HPHC Insurance Company
Medicare Enhance

P.O. BOX 9185 • QUINCY, MA 02169
1-888-888-HPHC(4742)

CHECK ONE

☐ ENROLLMENT _____ (REASON FOR ENROLLING) _____ EFFECTIVE DATE

☐ TERMINATION _____ (REASON FOR TERMINATION) _____ LAST DAY OF COVERAGE

☐ ADJUSTMENT _____ (REASON FOR CHANGE is: ADDRESS, NAME, ETC.) _____ EFFECTIVE DATE

INSTRUCTIONS

- **DO NOT WRITE IN SHADED AREAS**
- **PLEASE TYPE OR PRINT FIRMLY**
- **ATTACH A COPY OF MEDICARE CARD**

ID NUMBER
H P E

GROUP NO. | DIV. NO.

NAME — FIRST — MIDDLE — LAST

HOME PHONE # ( )

MAILING ADDRESS — NO. STREET/P.O. BOX — CITY — STATE — ZIP — APT # — COUNTY

SOCIAL SECURITY # — —

HOME ADDRESS — NO. STREET/P.O. BOX — CITY — STATE — ZIP — APT # — COUNTY

DATE OF BIRTH MO/ DAY/ YR/

SEX M ☐ F ☐

LANGUAGE CODES

WHAT LANGUAGE DO *YOU* SPEAK MOST OFTEN? → **PLEASE CIRCLE** ← THIS INFORMATION WILL HELP US WORK TOWARD BEST MEETING YOUR NEEDS.

ASL American Sign Language | CA Cantonese | CV Cape Verdean | EN English | FR French | HA Haitian | HM Hmong | IT Italian | KH Khmer | LO Laotian | MN Mandarin | PT Portuguese | RU Russian | SP Spanish | VI Vietnamese | OTHER ☐ _____ Specify

ARE YOU CURRENTLY A RESIDENT OF A NURSING HOME? ☐ YES ☐ NO IF YES, GIVE NAME & ADDRESS OF NURSING HOME AND ADMIT DATE BELOW:

NAME — ADDRESS — ADMIT DATE / /

FORMER/CURRENT EMPLOYER — EMPLOYER PHONE # — DATE OF RETIREMENT (IF APPLICABLE) / /

DATE OF DISABILITY (IF APPLICABLE) / /

ARE YOUR CURRENTLY A HARVARD PILGRIM HEALTH CARE MEMBER?

☐ YES ☐ NO

IF YES LIST ID # BELOW:

ID #

A COPY OF YOUR MEDICARE CARD MUST ACCOMPANY THIS FORM IN ORDER TO PROCESS YOUR ENROLLMENT.

IF YOU ARE UNDER AGE 65, IS THE ILLNESS OR CONDITION WHICH QUALIFIES YOU FOR MEDICARE END STAGE RENAL DISEASE? YES ☐ NO ☐

IF YES, WHAT IS YOUR ENTITLEMENT DATE? _____ .

IF NO, STATE THE ILLNESS OR CONDITION WHICH QUALIFIES YOU FOR MEDICARE.

HAVE YOU HAD A KIDNEY TRANSPLANT? YES ☐ NO ☐

ARE YOU COVERED BY MEDICAID? YES ☐ NO ☐ IF YES, MEDICAID NUMBER _____

ARE YOU CURRENTLY A MEMBER OF ANOTHER MEDICAL INSURANCE PLAN (EXCLUDING MEDICARE)? YES ☐ NO ☐

IF YES, PLEASE INDICATE NAME OF PLAN _____ SUBSCRIBER NAME _____

EFFECTIVE DATE _____ POLICY # _____

I UNDERSTAND THAT MEMBERSHIP WILL BECOME EFFECTIVE UPON ACCEPTANCE BY THE PLAN AND THAT BENEFITS UNDER THE PLAN WILL BE EXPLAINED IN A SEPARATE DOCUMENT. DURING MY MEMBERSHIP, I AUTHORIZE ANY HEALTH CARE PROVIDER OR OTHER HEALTH PLAN TO PROVIDE MEDICAL INFORMATION AND RECORDS TO THE PLAN, THE PLAN ADMINISTRATOR, OR PLAN AFFILIATED HEALTH CARE PROVIDERS. I ALSO AUTHORIZE THE PLAN, THE PLAN ADMINISTRATION, AND ANY PLAN HEALTH CARE PROVIDERS RENDERING SERVICES TO ME TO RECEIVE COPIES OF MY MEDICAL RECORDS. I AUTHORIZE THE USE BY THE PLAN, AND ITS AGENTS, OF ANY INFORMATION OBTAINED HEREUNDER FOR THE DELIVERY OF HEALTH SERVICE, TO DETERMINE ELIGIBILITY AND ENTITLEMENT TO BENEFITS (INCLUDING REIMBURSEMENT BY THIRD PARTIES), FOR EDUCATION AND RESEARCH IN ACCORDANCE WITH GOVERNMENT REGULATIONS, AND FOR THE OTHER PLAN PROFESSIONAL ACTIVITIES SUCH AS UTILIZATION REVIEW, QUALITY ASSURANCE, CASE MANAGEMENT, REFERRAL AND AUTHORIZATION, DISEASE MANAGEMENT, FRAUD DETECTION AND CERTAIN OVERSIGHT ACTIVITIES, SUCH AS ACCREDITATION AND REGULATORY AUDITS. I UNDERSTAND THAT A COPY OF THIS FORM WILL BE GIVEN TO ME, OR TO MY AUTHORIZED REPRESENTATIVE, UPON REQUEST.

THE EMPLOYEE MUST SIGN THIS FORM FOR ENROLLMENT.

_____ EMPLOYEE SIGNATURE _____ DATE _____ EMPLOYER SIGNATURE _____ DATE

HPHC Insurance Company

"I want a plan that complements my Medicare coverage."

Medicare Enhance℠

The individual shown is representative only. The comment is a composite of sentiments often expressed by our members.

5-RB, 01/12
MD0000002186

Schedule of Benefits

MEDICARE ENHANCE
HPHC INSURANCE COMPANY, INC.
Services are covered when Medically Necessary. Please see your Benefit Handbook for the details of your coverage.

INTRODUCTION

This Schedule of Benefits summarizes your coverage under Medicare Enhance (the Plan) and states the Subscriber cost sharing amounts you must pay for Covered Services. However, it is only a summary of your benefits. Please consult your *Benefit Handbook* and *Prescription Drug Brochure* (if you have the Plan's prescription coverage) for detailed information on the benefits covered by the Plan and the terms and conditions of coverage.

Please note that the information on Medicare benefits in this document is provided for informational purposes only. HPHC Insurance Company, Inc. (HPIC) is not responsible for Medicare Benefits. Please refer to the Medicare program handbook, *Medicare and You* or contact the Centers for Medicare and Medicaid Services (CMS), for information on your Medicare benefits. You may call CMS for information on Medicare Parts A and B at: 1-800-MEDICARE (1-800-633-4227).

SECTION 1: SUBSCRIBER COST SHARING (WHAT YOU PAY)

Subscribers are required to share the cost of the benefits provided under the Plan. The following is a summary of the cost sharing amounts under your plan.

A Copayment is a dollar amount that is payable by the Subscriber for certain Covered Services. The Copayment is due at the time services are rendered or when billed by the Provider. Your identification card contains the Copayment amounts that apply to the Plan's most frequently used services. Please see the tables below for a detailed list of the Copayments that apply to your Employer Group's Plan.

*The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any Subscriber cost sharing amounts that apply under your Plan.

MA Form No: 1431

SECTION 2: PREVENTIVE CARE SERVICES

Medicare covers a number of preventive care services at no cost to Members. The Plan will pay the Medicare Coinsurance and Deductible amounts for Medicare covered preventive care services, if any.

Medicare coverage includes a one-time "Welcome to Medicare" physical examination received within the first 12 months a beneficiary is covered by Medicare Part B. HPHC recommends that Subscribers utilize this benefit if available. After being enrolled in Medicare Part B for one year, Medicare also covers a yearly physical exam, known as a "Wellness" visit. The first yearly physical exam must take place at least 12 months after the "Welcome to Medicare" physical examination, if a beneficiary has had one.

When specific Medicare coverage criteria are met, Medicare also provides coverage for preventive services including, but not limited to: (1) Pap tests, pelvic and breast exams; (2) Mammograms; (3) Prostate cancer screenings; (4) Diabetes screenings and (5) bone mass measurements; (6) glaucoma testing; (7) medical nutrition therapy; (8) counseling to stop smoking; (9) colorectal cancer screening, including fecal occult blood tests, flexible sigmoidoscopy, colonoscopy and barium enema examinations; and (10) immunizations for flu, pneumonia and hepatitis B. Coverage for mammograms includes a baseline mammogram for women between ages 35 and 39 and an annual mammogram for women 40 years of age and older.

Please refer to Section III. D.2. of your Benefit Handbook for detailed information on additional preventive care services covered by the Plan. Please consult with your doctor and refer to the Medicare publication, *Medicare and You*, for additional information on preventive care services that may benefit you.

SECTION 3: COVERAGE OUTSIDE OF THE UNTED STATES

Your Plan provides limited coverage for Subscribers traveling outside of the United States. Please refer to Section III.D.3 of your Benefit Handbook for the details of your coverage.*

*The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any Subscriber cost sharing amounts that apply under your Plan.

SECTION 4: INPATIENT SERVICES

Service	Medicare Parts A or B Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Page**
Hospital Care (including acute, rehabilitation and psychiatric hospitalizations) Days 1-60 in Benefit Period	All but Medicare Deductible amount	Medicare Deductible amounts	No Copayment	9
Days 61-90 in Benefit Period	All but Medicare Coinsurance amounts	Medicare Coinsurance amounts	No Copayment	9
Up to 60 Lifetime Reserve Days (if any)	All but Reserve Days Daily Coinsurance amounts	Medicare Lifetime Reserve Days Daily Coinsurance amounts	No Copayment	9
After your 60 Lifetime Reserve Days are exhausted your Plan covers unlimited days	Nothing	All charges to the extent Medically Necessary	No Copayment	9
Rehabilitation Hospital Care After your 60 Lifetime Reserve Days are exhausted: Benefits are provided up to 100 days per calendar year for Medically Necessary rehabilitation	Nothing	All charges	No Copayment	9

*The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any Subscriber cost sharing amounts that apply under your Plan.
** Page numbers refer to your Medicare Enhance Benefit Handbook.

MA Form No: 1431

Service	Medicare Parts A or B Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Page**
Skilled Nursing Facility Care (SNF)				
Days 1-20	Medicare allowable amount	Nothing	No Copayment	10
Days 21-100	Medicare allowable amount minus SNF Daily Coinsurance amounts	The Medicare SNF Daily Coinsurance amounts	No Copayment	10
Days 100 +	Nothing	Nothing	All Charges	10
Religious Nonmedical Health Care Institutions	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	No Copayment	10
Physician and Other Professionals (inpatient services only)	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	No Copayment	9
Blood Transfusions				
First 3 pints of blood per calendar year	Nothing	Medicare Blood Deductible	No Copayment	9
Beyond 3 pints per calendar year	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	No Copayment	9
Human Organ Transplants (Including bone marrow transplants)	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	No Copayment	9

*The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any cost sharing that applies.

** Page numbers refer to your Medicare Enhance Benefit Handbook.

SECTION 5: OUTPATIENT SERVICES

Service	Medicare Parts A or B Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Page**
Emergency Services	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Emergency room Copayment per visit	$50 Emergency Room Copayment per visit, waived if admitted to a Hospital	10
Physicians and other covered Professionals (including mental health and substance abuse care)	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$15 Copayment per visit (Please note: No Copayment applies to diagnostic tests, x-rays, and immunizations if billed without a professional office visit and no additional services are provided)	10
House Calls by a physician	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$25 Copayment per visit	10
Administration of Allergy Injections	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$5 Copayment per visit	10
Medical Therapies including Outpatient Surgery	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	No Copayment	11
Chiropractic Services **Note:** Very limited coverage provided. See your *Benefit Handbook*	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit (if Medicare coverage is provided)	$15 Copayment per visit	10

*The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any cost sharing that applies.

** Page numbers refer to your Medicare Enhance Benefit Handbook.

Service	Medicare Parts A or B Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Page**
Podiatric Services **Note:** Limited coverage provided. See your *Benefit Handbook*	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit (if Medicare coverage is provided)	$15 Copayment per visit	11
Physical and Occupational Therapy	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$15 Copayment per visit	12
Speech Language and Hearing Services	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$15 Copayment per visit	12
Dental Care and Oral Surgery Services **Note:** Limited coverage provided. See your *Benefit Handbook*	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit (if Medicare coverage is provided)	$15 Copayment per visit	12
Hospice Care (including inpatient Respite Care)	100% of the Medicare allowable amount; and 95% of the cost of outpatient drugs and respite care (Medicare Hospice Coinsurance). Benefits are covered less the Medicare Deductible	Medicare Deductible and the Hospice Coinsurance amount	No Copayment	12
Diagnostic Tests and Procedures	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	No Copayment (Please note: No Copayment applies to diagnostic tests, x-rays, and immunizations if billed without a professional office visit and no additional services are provided)	11
Ambulance	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	No Copayment	12

*The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any cost sharing that applies.

** Page numbers refer to your Medicare Enhance Benefit Handbook.

Service	Medicare Parts A or B Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Page**
Durable Medical Equipment and Prosthetic Devices	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	No Copayment	11
Home Health Care Services	Medicare allowable amount	Nothing	No Copayment	11
Home Infusion Therapy **Note:** Very limited coverage provided. See your *Benefit Handbook*	Generally None	All charges minus any coverage by Medicare	No Copayment	17
Kidney Dialysis	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	No Copayment	12
Cardiac Rehabilitation Services	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$15 Copayment per visit	10

*The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any cost sharing that applies.

** Page numbers refer to your Medicare Enhance Benefit Handbook.

SECTION 6: STATE MANDATED BENEFITS

The plan will cover the benefits in this section when Medicare coverage is not available:

Service	Medicare Parts A or B Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Page**
Inpatient Mental Health Care				
For all Mental and Emotional disorders. **Note:** Benefits are provided up to 60 days per calendar year	Nothing	All charges	No Copayment	14
For Biologically-Based and Rape Related Mental and Emotional Disorders **(including Substance Abuse Disorders).** **Note:** Benefits are provided for the same number of days as the coverage provided for a physical illness.	Nothing	All charges	No Copayment	14
Outpatient Mental Health Care				
For all Mental and Emotional disorders. Benefits are provided up to 24 visits per calendar year	Nothing	All charges, less applicable Copayment per visit	$15 Copayment per visit	14
For Biologically-Based and Rape Related Mental and Emotional Disorders **(including Substance Abuse Disorders).** Benefits are provided for unlimited visits	Nothing	All charges, less applicable Copayment per visit (for unlimited) visits	$15 Copayment per visit	14

*The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any cost sharing that applies.

** Page numbers refer to your Medicare Enhance Benefit Handbook.

Service	Medicare Parts A or B Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Page**
Partial Hospitalization for Mental Health and Substance abuse	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	No Copayment	14
Detoxification, Psychopharmacological, Psychological Testing, and Neuropsychological Assessment Services	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$15 Copayment per visit	15
Scalp Hair Prosthesis (Wigs)	Nothing	Up to $350 per calendar year	All charges in excess of $350	15
Low Protein Foods	Nothing	Up to $5,000 per calendar year	All charges in excess of $5,000	15
Special Formulas for Malabsorption	Nothing	Full benefits	No Copayment	15
Hypodermic Needles and Syringes	Nothing	Full benefits, less applicable Copayment	If you have the Plan's prescription drug coverage, your Copayment is listed on your ID card. If you do not have the Plan's prescription drug coverage, then you will pay the lower of the pharmacy's retail price or a $10 Copayment.	15

*The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any cost sharing that applies.

** Page numbers refer to your Medicare Enhance Benefit Handbook.

SECTION 7: WHAT THE PLAN DOES NOT COVER

A. No benefits will be provided by the Plan for any of the following:

1. Any product or service that is not covered by Medicare unless specifically listed as a Covered Service in this *Benefit Handbook*, the *Schedule of Benefits* or the *Prescription Drug Brochure (if applicable).*

2. Any charges for products or services covered by a Medicare Advantage plan operated under Medicare Part C or a Prescription Drug Plan (PDP) under Medicare Part D.

3. Any product or service obtained at an unapproved hospital (or other facility) if Medicare requires that a service be provided at a hospital (or other facility) specifically approved for that service. This exclusion applies to weight loss (bariatric) surgery; liver, lung, heart and heart-lung transplants; and any other services Medicare determines must be obtained at a hospital (or other facility) that has been specifically approved for a specific service to be eligible for coverage by Medicare.

4. Any product or service that is provided to you after the date on which your enrollment in the plan has ended.

5. Any charges that exceed the Payment Maximum. (Please see the Glossary for the definition of "Payment Maximum.")

6. Any products or services received in a hospital not certified to provide services to Medicare beneficiaries, unless (1) the hospital is outside the United States, (2) the Subscriber's Plan includes benefits for services outside of the United States, and (3) coverage is available under that benefit.

7. Any product or service for which no charge would be made in the absence of insurance.

B. No Benefits will be provided by the Plan for any of the following unless covered by Medicare Parts A or B:

1. Any product or service that is not Medically Necessary.

2. Any product or service (1) for which you are legally entitled to treatment at government expense or (2) for which payment is required to be made by a Workers' Compensation plan or laws of similar purpose.

3. Any charges for inpatient care over the semi-private room rate, except when a private room is Medically Necessary.

4. Any product or service received outside of the United States that is: (1) related to the provision of routine or preventive care of any kind; (2) a service that was, or could have been, scheduled before leaving the United States, even if such scheduling would have delayed travel plans; (3) a form of transportation, including transportation back to the United States, except road ambulance to the nearest hospital; or (4) a service that would not be a covered by Medicare or the Plan in the United States.

5. Any product or service that is Experimental or Unproven. (Please see the Glossary for the definition of "Experimental or Unproven.")

6. Private duty nursing.

7. Cosmetic services or products, including, but not limited to, cosmetic surgery, except for services required to be covered under the Women's Health and Cancer Rights Act of 1998.

8. Rest or Custodial Care.

9. Eyeglasses and contact lenses, or examinations to prescribe, fit, or change eyeglasses or contact lenses unless specifically listed as a Covered Service in your *Schedule of Benefits*. (Note that Medicare provides limited benefits for eye glasses or contact lenses after cataract surgery.).

10. Hearing aids.

11. Biofeedback, massage therapy (including myotherapy), sports medicine clinics, treatment with crystals or routine foot care services such as the trimming of corns and bunions, removal of calluses, unless such care is Medically Necessary due to circulatory system disease such as diabetes.

12. Foot orthotics, except as required for the treatment of severe diabetic foot disease.

13. Any form of hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. (Please see Section III.C.3. for the coverage provided for wigs)

14. Dental Services, including, but not limited to, restorative, periodontal, orthodontic, endodontic, prosthodontic services (including any services related to dentures), or any Dental Services relative to the treatment of temporomandibular joint dysfunction (TMJ), except that (1) the Plan will cover the Medicare coinsurance and deductible amount for any Dental Service that has been covered by Medicare. (Please see the Glossary for the definition of "Dental Services.")

15. Infertility services or any related services supplies or drugs, including, but not limited to, in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intra-cytoplasmic sperm injection, donor egg procedures (including related egg and inseminated egg procurement), the preservation of eggs or sperm, voluntary sterilization or the reversal of voluntary sterilization, or any form or Surrogacy. (Please see the Glossary for the definition of "Surrogacy.")

16. Ambulance services except as specified in this *Benefit Handbook* or the *Schedule of Benefits*. No benefits will be provided for transportation other than by ambulance.

17. Exercise equipment; or personal comfort or convenience items such as radios, telephone, television, or haircutting services.

18. Any product or service provided by (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.

19. Refractive eye surgery, including laser surgery, orthokeratology or lens implantation for correction of myopia, hyperopia and astigmatism.

20. Any products or services related to diet plans or weight loss programs, including diet foods, drinks or drugs of any kind. (However, the Plan will cover Medicare Coinsurance and Deductible amounts for professional services or surgery covered by Medicare for the treatment of obesity.)

21. Drugs or medications that can be self-administered unless (1) the Employer Group has purchased prescription drug coverage on behalf of the Subscriber and coverage for such drug or medication is provided for in the *Prescription Drug Brochure*, (2) the drug or medication is covered by Medicare Parts A or B; or (3) coverage for the drug or medication is mandated by Massachusetts law.

22. Educational services or testing; services for problems of school performance; sensory integrative praxis tests, vocational rehabilitation, or vocational evaluations focused on job adaptability, job placement, or therapy to restore function for a specific occupation.

23. Planned home births.

24. Gender reassignment surgery or any related drugs and procedures.

25. Devices or special equipment needed for sports or occupational purposes.

26. 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 Service under this *Benefit Handbook.*

27. Acupuncture, aromatherapy, or alternative medicine

28. Mental health services that are (1) provided to Subscribers who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health.

SECTION 8: IMPORTANT NOTICES

Medical Emergency: You are always covered for care you need in a medical emergency within the United States. In the event of a medical emergency, you should go to the nearest emergency facility or call 911 or the local emergency number.

Coverage will be subject to the terms, conditions, exclusions and limitation of Medicare eligible services and supplies, and is subject to change pursuant to Medicare guidelines. This brochure is not intended as an explanation of Medicare benefits. Information and guidelines as established by the Centers for Medicare and Medicaid Services (CMS) regarding Medicare, may be obtained by contacting your local Social Security office.

This Plan is only available to Subscribers enrolled through employer groups. Coverage under the Plan is effective on the first day of the month chosen by your Employer and renews year to year on your Employer's anniversary date unless terminated in accordance with the terms of the Employer Agreement. Premiums are subject to change as set forth in the Employer Agreement between HPIC and your Employer Group as permitted by law. Please refer to your Benefit Handbook for information about your eligibility and continuation of coverage rights under this Plan.

Prescription Drug Coverage

PREMIUM 3 TIER

Covered prescription medications are available at participating pharmacies.

	Retail	Mail (up to a 90-day supply)
Tier 1	**Up to a 30-day supply:** $10 Copayment **Up to a 90-day supply:** $30 Copayment	$20 Copayment
Tier 2	**Up to a 30-day supply:** $20 Copayment **Up to a 90-day supply:** $60 Copayment	$40 Copayment
Tier 3	**Up to a 30-day supply:** $35 Copayment **Up to a 90-day supply:** $105 Copayment	$105 Copayment

Visit **www.harvardpilgrim.org/2020Premium3T** for participating pharmacy locations and mail order details. Be sure to show your Harvard Pilgrim ID card at the pharmacy to ensure you pay the correct cost-sharing amounts.

Harvard Pilgrim Health Care

WHAT YOU NEED TO KNOW:

Medicare Enhance℠ Preventive Plus

Thank you for your interest in **Medicare Enhance Preventive Plus**.* While Medicare remains your primary insurer, this plan features additional coverage for preventive care and pays the cost of your Medicare deductibles and coinsurance. With Medicare Enhance Preventive Plus:

- You can live anywhere in the United States as long as you are enrolled in Medicare Parts A and B.
- You can visit any doctor, hospital or other provider that accepts Medicare.
- You'll have worldwide emergency coverage.

Eligibility

To be eligible for Medicare Enhance Preventive Plus, you can live anywhere in the United States as long as you are a benefits-eligible employee or a retiree of an employer that offers this plan and you are enrolled in Medicare Parts A and B.

Depending on your employer's eligibility rules, your spouse may be able to join Medicare Enhance Preventive Plus if he or she is also enrolled in Medicare Parts A and B. Check with your employer for more information.

Each year your employer has an open enrollment period when you choose your health benefits. If you're not eligible for Medicare Enhance Preventive Plus during your employer's open enrollment period, you can become eligible to enroll on the date when you retire and sign up for Medicare Parts A and B.

* This is a limited health benefit policy. Its benefits complement Medicare benefits and are not intended to cover all medical expenses.

Receiving care

Medicare Enhance Preventive Plus is an indemnity plan. That means you can receive care from any doctor, hospital or other health care provider that accepts Medicare. You're not locked into a provider network and you don't have to choose a primary care provider, which means you're free to visit specialists for covered services. You don't need referrals or any kind of prior authorization from HPHC Insurance Company (HPHC).

After you enroll, you will receive a member identification (ID) card. **It will be important for you to show *both* your HPHC and Medicare ID cards whenever you visit the doctor, hospital or other providers.**

Continued ▸

HPHC Insurance Company

Paying for services

Most providers will charge you a fixed copayment at the time of service for office visits and emergency room visits, and then bill Medicare directly for the balance of the claim. Some providers may bill you directly for the services after receiving Medicare's payment, and you will need to submit a claim to HPHC.

When you become a member, your Benefit Handbook will have more information about provider billing and submitting claims to HPHC. But if you need help or have questions, you can always call our Member Services department.

Please see the Schedule of Benefits for Medicare Enhance Preventive Plus cost sharing and coverage amounts.

Worldwide emergency coverage

In a medical emergency, go to the nearest emergency room or call 911 or another local emergency number. Emergency room visits are subject to a copayment that will be waived if you are admitted to the hospital. Medicare Enhance Preventive Plus has you covered if you need emergency care in another part of the country or another part of the world.

HPHC Insurance Company

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STAY HEALTHY AND SAVE MONEY

Our discounts and savings program can help you save money on everything from eyewear and hearing aids to dental services and more.** Visit **www.harvardpilgrim.org** and click "Why Choose Us" to learn more about what's available.

** These savings programs are not insurance products. Rather, they are discounts for programs and services designed to keep members healthy and active. All programs subject to change without advance notice.

QUESTIONS?

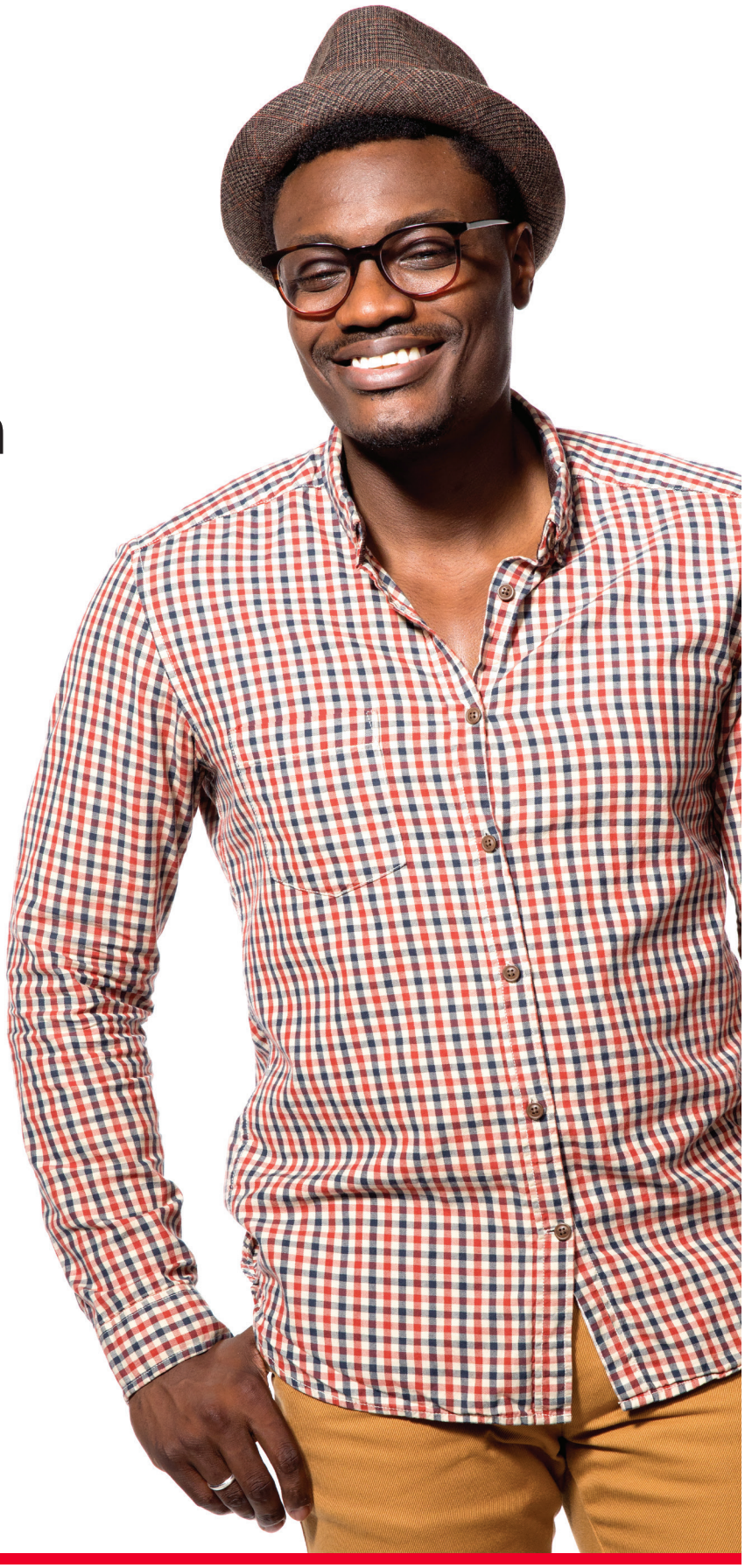
- If you're not yet a member, call **(800) 848-9995** weekdays between 8:30 a.m. and 5 p.m.
- If you're already a member, call Member Services with questions at **(888) 333-4742.** Representatives are available Monday, Tuesday and Thursday from 8 a.m. to 6 p.m., Wednesday from 10 a.m. to 6 p.m. and Friday from 8 a.m. to 5:30 p.m.
- For TTY service, call **711.**

To learn more about us in general, visit **www.harvardpilgrim.org.**

For questions about Medicare, visit **www.medicare.gov** or call **(800) MEDICARE.** For TTY service, call **(877) 486-2048.**

Harvard Pilgrim Health Care

Your guide to prescription drug coverage



Premium 3-Tier

FORM NO: NH_CC7782_0919

Our 3-tier prescription drug plan helps you get the most from your coverage.

Fact: Generic and brand-name drugs contain the same active ingredients.

All covered medications fall into one of three tiers.

TIER 1

Generic drugs and selected brand-name drugs

TIER 2

Brand-name drugs without generic equivalents and some high-cost generic drugs

TIER 3

Drugs not in Tier 1 or Tier 2

Which tier is my drug in?

For the most up-to-date information, visit **harvardpilgrim.org/rx**. Choose the year and then "Premium 3-Tier" to find out how your drugs are covered.

Do drugs ever change tiers?

The short answer—sometimes. The prescription drug market is rapidly changing with drug costs constantly rising. When drugs do change tiers, it usually happens in January of each year. We'll let you know in the fall about any upcoming changes to our prescription drug program.

Your drug coverage

What drugs are covered?

- Most generic drugs
- Brand-name drugs without generic equivalents
- Some non-prescription items

What drugs aren't covered?

- Brand-name drugs with generic equivalents
- Cosmetic drugs
- Some brand-name and higher-cost generic drugs

Are there limitations on certain drugs?

Yes, we may limit the quantity of some drugs we cover. For example, you may be able to receive only a certain number of pills or doses.

Do some drugs require prior authorization?

Yes, certain drugs do require prior authorization. This process helps us ensure that you are using the most effective and safe medications for your health conditions. Your prescriber must request prior authorization on your behalf.

What is step therapy?

Step therapy is a process that requires you to first try one drug for a medical condition before we cover another drug for that condition.

For example, if Drug A and Drug B both treat the same medical condition, we may require you to try Drug A first. If Drug A does not work, then we will cover Drug B. If you did not try Drug A first, then prior authorization would be required for Drug B.

Can I request an exception?

Yes. If you need a drug that we either don't cover or limit, you or your provider can ask us for an exception. For details, visit harvardpilgrim.org/rx. Choose the year and then "Premium 3-Tier" for information on exceptions.

How can I learn more?

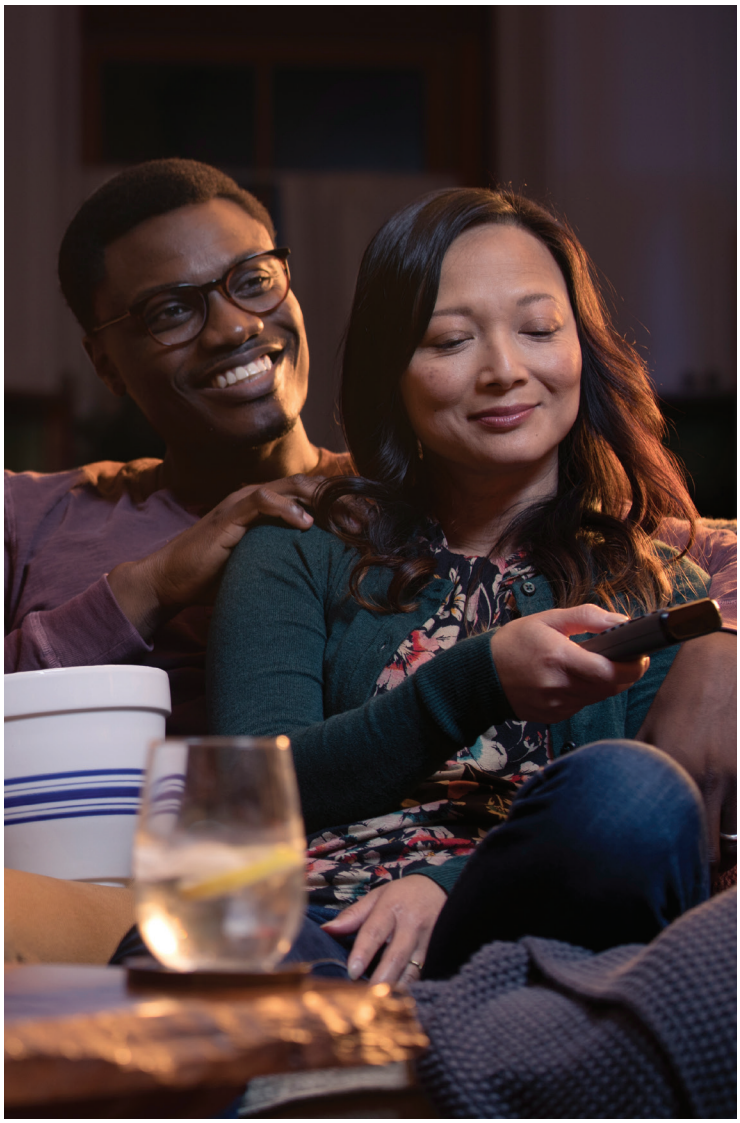
Use our online Prescription Drug List to find out which drugs we cover. It will show you which ones have quantity limits or require prior authorization or step therapy. Visit harvardpilgrim.org/rx. Choose the year and then "Premium 3-Tier" to find out how your drugs are covered.

Filling your prescriptions

Where can I get my prescriptions filled?
You can get your prescriptions filled at any of 65,000 retail pharmacies that belong to our national participating pharmacy network. To confirm whether your local pharmacy is in the network, visit harvardpilgrim.org/rx. Choose the year and then "Premium 3-Tier" to find participating pharmacies.

Can I get a 90-day supply?
If you take maintenance medications (i.e., ones you take continually for conditions such as heart disease, diabetes or depression), you can get a 90-day supply from many retail pharmacies or through our mail order program. To learn more about these options, visit harvardpilgrim.org/rx. Choose the year and then "Premium 3-Tier" for details. Depending on your coverage, your cost sharing may be lower when you get these drugs through the mail order program or at retail pharmacies in Maine.

What if I take specialty medications?
If you take medications for conditions such as hepatitis C, multiple sclerosis or rheumatoid arthritis, your provider must order your prescriptions through our designated specialty pharmacy. Visit harvardpilgrim.org/rx for information on our specialty pharmacy program. Choose the year and then "Premium 3-Tier" for details.



Questions?

If you have questions about your prescription drugs, please speak with your doctor.

To learn more about Harvard Pilgrim's pharmacy program:

Visit harvardpilgrim.org/rx

Call | **Already a member?** (888) 333-4742
Not yet a member? (800) 848-9995
TTY: 711

What do I pay for my medications?

Depending on your plan, your payments—also called "cost sharing"—may include a combination of copayments, coinsurance and a deductible. Refer to the Prescription Drug Coverage insert or Schedule of Benefits to find out what you will pay when you pick up prescriptions at the pharmacy.

Copayment – A fixed dollar amount you pay for a prescription. Your copayment is typically different for each tier. Each copayment covers an individual prescription up to a 30-day supply or one refill.

Coinsurance – A fixed percentage of costs that you pay for medication. Each tier may have a different cost percentage. Your coinsurance charge will be calculated using the lower of the pharmacy's retail price or Harvard Pilgrim's discount price for the drugs.

Deductible – Depending on your plan, a set amount of money you pay out of your own pocket for medical services and/or prescriptions. If your prescriptions fall under a deductible, you will pay the lower of the pharmacy's retail price or Harvard Pilgrim's discount price for the drugs.

Out-of-pocket maximum – A limit on the total amount you pay for a year in copayments, coinsurance and deductibles. Your plan may include an out-of-pocket maximum for prescription drugs. Find out in the Prescription Drug Coverage insert or Schedule of Benefits.

Harvard Pilgrim Health Care

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

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harvardpilgrim.org

Important information about your plan

The following information refers to plans offered by Harvard Pilgrim Health Care and its affiliates ("Harvard Pilgrim").

Member confidentiality

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

Harvard Pilgrim 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 Harvard Pilgrim's confidentiality and privacy standards.

When Harvard Pilgrim uses or discloses your personal information, it does so using the minimum amount of information necessary to accomplish the specific activity. Harvard Pilgrim discloses its members' personal information only: (1) in connection with the delivery of care or administration of benefits, such as utilization review, quality assurance activities and third-party reimbursement by other payers, including self-insured employer groups; (2) when you specifically authorize the disclosure; (3) in connection with certain activities allowed under law, such as research and fraud detection; (4) when required by law; or (5) as otherwise allowed under the terms of your *Benefit Handbook*. Whenever possible, Harvard Pilgrim 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. Harvard Pilgrim 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 laws, Harvard Pilgrim and all of its contracted health care providers agree to give members access to, and a copy of, their medical records upon a member's request. In addition, your medical records cannot be released to a third party without your consent or unless permitted by law.

Visit **www.harvardpilgrim.org** for a copy of Harvard Pilgrim's *Notice of Privacy Practices*.

Harvard Pilgrim Health Care

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