating Provider, you are responsible for obtaining Prior Approval. The Prior Approval process is initiated by calling: **1-877-213-5225**. Further information about Prior Approval may be found in section B.4.

c. Rehabilitation Hospital Care

The Plan covers Rehabilitative Services in a facility licensed to provide rehabilitative care on an inpatient basis. Coverage is provided when you need daily Rehabilitative Services that must be provided in an inpatient setting. Rehabilitative Services include physical, speech and occupational therapies.

Approval is required for all inpatient services. If you use a Participating Provider, he or she will obtain Prior Approval for you. If you use a Non-Participating Provider, you are responsible for obtaining Prior Approval. The Prior Approval process is initiated by calling: **1-877-213-5225.** Further information about Prior Approval may be found in section B.4.

d. Skilled Nursing Facility Care

The Plan covers care in a health care facility licensed to provide skilled nursing care on an inpatient basis. Coverage is provided only when you need daily skilled nursing care that must be provided in an inpatient setting. The benefit limit for inpatient Skilled Nursing Facility care services will be stated in the Summary of Benefits (Section A).

Prior Approval is required for all inpatient services. If you use a Participating Provider, he or she will obtain Prior Approval for you. If you use a Non-Participating Provider, you are responsible for obtaining Prior Approval. The Prior Approval process is initiated by calling: **1-877-213-5225**. Further information about Prior Approval may be found in section B.4.

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
- Hospital charges after your hospital discharge
- Charges after the date on which your membership ends, except as required by Maine law

5. MENTAL HEALTH AND DRUG AND ALCOHOL REHABILITATION SERVICES

The Plan covers both inpatient and outpatient mental health care and drug and alcohol rehabilitation services. For coverage of mental health and drug and alcohol rehabilitation services, please call the Behavioral Health Access Center at **1-877-213-5225**. The phone line is staffed by licensed mental health clinicians. A clinician will assist you in (1) determining the type of care you need, (2) finding

appropriate mental health providers, and (3) arranging the services you require.

a. Services for Biologically Based Mental Illness

The Plan covers the Medically Necessary treatment of Biologically Based Mental Illness, including drug and alcohol rehabilitation services, at the same level as for any other medical condition.

Biologically Based Mental Illnesses include the following diagnoses: psychotic disorders including paranoia and schizophrenia; dissociative disorders; mood disorders including bipolar disorder and major depressive disorder; anxiety disorders including panic disorder and obsessive compulsive disorder; personality disorders; paraphilias; attention deficit and disruptive behavior disorders; pervasive developmental disorders including autism; tic disorders; eating disorders including bulimia and anorexia; and substance abuse-related disorders.

Coverage for mental health services includes:

- Inpatient care
- Outpatient care
- Outpatient home care
- Psychological testing

Coverage for drug and alcohol rehabilitation services includes:

- Inpatient drug and alcohol rehabilitation, including partial hospitalization if you and your Provider agree that this treatment is best for you
- Outpatient drug and alcohol rehabilitation, including evaluation, diagnosis, treatment and crisis intervention
- Inpatient detoxification
- Outpatient detoxification and medication management

b. Mental Health Care Services for non-Biologically Based Mental Illness

1) Inpatient Mental Health Services

- Inpatient care is covered up to the limit described in the Summary of Benefits (Section A).
- Coverage includes care in a partial hospitalization program. 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 available for inpatient services described in the Summary of Benefits (Section A). Partial hospitalization will only be covered if you and your Provider agree that this treatment is best for you.
- Inpatient mental health care in a licensed general hospital is covered as long as it is Medically Necessary.

2) Outpatient Mental Health Services

The Plan covers outpatient mental health care, including evaluation, diagnosis, treatment and crisis intervention. Coverage is provided up to the limit described in the Summary of Benefits (Section A).

3) Psychological Testing

The Plan covers psychological testing when Medically Necessary.

RELATED EXCLUSIONS FOR ALL MENTAL HEALTH AND DRUG AND ALCOHOL REHABILITATION SERVICES:

- Educational services or testing. No benefits are provided for educational services intended to enhance educational achievement (e.g. subject achievement testing), or to resolve problems regarding school performance; or services to treat learning disabilities in a school based setting.
- Sensory integrative praxis tests
- Services for any mental illness with a V designation in the Diagnostic and Statistical Manual of Mental Disorders
- Methadone Maintenance

6. DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES

The Plan covers durable medical equipment, including prosthetic devices, when Medically Necessary and ordered by your Provider. HPIC will determine whether to rent or buy all equipment. The

cost of the repair and maintenance of covered equipment is also covered. Covered Charges are based on the cost of equipment to HPIC for In-Network coverage and the Usual, Customary, and Reasonable Charge for Out-of-Network coverage.

Coverage is only available for:

- The least costly equipment (excluding prosthetic arms and legs) adequate to allow you to do Activities of Daily Living; and
- 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 your Summary of Benefits (Section A). Charges for oxygen and respiratory equipment, breast prostheses (including replacements and mastectomy bras), prosthetic arms and legs, diabetes equipment and supplies (as listed below), and durable medical equipment ordered as part of authorized home health care services do not apply to the maximum limit.

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
- Blood glucose monitors

Covered prostheses include:

- Prosthetic arms and legs, other than electronic and myoelectric devices that contain a microprocessor
- Artificial eyes
- Breast prostheses, including replacements and mastectomy bras
- Ostomy supplies
- Hearing aids, up to the benefit limit described in your Summary of Benefits

Covered diabetes equipment and supplies includes:

- Blood glucose monitors
- Insulin pumps (including supplies) and infusion devices
- Therapeutic molded shoes and inserts when needed to prevent or treat complications of diabetes.
- Voice synthesizers
- Visual magnifying aids
- Dosage gauges
- Injectors
- Lancet devices

SECTION D. Exclusions

The Plan does not cover the following:

- Artificial hearts
- Services rendered before a Member's effective date of coverage
- Routine circumcision
- Cosmetic procedures, except as described in this Handbook.
- Commercial diet plans, weight loss programs and any services in connection with such plans or programs.
- Gender reassignment surgery and all related drugs or procedures.
- Drugs, devices, treatments or procedures that are Experimental or Unproven.
- Refractive eye surgery, including, but not limited to, laser surgery, orthokeratology and lens implantation for the correction of myopia, hyperopia and astigmatism.
- Transportation other than by ambulance.
- Transportation by wheelchair van.
- Costs for any services for which you are legally entitled to treatment at government expense, including military service connected disabilities.
- Costs for services covered by third party liability, other insurance coverage, and which are required to be covered by a workers' compensation plan or an employer under state or federal law, unless a notice of controversy has been filed with the Workers Compensation Board contesting the work-relatedness of the claimant's condition and no decision has been made by the Board.
- Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy.
- Routine foot care, biofeedback, pain management programs, and sports medicine clinics.
- Massage therapy when performed by anyone other than a licensed physical therapist/physical therapy assistant or occupational therapist/certified occupational therapy assistant.
- Myotherapy
- Any treatment with crystals.
- Educational services or testing, except such services covered under the Outpatient Mental Health and Drug and Alcohol Rehabilitation benefits. No benefits are provided for educational services intended to enhance educational achievement (e.g. subject achievement testing), or to resolve problems regarding school performance; or services to treat learning disabilities in a school based setting
- Health resorts, recreational programs, camps, wilderness programs, outdoor skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs
- Sensory integrative praxis tests.
- Testing of central auditory processing.
- Physical examinations and testing for insurance, licensing, or employment purposes.
- Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
- Rest or custodial care.
- Personal comfort or convenience items, including telephone, television charges and exercise equipment.
- Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.
- Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services.
- Reversal of voluntary sterilization (including procedures necessary for conception as a result of voluntary sterilization).
- Any form of surrogacy.
- Devices or special equipment needed for sports or occupational purposes.
- 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, or treatment of infections and diagnostic testing for chiropractic care other than an initial x-ray.

- Services for which no charge would be made in the absence of insurance.
- Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit under this Handbook.
- Services for non-Members and services after the date on which your membership is terminated, except as required by Maine law.
- Services or supplies given to you by: (1) anyone related to you by blood, marriage, or adoption, or, (2) anyone who ordinarily lives with you.
- Charges for missed appointments.
- Services that are not Medically Necessary.
- Services for which no coverage is provided in this Handbook, your Summary of Benefits or Prescription Drug Brochure.
- Any home adaptations, including, but not limited to, home improvements and home adaptation equipment.
- All charges over the semi-private room rate, except when a private room is Medically Necessary.
- Hospital charges after the date of discharge.
- Acupuncture, aromatherapy and alternative medicine.
- Pre-implantation of genetic diagnosis (PGD).
- Costs of tests or measurements conducted primarily for the purpose of a clinical trial.
- Any services or devices reasonably expected to be paid for by the sponsors of an approved clinical trial.
- Services for any mental illness with a V designation in the Diagnostic and Statistical Manual of Mental Disorders.
- Methadone maintenance.
- A provider's charge to file a claim or to transcribe or copy your medical records.
- Any service or supply furnished along with a non-Covered Benefit.
- Taxes or assessments on services or supplies.
- Home health care services that extend beyond a short-term intermittent basis, as described in the home health care benefit section.
- Private duty nursing, unless received as an inpatient care service.
- Any Dental Care, except the specific dental services listed in this Handbook.
- Orthognathic surgery
- Wigs
- Eyeglasses, contact lenses and fittings, except as listed in this Handbook.
- Foot orthotics, except when Medically Necessary for the treatment of certain medical conditions.
- Infertility treatment, including consultation, evaluation and related laboratory testing.
- Infertility treatment using advanced reproductive technologies, including, but not limited to, in-vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer, intra-cytoplasmic sperm injection and, donor egg procedures, including related egg and inseminated egg procurement, processing and banking.
- Infertility treatment using therapeutic donor insemination, including related sperm procurement and banking.
- Medical treatment of temporomandibular joint dysfunction (TMD).

SECTION E. Reimbursement and Claims Procedures

The information in this section applies when you wish to file a claim or seek reimbursement when you receive Covered Benefits from a Non-Participating Provider. In most cases you should not receive bills from Participating Providers for Covered Benefits.

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

Proof of loss is administered under this Handbook by filing a claim on HPIC claims forms. Such forms may be obtained from your Employer Group or by calling Customer Service Unit at **1-877-213-5225** or at **1-877-213-5556** for TTY service.

Standard health care industry claim forms, known as the CMS 1500 and the UB-92, will also be accepted. Such forms are also available at most hospitals and physician's offices. In order to be paid by HPIC, all claims must be filed in writing or electronically. (Providers should contact HPIC for instructions concerning electronic filing.) Claims for services must be submitted to the following addresses:

Claims for Pharmacy Services:

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

Claims for Mental Health and Drug and Alcohol Rehabilitation Services:

Behavioral Health Access Center
PO Box 5225
Westborough, MA 01581

All Other Claims:

HPIC Claims
PO Box 5225
Westborough, MA 01581

Please note that Prior Approval is required to receive full coverage for certain Out-of-Network services. Please see Section B.4. for information on Prior Approval requirements.

2. INFORMATION NEEDED FOR CLAIMS PROCESSING

Here is the information we need to process your claim:

- The Member's full name and address
- The Member's date of birth
- The Member's Plan ID number (on the front of the patient's Plan ID card)
- The name and address of the person or institution providing the services for which a claim is made and their tax identification number
- The Member's diagnosis
- The date the service was rendered
- The CPT code (or a brief description of the illness or injury) for which payment is sought
- The amount of the Provider's charge

For pharmacy items, you must also send a drug store receipt stating:

- The Member's name and Plan ID number
- The name of the drug or medical supply
- The drug National Drug Code ("NDC") number
- The quantity
- The number of days supply
- The date the prescription was filled
- The prescribing Provider's name
- The pharmacy name and address
- The amount you paid

Member's can contact the MedImpact help desk at 1-800-788-2949 regarding pharmacy claims.

If you have paid a Provider for Covered Benefits and want the Plan to reimburse you, please send the receipts from the Provider to show proof of payment.

3. LIMITS ON THE SUBMISSION AND PAYMENT OF CLAIMS

To be eligible for payment, claims must be received by HPIC within one year of the date care was received, unless you can show that due to physical or mental incapacity it was impossible for you or your designee to send the claim in that time.

We limit the amount we will pay for Covered Benefits that are not rendered by Participating Providers. The most we will pay for such services is the Usual, Customary and Reasonable Charge. You may be responsible for the balance if the claim is for more than the Usual, Customary and Reasonable Charge. Please contact the Customer Service Unit at **1-877-213-5225** or at **1-877-213-5556** for TTY service if you have questions about the maximum allowable charge that may be permitted by HPIC for a service provided Out-of-Network.

4. MISCELLANEOUS CLAIMS PROVISIONS

Benefits will be paid to the Member who received the services for which a claim is made unless such Member is a minor. In such case, benefits will be paid to the parent or custodian with whom the child resides. The Member may authorize HPIC to pay benefits directly to the health care provider whose charge is the basis for the claim.

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

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

SECTION F. HPIC Utilization and Case Management Services

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

If you are utilizing your Out-of-Network option, HPIC case managers will assist in coordinating your Out-of-Network care through the Prior Approval program. (Please see Section B.4. for a description of the Prior Approval Program.)

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 Participating Provider may also request case management services for a Member at other times. The nurse case managers will assist your Participating Provider in managing your short and long-term health care needs throughout the different health care settings.

When notified of a scheduled admission 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.

For In-Network care, your Participating Provider 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 HPIC Prior Approval when required.

If the Prior Approval 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 Participating Provider(s) had the intention to have the service approved, as well as evaluate the medical appropriateness and the quality of care.

Determination of Medical Necessity is made by HPIC clinical staff and is based on the Member's medical condition, accepted medical practice and appropriateness of care. For Medical Necessity determinations requiring Prior Approval, HPIC makes the initial coverage determinations within two working days of obtaining all necessary information. For Medical Necessity determinations involving ongoing care, HPIC makes the coverage determination within one working day of obtaining all necessary information. Ongoing care will be continued without liability to the Member until the Member is notified of the coverage determination. (Please refer to the definition of Medically Necessary in the Glossary Section of this Handbook). 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 G, Appeals and Complaints.

SECTION G. 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 HPIC Customer Service Representative before filing an appeal. A Customer Service Representative can be reached toll free at **1-877-213-5225** or at **1-877-213-5556** for TTY service.

The Customer 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 Customer Service Representative, you may file an appeal using the procedures outlined below.

2. MEMBER APPEAL PROCEDURES

If you are dissatisfied with a decision on the Plan's coverage of services, you may appeal to HPIC. 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 the Customer Service Unit toll free at **1-877-213-5225** or at **1-877-213-5556** 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 three hundred and sixty-five (365) days of the denial of coverage, except in cases of extenuating circumstances.

Please send your appeal to the following address:

Customer Service Unit
PO Box 5225
Westborough, MA 01581

Telephone: **1-877-213-5225**
FAX: **1-508-329-4820**

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

Behavioral Health Access Center
PO Box 5225
Westborough, MA 01581

Telephone: **1-877-213-5225**
FAX: **1-508-329-4820**

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, HPIC utilizes mediation to resolve some coverage disputes. Both HPIC 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 HPIC 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.

c. Second Level Appeal Process

If you are dissatisfied with the decision of the first level appeal process, you may ask that your appeal be reviewed by an HPIC review committee. You have a right to attend the meeting to discuss your case with the review committee. Just let your Appeals Coordinator know if you wish to attend. You may also participate in the meeting by telephone if you wish. We will hold a review meeting within 45 working days of your request for a second level appeal. You will be notified in writing at least 15 working days in advance of the review meeting. You may submit supporting materials both before and at the review meeting. You also may bring someone with you or be represented by someone at the review meeting. The decision of the review committee will be sent to you in writing within five working days of the meeting. The decision of the review committee is the final decision of HPIC.

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

If HPIC denies your second level appeal 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; and (6) a description of the process to obtain a independent external review.

3. INDEPENDENT EXTERNAL REVIEW OF APPEALS

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

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

4. MEMBER COMPLAINTS

If you have any complaints about your care under the Plan or about HPIC'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:

Customer Service Unit
PO Box 5225
Westborough, MA 01581

Telephone: **1-877-213-5225**

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

Behavioral Health Access Center
PO Box 5225
Westborough, MA 01581

Telephone: **1-877-213-5225**
FAX: **1-508-329-4820**

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)

SECTION H. Eligibility

This section describes requirements concerning eligibility under the Plan, including information on dependent eligibility. This document incorporates by reference any agreement or enrollment form between your Employer or you and HPIC, as applicable.

1. TRANSITION OF MEMBERSHIP TO HPIC

HPIC is assuming administration of DirigoChoice pursuant to an arrangement with the Dirigo Health Agency effective January 1, 2008.

Members will be enrolled in accordance with the rules and procedures of the Dirigo Health Agency and HPIC. For Subscribers with anniversary dates after January 1, 2008, this Handbook will be accepted and binding upon payment of their premium for January 2008. Upon anniversary dates on or after January 1, 2008, all Subscribers must submit an HPIC application for enrollment to continue their membership under the Plan.

2. MEMBER ELIGIBILITY

a. Subscriber Eligibility

To be a Subscriber under this Handbook, you must be an Eligible Individual or an Eligible Employee whose application and/or payment of required premiums have been accepted by HPIC.

b. Dependent Eligibility

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

1. The legal spouse or domestic partner of the Subscriber.

2. An unmarried child (including an adopted child or stepchild) of the Subscriber, spouse, or domestic partner of the Subscriber under the age of 19 years who: (a) has the same principal residence as the Subscriber or spouse and (b) qualifies as a dependent for federal tax purposes.

3. An unmarried child (including an adopted child or stepchild) of the Subscriber, spouse, or domestic partner of the Subscriber, who is at least 19 years of age but not yet 23 years of age, who (a) is enrolled as a full-time student in an accredited educational institution; (b) receives over one-half of his or her support from the Subscriber, spouse, or domestic partner; and (c) is registered annually with HPIC as a student Dependent in advance of the school year.

   Notwithstanding the above requirements, such eligible student Dependent who is unable to remain enrolled in an accredited educational institution on a full-time basis due to a medically determinable mental or physical illness or accidental injury, as documented in writing by both a health care provider and such educational institution, shall be eligible for continued enrollment in the Plan up to the age at which coverage for student Dependents otherwise terminates under this section.

4. An unmarried child (including an adopted child or stepchild) of the Subscriber, spouse, or domestic partner of the Subscriber, age 19 years or older who meets each of the following requirements: (a) is currently Disabled; (b) was Disabled on his or her 19th birthday or became Disabled while enrolled as a full-time student in an accredited educational institution before age 23; (c) lives either with the Subscriber, spouse, domestic partner, 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.

5. An unmarried child under the age of 19 years for whom the Subscriber, Subscriber's spouse, or domestic partner is the court appointed legal guardian. Proof of guardianship must be submitted to HPIC prior to enrollment.

6. 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.

3. 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.

HPIC 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 HPIC is not notified within sixty (60) days of the effective date, Dependents may be added only on the Anniversary Date.

4. 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 thirty (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.

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, your spouse, or your domestic partner. "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. EFFECTIVE DATE – OFF-CYCLE ENROLLMENTS

Under the Health Insurance Portability and Accountability Act, or Maine law (as applicable), individuals covered under an employer-sponsored group health plan may enroll in the Plan at any time if: 1) the employee's spouse or eligible dependent has lost other group health insurance; 2) the employee marries; 3) employer contributions toward dependent's coverage are terminated; 4) the employee has a newborn or adoptive child; 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 HPIC'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 HPIC's receipt of the enrollment request. For reason 4, the effective date must be the date of birth in the case 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.

7. CHANGE IN STATUS

It is your responsibility to inform HPIC, and if applicable your Employer, 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 HPIC must have your current address on file in order to correctly process claims for Out-of-Network care.

8. ADDING A DEPENDENT

Dependents who meet the eligibility guidelines described in this Handbook will be enrolled in the Plan using HPIC enrollment forms or in a manner otherwise agreed to in writing by the Plan and the Dirigo Health Agency. HPIC must receive proper notice of any Member enrollment in, or termination from, the Plan no more than sixty (60) days after such change is to be effective unless otherwise required by law.

9. SPECIAL ENROLLMENT

If you decline enrollment in an employer-sponsored group health plan, participating in this Plan, for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll in this Plan in the future along with your dependents, provided that enrollment is requested within thirty (30) days after other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, or if a court order is issued changing custody of a child, or if a dependent has other coverage and loses eligibility under that coverage, you may be able to enroll along with your dependents, provided that enrollment is requested within thirty (30) days after the marriage, birth, adoption or placement for adoption, or court order changing custody of a child, or a dependent's loss of eligibility under other coverage.

1. TERMINATION BY THE SUBSCRIBER

You may end your membership under this Plan by submitting a completed Enrollment/Change form to the Plan within 60 days of the date you want your membership to end.

2. TERMINATION FOR LOSS OF ELIGIBILITY

Your coverage may end under this Plan for failing to meet any of the specified eligibility requirements.

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

You may be eligible for continued enrollment under federal or state law if your membership is terminated and you had coverage through an employer-sponsored group health plan. See "Continuation of Employer Group Coverage" in this Section for more information (if applicable).

PLEASE NOTE THAT HPIC MAY NOT HAVE CURRENT INFORMATION CONCERNING YOUR MEMBERSHIP STATUS. YOU OR YOUR EMPLOYER GROUP (IF APPLICABLE) HAS UP TO 60 DAYS TO NOTIFY US OF ENROLLMENT CHANGES. AS A RESULT, THE INFORMATION WE HAVE MAY NOT BE CURRENT.

3. MEMBERSHIP TERMINATION

HPIC may end your coverage for any of the following:

a. For Cause

For cause includes:

- Providing false or misleading information on an application for membership
- Committing or attempting to commit fraud to obtain benefits for which you are not eligible under this Handbook
- Obtaining or attempting to obtain benefits under this Handbook for a person who is not a Member

Termination of membership for misrepresentation or fraud to the Plan may go back to the Member's effective date or the date of the misrepresentation or fraud as determined by the Plan. Notice of termination of membership for the other causes will be effective fifteen (15) days after notice. Premium paid for periods after the effective date of termination will be refunded.

b. For Nonpayment

HPIC may end your coverage for failure to make required premium payments in a timely manner. Termination for failure to make required premium payments will be effective at the end of the payment grace period. Premium payments must be received by HPIC within 30 days of the due date. No grace period will apply unless the first month's premium has been paid.

4. CONTINUATION OF EMPLOYER GROUP COVERAGE REQUIRED BY LAW

Under the circumstances that are detailed in Sections a. and b. below, you or your Dependents may be eligible for continuation of coverage under both federal or Maine law if you had coverage under an employer-sponsored group health plan. You should be sure to comply with the time limits stated below to avoid losing important rights.

You may also have the right to enroll in an individual plan directly with HPIC as described below in subsection 5.

a. Maine Law

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

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

b. Federal Law

If you lose employer eligibility, you may be eligible for continuation of group coverage under the federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA).

COBRA provides rights for the continuation of Employer Group health coverage to Members through most Employer Groups with 20 or more employees that provide an employer-sponsored group sponsored health plan. The length

of time continuation is available depends upon the event causing the loss of group health coverage, known as "qualifying event."

Your rights and responsibilities under COBRA are summarized here for informational purposes only. Please note that COBRA is primarily administered by employers and that the Plan can take no responsibility for such administration.

1) Continuation of Coverage

a) Continuation of Employer Group health coverage may be available for up to 36 months, usually from the date of a qualifying event that causes the loss of health coverage, in the following situations:

- The death of the employee
- The divorce or legal separation of the employee
- The employee becomes entitled to Medicare coverage.

b) Continuation of Employer Group health coverage may be available for up to 18 months, usually from the date of a qualifying event that causes the loss of employer sponsored group health coverage, in the following situations:

- The subscriber's employment is terminated, for reasons other than gross misconduct or
- The subscriber's work hours are reduced, making the subscriber ineligible for coverage.

The 18 month period may be extended to 29 months if a qualified beneficiary is determined to have been disabled under the Social Security Act at the time employment is terminated or hours of work are reduced if notice of a determination of Social Security disability is given to the employer's plan administrator within 60 days of the disability determination and within the 18 month period.

c) In the event of the bankruptcy of an employer, qualified beneficiaries, including retirees eligible for health benefits, may be eligible to elect and pay for continuation of coverage for life. Please ask your Employer Group's plan administrator for further information if this may apply to you.

2) Notification

a) Dependents entitled to benefits under COBRA must notify the subscriber's employer in writing within 60 days of the following events:

- The subscriber's divorce or legal separation from his or her covered spouse or
- A dependent child ceases to be eligible for coverage

b) The employer must notify you or your dependents of your right to continuation of coverage under COBRA after receiving notice of a qualifying event.

c) If you or your dependents are entitled to benefits under COBRA, you must notify your employer in writing of the election of continued coverage within 60 days of receipt of notice of COBRA eligibility from the employer group.

3) Termination of Continued Coverage

An employer may terminate continued health coverage under COBRA when one of the following occurs:

a) The initial period of continuation ends;

b) The employer group ceases to make any health program available to any employee;

c) A person entitled to benefits under COBRA fails to make timely payments of premium;

d) The person entitled to benefits under COBRA is covered under any other group health plan, except that eligibility may continue up to the maximum provided by COBRA if the new plan omits or excludes coverage for a preexisting condition of such covered person;

e) The person entitled to benefits under COBRA becomes eligible for Medicare; or

f) A person entitled to benefits under COBRA remarries and becomes covered by another group health plan.

4) Premium Payments

If a person entitled to benefits under COBRA elects continuation of coverage, that person will be required to pay up to 102% of the total premium. There is no employer contribution. Payments must be made directly to the employer group.

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

5. NONGROUP AND BUY DIRECT COVERAGE

HPIC and its affiliated companies offer health plans directly for some people who are no longer eligible for coverage through a a group or an employer group.

HPIC's affiliate, Harvard Pilgrim, offers "Nongroup" health plans for Maine residents, and "Buy Direct" health plans for Massachusetts residents. Coverage purchased on a Nongroup or Buy Direct basis directly from Harvard Pilgrim may differ from the coverage under your previous plan. Individuals may enroll only in a plan offered in their state of residence and must satisfy all eligibility guidelines. Your state of residence will have specific rules about eligibility and coverage.

Maine residents: The plans we sell directly to residents of Maine are called Nongroup plans. We must receive your application within 90 days of your last date of employer coverage to avoid a possible preexisting condition exclusion period.

Massachusetts residents: The plans we sell directly to residents of Massachusetts are called Buy Direct plans, and there are many options available. If you are eligible, your effective date will be the first of the month following the date we receive complete and accurate enrollment materials and your first month's premium payment. We must receive the enrollment material at least five days prior to your coverage start date (e.g., by June 25 for a July 1 start date).

Questions
If you have any questions, please call us at one of the following numbers. One of our representatives will be glad to assist you.

Maine residents
For Nongroup coverage questions
1-888-333-4742 - weekdays 8 a.m. - 5:30 p.m.
Monday and Wednesday until 7:30 p.m.

Massachusetts residents
For Buy Direct coverage questions
1-800-208-1221 - weekdays 8:30 a.m. -5 p.m.

6. EXTENSION OF BENEFITS UPON DISCONTINUATION OF GROUP COVERAGE IF YOU ARE TOTALLY DISABLED

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

Benefits under this Benefit Handbook will be continued for the treatment of the impairment causing the disability until the earlier of:

a) the date on which the treatment of the impairment causing disability is no longer Medically Necessary; or

b) the expiration of six months.

For purposes of this section only, the term "totally disabled" means for a Member:

a) who was gainfully employed prior to disability, the inability to engage in any gainful occupation for which he or she is suited by training, education and experience; or

b) who was not gainfully employed prior to disability, the inability to engage in most normal activities of a person of like age in good health.

For the purposes of this extension of benefits, all of the terms, conditions and limitation of your Plan coverage under this Handbook shall apply, except that no premium shall be charged. In the event you become covered under replacement coverage, your new coverage will be the primary payor and your replaced coverage for expenses directly relating to the condition causing the total disability during the extension of benefits will be the secondary payor.

After discontinuation of the coverage by your group, HPIC is only liable for: (1) accrued liabilities and (2) extensions of benefits for the condition relating to your disability if you are totally disabled upon discontinuation of the Plan.

SECTION J. 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 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 other plan will determine the order of benefits.

c. Dependent Child/Separated or Divorced Parents

Unless a court order, of which HPIC 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;

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 are

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. PAYMENT WHEN HPIC COVERAGE IS PRIMARY OR SECONDARY

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

When HPIC is secondary, HPIC is responsible for processing claims for Covered Benefits after the primary plan has issued a benefit determination. HPIC will first review the primary plan's benefit determination. HPIC will then pay or provide Covered Benefits as the secondary payor. HPIC may recover any payments made for services in excess of the HPIC's liability as the secondary plan, either before or after payment by the primary plan.

HPIC's benefits will be reduced so that the total amount paid by all plans for a Covered Benefit will not exceed the amount payable under this Handbook. This means that HPIC will not pay more than the maximum amount payable under this Plan. In addition, if another plan pays a certain amount for a Covered Benefit, HPIC will then only pay the difference, if any, between the amount allowed under this Plan and the amount paid by the other plan for the same Covered Benefit subject to the provisions above.

3. WORKER'S COMPENSATION/ GOVERNMENT PROGRAMS

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

4. SUBROGATION

Subrogation is a means by which HPIC 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 your illness or injury which have been paid for or provided by HPIC, HPIC 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 HPIC. HPIC 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. HPIC's right to recovery shall apply even if a recovery the Member receives for the illness or injury is designated or described as being for injuries other than health care expenses. HPIC will also be entitled to recover from a Member up to 100% of the value of the services provided or paid for by HPIC 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, which means any factors that reduce the potential value of services may likewise reduce HPIC's claim.

To enforce its subrogation rights under this Handbook, HPIC 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 HPIC for which such party is, or may be, liable. By signing your enrollment form requesting coverage under the Plan, you have authorized HPIC's right of subrogation.

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, HPIC has the right to coordinate with other insurance carriers under its subrogation rights. The benefits under this Handbook shall not duplicate any benefits to which the Member is entitled under any medical payment policy or

benefit. All sums payable for services provided under this Handbook to Members that are covered under any medical payment policy or benefit are payable to HPIC.

6. MEMBER COOPERATION

The Member agrees to cooperate with HPIC in exercising its rights of subrogation and coordination of benefits under this Handbook. Such cooperation will include, but not be limited to, a) the provision of all information and documents requested by HPIC, b) the execution of any instruments deemed necessary by HPIC to protect its rights, including its right to subrogation, and, c) the prompt assignment to HPIC of any moneys received for services provided or paid for by HPIC and d) the prompt notification to HPIC of any instances that may give rise to HPIC's rights. The Member further agrees to do nothing to prejudice or interfere with HPIC'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 HPIC for any expenses HPIC may incur, including reasonable attorneys' fees, in enforcing its rights under this Handbook.

7. HPIC'S RIGHTS

Nothing in this Handbook shall be construed to limit HPIC'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

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

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

SECTION K. Administration of this Benefit Handbook

1. COVERAGE WHEN MEMBERSHIP BEGINS WHILE HOSPITALIZED

a. General Coverage Rules

If your membership begins while you are hospitalized, coverage begins from the time membership is effective. All other terms and conditions of coverage under this Handbook will apply.

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

If you are hospitalized at an Out-of-Network hospital, you must call HPIC for Prior Approval. The Prior Approval process is initiated by calling **1-877-213-5225** for medical services. For all mental health and drug and alcohol rehabilitation services please call **1-877-213-5225**. Further information about Prior Approval may be found in Section B.4.

b. Newborn Coverage

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

2. MISSED APPOINTMENTS

Participating Providers may charge you for appointments you miss. If you do not cancel before the scheduled appointment, and you were physically able to do so, you may be responsible for the Cost Sharing. You can call the Provider to find out how much advance notice is needed to cancel an appointment. Missed appointments will not count toward any benefit limits.

3. LIMITATION ON LEGAL ACTIONS

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

4. ACCESS TO INFORMATION

You agree that, except where restricted by law, HPIC may have access to (1) all health records and medical data from health care providers providing services 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. HPIC 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 records.

5. CONFIDENTIALITY

HPIC is committed to ensuring and safeguarding the confidentiality of its Members' information in all settings, including personal and medical information. HPIC staff access, use and disclose Member information only in connection with providing services and benefits and in accordance with HPIC's confidentiality policies. HPIC permits only designated employees, who are trained in the proper handling of Member information, to have access to and use of your information. HPIC 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 HPIC's confidentiality and privacy standards.

When you enrolled with HPIC, you consented to certain uses and disclosures of information 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 and regulatory audits. When HPIC uses or discloses Member information, it does so using the minimum amount of information necessary to accomplish the specific activity.

HPIC 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 payors, 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, HPIC 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. HPIC 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, HPIC and all of its contracted health care providers agree to provide Members access to, and a copy of, their medical records upon a Members request. In addition, your medical records cannot be released to a third party without your consent or unless permitted by law.

Note: To obtain a copy of HPIC's Notice of Privacy Statement, please call our Customer Service Unit at **1-877-213-5225** or at **1-877-213-5556** for TTY service. This information is also available on our website at www.healthplansinc.com.

6. NOTICE

Any notice to a Member will be sent to the last address of the Member on file with HPIC. Notice to HPIC should be sent to HPIC Insurance Company, PO Box 5225, Westborough, MA 01581.

Premium rate information is available from your Employer Group (if applicable), or the Dirigo Health Agency.

7. MODIFICATION OF THIS HANDBOOK

This Handbook, Summary of Benefits and Prescription Drug Brochure may be amended by HPIC upon sixty (60) days written notice to your Employer Group or you, as applicable. Amendments do not require the consent of Members.

This Handbook, including the Summary of Benefits and Prescription Drug Brochure and incorporated form, is the entire contract between you and HPIC. It can only be modified in writing by an authorized officer of HPIC. No other action by HPIC, including the deliberate non-enforcement of any benefit limit, shall be deemed to waive or alter any part of this Handbook.

8. RELATIONSHIP OF PARTICIPATING PROVIDERS AND HPIC

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

For any questions regarding this Handbook, Members may contact Customer Service at **1-877-213-5225** or at **1-877-213-5556** for TTY services.

9. MAJOR DISASTERS

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

10. EVALUATION OF NEW TECHNOLOGY

The Plan covers medical devices, diagnostic, medical and surgical procedures and drugs as described in your Handbook, Summary of Benefits, and 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 or Unproven.

HPIC has a dedicated team of corporate staff that evaluates diagnostics, testing, interventional treatment, therapeutics, medical/behavioral 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 and literature, consulting with expert practitioners, and benchmarking. The team presents its recommendations to internal policy committees responsible for making decisions regarding coverage of the new technology under the Plan.

11. HIPAA CERTIFICATE OF CREDITABLE COVERAGE

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), members are entitled to a Certificate of Creditable Coverage, which verifies the most recent period of coverage under the member's 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 group 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 group's health plan must be reduced by the number of days of coverage shown on the Certificate.

HPIC will automatically send you a Certificate of Creditable Coverage upon termination of your membership from the Plan unless your group has specifically notified HPIC in writing that it will send such certificates and has instructed HPIC not to do so. You may also call the Customer Service Unit at any time within two (2) years from the date coverage ended to request a free copy of their Certificate from HPIC.

SECTION L. Glossary

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

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.

Adverse Utilization Determination

A determination by HPIC that: (1) an admission, availability of care, continued stay or other health care service has been reviewed and does not meet HPIC'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.

Anniversary Date

The date upon which the yearly premium rate is adjusted and benefit changes normally become effective. This Benefit Handbook, the Summary of Benefits, Prescription Drug Brochure, will terminate unless renewed on the Anniversary Date.

Behavioral Health Access Center

The organization, designated by HPIC, responsible for coordinating services for Members in need of mental health or drug or alcohol rehabilitation care. If you need mental health or drug and alcohol rehabilitation care, you may call the Behavioral Health Access Center at **1-877-213-5225**.

Benefit Handbook (or Handbook)

This legal document, including the Summary of Benefits and the Prescription Drug Brochure, which sets forth the services covered by the Plan, the exclusions from coverage and the conditions of coverage for Members.

Biologically Based Mental Illness

Biologically Based Mental Illnesses include the following diagnoses: psychotic disorders including paranoia and schizophrenia; dissociative disorders; mood disorders including bipolar disorder and major depressive disorder; anxiety disorders including panic disorder and obsessive compulsive disorder; personality disorders; paraphilias; attention deficit and disruptive behavior disorders; pervasive developmental disorders including autism; tic disorders; eating disorders including bulimia and anorexia; and substance abuse-related disorders.

Coinsurance

A percentage of the Covered Charge for certain Covered Benefits that must be paid by the Member. Coinsurance amounts applicable to your Plan are stated in your Summary of Benefits.

Copayment

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

Cost Sharing

The responsibility of Members to assume a share of the cost of the benefits provided under the Plan. Cost Sharing may include Deductible, Copayments and Coinsurance. Please refer to your Summary of Benefits (Section A) for the specific Cost Sharing amounts that apply to your Plan.

Covered Benefits

The medical services and supplies that a Member is eligible to receive, or obtain payment for under the Plan. Covered Benefits must be: (1) Medically Necessary, and (2) not excluded from coverage under Section D.

Covered Charge

Expenses incurred by a Member for a Covered Benefit. Covered Charges do not include any amount in excess of a benefit limit stated in this Handbook, or in the excess of Usual, Customary and Reasonable Charges.

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.

Deductible

A specific dollar amount that you pay for most Covered Benefits each calendar year before any benefits subject

to the Deductible are payable by the Plan. Your Plan may include separate Deductibles that must be met for medical services and non-Biologically Based Mental Illness services. Deductible amounts are incurred on the date of service. Deductible amounts applicable to your Plan are stated in the Summary of Benefits.

Deductible Rollover

A feature of the Plan under which expenses incurred toward the Deductible by a Member during the last 3 months of a calendar year are applied toward the Deductible requirement for the next year. To be eligible for a Deductible Rollover, a Member must have had continuous coverage under DirigoChoice at the time the charges in the prior year were incurred.

Dental Care

Any service provided by a person licensed as a dentist involving the diagnosis or treatment of any disease, pain, injury, deformity or other condition of the human teeth, alveolar process, gums, jaw or associated structures of the mouth.

Dependent

A Member of the Subscriber's family who (1) meets the eligibility requirements for coverage through a Subscriber as set forth in this Benefit Handbook or as otherwise agreed to by the DHA and HPIC and (2) who is enrolled in the Plan.

Dirigo Health Agency (DHA)

An independent executive agency of the State of Maine that arranges for the provision of comprehensive health care coverage to eligible small employers, including the self-employed, their employees and dependents, and individuals.

Eligible Business

A business that employs at least two but not more than 50 eligible employees, the majority of whom are employed in the State of Maine, including a municipality that has 50 or fewer employees.

Eligible Individual

An individual who 1) resides in the State of Maine, 2) is not eligible for Medicare as a new enrollee with DirigoChoice, and 3) is,

a. an unemployed individual;

b. an individual employed in an Eligible Business that does not offer health insurance and has not provided the individual access to an employer-sponsored benefits plan in the twelve month period immediately preceding the individual's application;

c. an employer or employee of an Eligible Business that offered DirigoChoice but that did not meet the 75% participation requirement;

d. an individual who does not work more than 20 hours a week for a single employer and is not self employed;

e. an early retiree (i.e. under age 65) who worked for an Eligible Business that does not contribute to the early retiree's health insurance coverage;

f. an individual who is employed by a household and works more than 20 hours a week and is not offered health insurance coverage by the household; or,

g. an individual who is eligible for the Health Care Coverage Tax Credit (HCTC) program.

Individuals and their eligible dependents are required to certify how they meet Eligible Individual eligibility requirements.

Eligible Employee

An employee of an Eligible Business who works at least 20 hours per week for that Eligible Business. Eligible Employee does not include an employee who works on a temporary or substitute basis or who does not work more than 26 weeks annually.

Employer Group or Employer

An entity that has contracted with the DHA to provide health care coverage for its employees under the Plan.

Experimental or Unproven

A service, procedure, device, or drug will be deemed Experimental or Unproven by HPIC 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 medical standards, primary reliance will be placed upon data from published reports in authoritative medical or scientific publications that are subject to peer review by qualified medical or scientific experts prior to publication. In the absence of any such reports, it will generally be determined that a service, procedure, device or drug is not safe and effective for the use in question.

b. In the case of a drug, the drug has not been approved by the United States Food and Drug Administration (FDA) (This does not include off-label uses of FDA approved drugs).

Family Coverage

Coverage for a Member and one or more Dependents.

HPHC Insurance Company, Inc. (HPIC)

HPHC Insurance Company, Inc. (HPIC) is an insurance company licensed in the state of Maine that is affiliated with Harvard Pilgrim Health Care, Inc.

Hospital

A facility that is licensed to provide inpatient medical, surgical or rehabilitative services. A hospital does not include a Skilled Nursing Facility or any place operated primarily to provide convalescent or custodial or chronic care.

Individual Coverage

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

In-Network

The level of benefits or coverage a Member receives when Covered Benefits are obtained through a Participating Provider.

Lifetime Benefit Maximum

The total amount payable by HPIC for Covered Benefits to one Member under this Benefit Handbook. If your Plan includes a Lifetime Benefit Maximum, it will be stated in your Summary of Benefits.

Medical Emergency

A sudden and unexpected onset of a condition with symptoms so severe, that a person possessing average knowledge of health and medicine would expect that without prompt medical attention, his or her health (physical or mental) would be in serious jeopardy; or his or her 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

Medically Necessary or Medical Necessity

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

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

Member

Any Subscriber or Dependent covered by this Handbook.

Non-Participating Provider

Providers who are not under contract to provide care to Plan Members. The payment schedule for services received from Non-Participating Providers is based on Usual, Customary and Reasonable Charges. When care is received from a Non-Participating Provider, Members are responsible for Deductibles, Coinsurance and Copayments and any amounts in excess of the payment schedule. These Cost Sharing requirements are described in your Summary of Benefits.

Out-of-Network

The level of benefits or coverage a Member receives when Covered Benefits are obtained through a Non-Participating Provider.

Out-of-Pocket Maximum

An Out-of-Pocket Maximum is a limit on the amount of Cost Sharing that you must pay for Covered Benefits per calendar year. Certain expenses do not apply to the

Out-of-Pocket Maximum. These include, but may not be limited to, Copayments, Cost Sharing payments for non-Biologically Based Mental Illness services, Cost Sharing payments for prescription drugs, any charges incurred by a Member in excess of the Usual, Customary and Reasonable Charge for a service, and any Penalty for failure to receive Prior Approval when required. If your Plan includes an Out-of-Pocket Maximum, your specific Out-of-Pocket Maximum amount is listed in your Summary of Benefits (Section A).

Participating Provider

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

Penalty

The amount that a Member is responsible to pay for certain Out-of-Network services when Prior Approval has not been received before receiving the services. The Penalty charge is in addition to any Member Cost Sharing amounts. Please refer to Section B.4. for a detailed explanation of the Prior Approval program.

Plan

A package of health care benefits known as the DirigoChoice PPO Plan underwritten by HPHC Insurance Company.

Prior Approval

A program to verify that certain Covered Benefits are, and continue to be, Medically Necessary and provided in an appropriate and cost-effective manner. The Prior Approval program is described in Section B.4.

Provider

Providers of health care services including, but not limited to, hospitals; skilled nursing facilities; and medical professionals, including: physicians, psychiatrists, nurse practitioners, physician assistants, certified nurse midwives, certified registered nurse anesthetists, registered first nurse assistants, chiropractors, and licensed mental health professionals, including psychologists, clinical social workers, licensed clinical professional counselors, 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). Participating Providers are listed in the Provider Directory.

Provider Directory

A directory that identifies HPIC Participating Providers. HPIC may revise the Provider Directory from time to time without notice to Members.

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 Dependent enrolled under a QMSO is subject to the same terms, conditions and limitations stated in this Handbook, Summary of Benefits and Prescription Drug Brochure.

Rehabilitative Services

Health care services designed to restore a person's ability to perform Activities of Daily Living after a disabling injury or illness. Only the following Rehabilitative Services are covered: physical therapy; speech therapy; occupational therapy; cardiac rehabilitation; or an organized program of these services.

Skilled Nursing Facility

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

Subscriber

The person who meets the eligibility requirements described in this Handbook or as agreed to by the DHA and HPIC, and who is enrolled in the Plan.

Surgical Day Care (SDC)

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

Surrogacy

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

Usual, Customary and Reasonable Charge

An amount that is consistent, in the judgment of HPIC, 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. The Usual, Customary, and Reasonable Charge is the maximum amount that HPIC will pay for Covered Benefits. Please refer to Section B.3.h for additional information concerning Usual, Customary and Reasonable Charges.

SECTION M. 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.

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 HPIC or its designee. All complaints must be submitted in writing and addressed to HPIC or one of the regulatory offices listed below:

HPHC Insurance Company
Customer Service Unit
PO Box 5225
Westborough, MA 01581
Telephone: **1-877-213-5225**
Internet: www.healthplansinc.com

For Maine Physicians:

Board of License in Medicine
137 State House Station
Augusta, ME 04333
Telephone: **1-888-365-9964**
Internet: **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)
Internet: **www.maineinsurancereg.org**

For Massachusetts Physicians:

Board of Registration in Medicine
560 Harrison Avenue, Suite G-4
Boston, MA 02118
Telephone: **1-617-654-9800**

Massachusetts Department of Public Health
250 Washington Street
Boston, MA 02108-4619
Telephone: **1-617-624-5200**

For New Hampshire Physicians:

Board of Medicine
2 Industrial Park Drive
Suite #8
Concord, NH 03301-8520
Telephone: **1-603-271-1203**

State of New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301
Telephone: **1-800-852-3416**

For Vermont Physicians:

Vermont Board of Medical Practice
P.O. Box 70
Burlington, VT 05402-0070
Telephone: **1-802-657-4220**

Vermont Division of Health Care Administration
89 Main Street
Drawer 20
Montpelier, VT 05620-3101
Telephone: **1-800-631-7788 (in state)**

SECTION N. Member Rights and Responsibilities

- Members have a right to receive information about HPIC, 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 HPIC or the care provided.
- Members have a right to make recommendations regarding HPIC's Member rights and responsibilities policies.
- Members have a responsibility to provide, to the extent possible, information that HPIC 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 responsibility to understand their health problems and participate, to the extent possible, in developing mutually agreed upon treatment goals to the degree possible.

HPHC Insurance Company, Inc.

DirigoChoice Prescription Drug Brochure

Three-Tier

This brochure is a legal document that explains the prescription drug benefits provided by the HPHC Insurance Company (the "Plan") to Members. This brochure is applicable to the HPHC Insurance Company, Inc. DirigoChoice PPO Plan.

Prescription Drug Coverage

Prescription medications can play an important role in keeping you healthy. Your coverage includes an outpatient prescription drug benefit to help make paying for these medications more affordable. Your benefit covers most outpatient prescription drugs and some non-prescription drugs and medical supplies. Prescription drugs are not subject to the Deductible.

In this brochure, you'll find information about:

- The Plan's three-tier prescription drug benefit
- Copayments
- Covered and non-covered drugs
- Where to buy your prescriptions
- The Mail Service Prescription Drug Program
- Drug coverage policies

You will find words in this brochure that have special meanings. When we use one of those words, we start it with a capital letter. Capitalized terms that are not defined in this brochure are defined in the Glossary of your Benefit Handbook.

Three-Tier Prescription Drug Benefit

The Plan places all covered drugs into one of three levels or "tiers." Each tier has its own Copayment amount, which is listed on your Member identification (ID) card. The three tiers are described below.

Tier 1

Tier 1 is primarily made up of generic drugs. These drugs contain the same active ingredients as their brand-name counterparts. Tier 1 may also include brand-name drugs that the Plan has determined to be more effective, less costly or to have fewer side effects than similar medications. You pay the lowest Copayment amount for Tier 1.

The Tier 1 Copayment is: $10

Tier 2

Tier 2 is primarily made up of brand name drugs for which generic equivalents are not available. These drugs have been selected by the Plan based on review of the relative safety, effectiveness and cost of the many brand name drugs on the market. Tier 2 may also include generic drugs that the Plan has determined to be more costly than their brand name alternatives.

The Tier 2 Copayment is: $30

Tier 3

Tier 3 is made up of drugs that the Plan has not included in Tier 1 or Tier 2. You pay the highest Copayment Amount on Tier 3 drugs.

The Tier 3 Copayment is: $50

Getting a Copy of the Drug List

You can get a copy of the Plan's Three-Tier Prescription Drug List by calling the Customer Service Unit at1-877-213-5225. The list is also available online at www.healthplansinc.com.

Member Cost Sharing

Members are required to share the cost of the benefits provided under the Plan. Your payments, called Cost Sharing, include Copayments. Prescription drugs are not subject to the Deductible.

This section describes how the Plan administers the different types of cost sharing. The specific Cost Sharing that applies to your Plan is listed on your Member ID card.

Discount Rate

In this brochure, we refer to the term "Discount Rate." The Discount Rate is a discount price for prescription drugs that the Plan has negotiated with participating pharmacies. The Discount Rate is the basis for calculating your Cost Sharing under the Plan.

Note: The Discount Rate is not a fixed discount. The Plan may modify the discount as market conditions change.

How the Discount Rate Benefits Members

The Discount Rate is usually lower than the retail price pharmacies charge for drugs. If a participating pharmacy's retail price is less than the Discount Rate, your cost sharing is always based on the lower amount.

Note: The Plan's cost for covered drugs is generally lower than the Discount Rate.

Copayments

The Plan provides prescription drug coverage with Copayments. Copayments are fixed dollar amounts you must pay for covered medications. Copayments are paid to the pharmacy at the time of purchase. Different Copayment amounts apply to each of the three drug tiers. Your Copayment amount is listed on your ID card.

What You Pay

Copayments are calculated in two ways, depending on whether you use a participating or non-participating pharmacy:

Participating Pharmacy	Non-Participating Pharmacy
If you buy your prescriptions at a participating pharmacy, you pay the lower of the Copayment, the Discount Rate, or the pharmacy's retail price.	If you buy your prescriptions at a non-participating pharmacy, the Discount Rate does not apply. You pay the lower of the Copayment or the pharmacy's retail price.

Please see "Buying Prescriptions" for more information on participating and non-participating pharmacies.

What the Copayment Covers

Each Copayment covers up to a 30-day supply for each prescription or refill, except where limited by the Plan. If your physician prescribes less than a 30-day supply of a medication, each Copayment covers the amount prescribed. Benefits may also be provided for up to a 90-day supply if prescribed by your physician as Medically Necessary. The Plan may limit the quantity of a drug available per 30-day period, 90-day period, or per Copayment.

What is Covered

Your prescription drug benefit covers all Medically Necessary drugs that require a prescription by law, except drugs the Plan excludes or limits. Your benefit also covers the non-prescription items, listed below. All covered drugs are subject to the applicable cost sharing amounts. Please check your Member ID card for the cost sharing amounts that apply to your drug coverage.

Your Plan covers the following prescription and non-prescription items:

Covered Prescription Drugs

- FDA approved prescription drugs prescribed by a physician
- Needles and syringes needed to administer covered drugs
- FDA approved contraceptive drugs and devices
- Prenatal vitamins
- FDA approved hormone replacement therapy (HRT)
- Off-label uses of FDA approved drugs, including drugs for the treatment of cancer and HIV/AIDS
- Compounded prescriptions, as long as one or more agents within the compound is FDA approved and requires a prescription

Covered Non-Prescription Drugs

- Insulin
- Oral agents for controlling blood sugar
- Lancets
- Blood glucose testing strips
- Urine diabetic testing strips
- Ketone diabetic testing strips

Buying Prescriptions

Participating Pharmacies

You should fill prescriptions at a Plan participating pharmacy whenever possible. If you use a participating pharmacy, you only have to show your Member ID card and pay the applicable Cost Sharing amounts. If you do not use a participating pharmacy, you must pay the retail price for the medication and submit a claim for reimbursement.

There are over 45,000 Plan participating pharmacies in the United States, including:

- Brooks Pharmacy
- CVS/pharmacy
- Eckerd
- Kmart Pharmacy
- Rite Aid
- Star Market
- Stop & Shop
- Walgreens
- Wal-Mart
- Many independent drug stores

You can get more information on participating pharmacies by calling our Customer Service Unit at **1-877-213-5225**. You may also search for participating pharmacies in any area of the country on our website at www.healthplansinc.com**.**

The Specialty Pharmacy Program

The Plan has designated pharmacies that you must use to obtain certain specialty medications. These include drugs for the treatment of hepatitis C, osteoarthritis, multiple sclerosis, rheumatoid arthritis and certain hereditary diseases. A list of the drugs that must be purchased from the specialty pharmacies may be obtained on our website at www.healthplansinc.com**.** This information may also be obtained by calling our Customer Service Unit at **1-877-213-5225**.

The Plan's specialty pharmacies have expertise in the delivery of the drugs they provide. They maintain these medications in stock at all times and can deliver them by overnight mail with the medical supplies necessary for their use. In an emergency, same day delivery can also be provided. The specialty pharmacies will give you instructions in the administration of the drugs they provide. Additional drugs may be added to the specialty pharmacy program from time to time.

Your Cost Sharing at the specialty pharmacies is the same as at other participating pharmacies. The specialty pharmacies are not part of the Plan's Mail Order Prescription Drug Program, to which different Cost Sharing rules apply.

Non-Participating Pharmacies

If you fill a prescription for a covered drug at a non-participating pharmacy, you must pay the retail price for the drug, then submit a claim for reimbursement from the Plan. The reimbursement procedures for pharmacy items are explained in your Benefit Handbook. Reimbursement for drugs purchased at non-participating pharmacies will be paid minus the Copayment. Payment will be limited to the Usual, Customary and Reasonable Charge for the drug.

Mail Service Prescription Drug Program

The Plan provides a Mail Service Prescription Drug Program for Members who prefer the convenience of receiving their prescriptions through the mail. You may purchase up to a 90-day supply of maintenance medications through the Mail Service Program.

Although most maintenance medications are available from the Mail Service Program, the Plan may exclude drugs from the program for clinical reasons or to prevent potential waste. In addition, drugs included in the Specialty Pharmacy Program, discussed above, are not available through the Mail Service Program.

Please see your ID card for your Mail Service Copayments. The Mail Service Copayment amounts listed on your ID card apply only to the Plan's Mail Service Program.

For more information about the Plan's Mail Service Prescription Drug Program, including any drug limitations or exclusions, please call **1-877-347-3216** (**TTY 1-877-517-9301**).

The Copayments applicable to Mail Service coverage are:
Tier 1 drugs Copayment $20 for up to a 90-day supply
Tier 2 drugs Copayment $60 for up to a 90-day supply
Tier 3 drugs Copayment $100 for up to a 90-day supply

What is Not Covered or has Limited Coverage

There are a number of prescription drugs that are either not covered by the Plan or for which coverage is limited. The Plan covers only drugs that are Medically Necessary for preventive care or for treating illness, injury, or pregnancy. (Drugs that are not covered include, but are not limited to, drugs primarily used for cosmetic purposes and weight loss.)

The Plan also limits the coverage of specific drugs for reasons of cost and to assure their safe and effective use. Limitations may be placed on either the quantity of a drug covered or the medical conditions for which a covered drug may be prescribed.

Drugs that are excluded, limited, or require prior authorization are listed in the Plan's Three-Tier Prescription Drug List. You may request a copy of this list by calling the Customer Service Unit at 1-877-213-5225 or view it online at www.healthplansinc.com.

Non-Covered or Limited Coverage Prescription Drugs

The Plan does not cover the following:

- Drugs that are not Medically Necessary for preventive care or for treating illness, injury or pregnancy.
- Drugs that the Plan specifically excludes, including, but not limited to, drugs primarily used for cosmetic purposes and weight loss.
- Drugs in excess of coverage limitations imposed by the Plan. (Limitations may be placed on either the quantity of a drug covered or the medical conditions for which a drug may be prescribed.)
- Non-prescription items, other than those specifically listed above.
- Drugs that have not been approved by the FDA.
- Drugs prescribed as part of a course of treatment that the Plan does not cover.
- Drugs that must be administered by a health care professional. (Such drugs may be covered through the provider but may not be purchased by you under the pharmacy benefit.)
- Drugs that must be obtained through the Specialty Pharmacy Program if not purchased from one of the program's specially designated pharmacies.
- Any sales tax or governmental assessment on pharmacy items.

Exception Policy

The Plan will not grant individual exceptions to waive or reduce the Copayment amount for a particular drug. However, medical providers may submit a request to the Plan to review or reconsider coverage of a drug.

Medical providers may also request an exception on behalf of a Member for coverage of any drug that is excluded or limited. Exceptions may be granted only for clinical reasons.

About Your Drug Benefit

Pharmacy and Therapeutics Committee

The Plan's Pharmacy and Therapeutics Committee is an advisory group that makes recommendations for the placement of drugs in the different Tiers, as well as setting exclusions and limitations on drug coverage. The Committee is made up of physicians and pharmacists, who are advised by physician consultants from a large number of medical specialties.

Tier Changes

The Plan regularly reviews and updates the Three-Tier drug list as new drugs or drug information becomes available. As a result, the tier placement of covered drugs may change at any time. You can get an updated Three-Tier Drug List by calling the Customer Service Unit at 1-877-213-5225 or view it online at www.healthplansinc.com.

Important Notice

In the event of a Medical Emergency, seek immediate care. You may call **911** or your local emergency number. Please see your Benefit Handbook, including the Summary of Benefits for information on your coverage.