Access to Network Providers – HMO NHCAR Ins. 2701.09(g)(7) and (9)

(7) The health carrier's method of informing covered persons of the requirements and procedures for gaining access to network providers, including but not limited to the following:

a. The process for choosing and changing network providers.

- Please see the Benefit Handbook excerpt, pages 1-6.

b. The process for providing and approving emergency, urgent, and specialty care.

- Please see the Benefit Handbook excerpt, page 4.

c. The identity of all of the plan's participating providers and facilities, including a specification of those participating providers, if any, that are accessible only at a reduced benefit level.

- Please see the online Provider Directory at www.harvardpilgrim.org.

d. Whether and when referral options are restricted to less than all providers in the network who are qualified to provide covered specialty services.

- Please see the Benefit Handbook excerpt, pages 2-4.

(9) The health carrier's process for enabling covered persons to change primary care providers.

- Please see the Benefit Handbook excerpt, pages 1-2.

This information is provided as part of Harvard Pilgrim's 2017 Health Care Access Report as required by the State of New Hampshire's network adequacy requirements. For more information specific to your plan, please refer to your Benefit Handbook, available on HPHConnect.

Harvard Pilgrim Health Care

Harvard Pilgrim Health Care *of New England*

Benefit Handbook

THE HARVARD PILGRIM HMO
NEW HAMPSHIRE
EMPLOYER GROUP PLAN

Coverage under this Plan is under the jurisdiction of the New Hampshire Insurance Commissioner.

IMPORTANT INFORMATION: This policy reflects the known requirements for compliance under The Affordable Care Act as passed on March 23, 2010. As additional guidance is forthcoming from the US Department of Health and Human Services and the New Hampshire Insurance Department, those changes will be incorporated into your health insurance policy.

EFFECTIVE DATE: 01/01/2017
FORM #1079_07

I. How the Plan Works

This section describes how to use your Benefit Handbook and how your coverage works under The Harvard Pilgrim HMO (the Plan).

A. HOW TO USE THIS BENEFIT HANDBOOK

1. Why This Benefit Handbook Is Important

This Benefit Handbook, the Schedule of Benefits, the Prescription Drug Brochure and any amendments (collectively referred to as the Evidence of Coverage) make up the legal agreement stating the terms of the Plan. This document also incorporates by reference an Employer Agreement issued to your employer, which includes information on dependent eligibility. If you have any eligibility questions, we recommend that you see your employer for information.

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

- Covered Benefits
- Exclusions
- The requirement to receive services from a Plan Provider
- The requirement to go to your PCP for most services

You can view your Benefit Handbook, Schedule of Benefits, Prescription Drug Brochure, and any amendments online by using **your secure online account** at **www.harvardpilgrim.org**.

2. Words With Special Meaning

Some words in this Handbook have a special meaning. These words are capitalized and are defined in the *Glossary*.

3. How To Find What You Need To Know

This Handbook's Table of Contents will help you find the information you need. The following is a description of some of the important sections of the Handbook.

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

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

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

B. HOW TO USE YOUR PROVIDER DIRECTORY

The Provider Directory identifies the Plan's PCPs, specialists, hospitals and other providers you must use for most services. It lists providers by state and town, specialty, and languages spoken. You may view the Provider Directory online at our web site, **www.harvardpilgrim.org**. You can also get a copy of the Provider Directory, free of charge, by calling the Member Services Department at **1-888-333-4742**.

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

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

C. MEMBER OBLIGATIONS

1. Choose a Primary Care Provider (PCP)

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

A PCP may be a (1) physician or (2) advanced practice registered nurse specializing in one or more of the following specialties: internal medicine, pediatrics or family practice. PCPs are listed in the Provider Directory. You can access our website at **www.harvardpilgrim.org** or call the Member Services Department at **1–888–333–4742** to confirm that the PCP you select is available.

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

You may change your PCP at any time. Just choose a new PCP from the Provider Directory. You can change your PCP online by using **your secure online account** at **www.harvardpilgrim.org** or by calling the Member Services Department at **1–888–333–4742**. The change is effective immediately.

2. Obtain Referrals to Specialists
In order to be eligible for coverage by the Plan, most care must be provided or arranged by your PCP. For more information, please see section *I.D. HOW TO OBTAIN CARE*.

If you need to see a specialist, you must contact your PCP for a Referral prior to the appointment. Referrals to Plan Providers may be given orally or in writing.

3. Show Your Identification Card
You should show your identification (ID) card every time you request health services. If you do not show your ID card, the Provider may not bill us for Covered Benefits, and you may be responsible for the cost of the service. You can order a new ID card online by using **your secure online account** at **www.harvardpilgrim.org** or by calling the Member Services Department at **1–888–333–4742**.

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

- Copayments
- Coinsurance
- Deductibles

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

5. More About Copayments
A Copayment is a fixed dollar amount that you must pay for certain Covered Benefits. Copayments are due at the time of the service or when billed by the Provider.

There may be two types of office visit Copayments that apply to Plan: a lower Copayment known as "Level 1" and a higher Copayment known as "Level 2."

If a Provider is categorized as both a Level 1 and a Level 2 Provider, the Level 1 Copayment applies. For example, if a Provider is both a PCP and a Cardiologist, you will be responsible for the Level 1 Copayment.

Your Plan may have other Copayment amounts. For more information about Copayments under your Plan, including your specific Copayment requirements, please refer to your Schedule of Benefits.

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

D. HOW TO OBTAIN CARE

IMPORTANT POINTS TO REMEMBER

1) You and each Member of your family must select a PCP.
2) In order to receive Covered Benefits you must use Plan Providers, except as noted below.
3) If you need care from a specialist, you must contact your PCP for a Referral. For exceptions, see *I.D.7. Services That Do Not Require a Referral* below.
4) In the event of a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. You do not need a Referral for Medical Emergency services.

1. Your PCP Manages Your Health Care
When you need care, call your PCP. In order to be eligible for coverage by the Plan, most services must be provided or arranged by your PCP. The only exceptions are:

- Care in a Medical Emergency.
- Care when you are temporarily traveling outside the Service Area as described below. The Service Area is the state in which you live.
- Care received by a Dependent living outside of the Enrollment Area. Please see section *V. Out-of-Area Dependent Coverage* for the requirements that apply to this coverage.
- Mental health care, which may be arranged by calling the Behavioral Health Access Center at **1-888-777-4742**. The telephone number for the Behavioral Health Access Center is also listed on your ID card. Please see section *III. Covered Benefits*, *Mental Health and Drug and Alcohol Rehabilitation Services* for information on this benefit.
- Special services that do not require a Referral that are listed in section *I.D.7. Services That Do Not Require a Referral* below.

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

You may change your PCP at any time. Just choose a new PCP from the Provider Directory. You can change your PCP online by using **your secure online account** at **www.harvardpilgrim.org** or by calling the Member Services Department at **1–888–333–4742**. The change is effective immediately. If you select a new PCP, all Referrals from your prior PCP become invalid. Your new PCP will need to assess your condition and provide new Referrals.

2. Referrals for Hospital and Specialty Care

When you need hospital or specialty care, you must first call your PCP, who will coordinate your care. This helps your PCP manage and maintain the quality of your care. Plan Providers with recognized expertise in specialty pediatrics are covered with a Referral from your PCP. Pediatric mental health care may be obtained by calling the Behavioral Health Access Center at **1-888-777-4742**.

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

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

There are certain specialized services for which you will be directed to a Center of Excellence for care. Please see section *I.D.4. Centers of Excellence* for more information.

Certain specialty services may be obtained without involving your PCP. For more information please see section *I.D.7. Services That Do Not Require a Referral*.

3. Using Plan Providers

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

1) The service was received in a Medical Emergency. Please see section *I.D.5. Medical Emergency Services* for information on your coverage in a Medical Emergency.
2) The service was received while you were outside of the Service Area and coverage is available under (1) the benefit for temporary travel or (2) the benefit for Dependents living outside the Enrollment Area. Please see sections *I.D.6. Coverage for Services When You Are Temporarily Traveling Outside the Service Area* and *V. Out-of-Area Dependent Coverage* for information on these benefits.
3) No Plan Provider has the professional expertise needed to provide the required service. In this case, services by a Non-Plan Provider must be authorized in advance by us, unless one of the exceptions above applies.
4) Your physician is disenrolled as a Plan Provider and one of the exceptions stated in section *I.E. SERVICES PROVIDED BY A DISENROLLED OR NON-PLAN PROVIDER* applies. Please refer to that section for the details of these exceptions.
5) The Plan replaced your prior Employer Group health plan and your prior plan was covering services by a mental health provider who is not a Plan Provider. Please refer to the section *III. Covered Benefits*, *Mental Health and Drug and Alcohol Rehabilitation Services* for the specific terms and conditions of this exception.

To find out if a provider is in the Plan network, see the Provider Directory. The Provider Directory is available online at **www.harvardpilgrim.org** or by calling our Member Services Department at **1-888-333-4742**.

4. Centers of Excellence
Certain specialized services are only covered when received from designated Plan Providers with special training, experience, facilities or protocols for the service. We refer to these Plan Providers as "Centers of Excellence."

Centers of Excellence are selected by us based on the findings of recognized specialty organizations or government agencies such as Medicare.

In order to receive benefits for the following service, you must obtain care at a Plan Provider that has been designated as a Center of Excellence:

- Weight loss surgery (bariatric surgery)

Important Notice: No coverage is provided for the service listed above unless it is received from a Plan Provider that has been designated as a Center of Excellence. To verify a Provider's status, see the Provider Directory. The Provider Directory is available online at **www.harvardpilgrim.org** or call our Member Services Department at **1-888-333-4742**.

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

5. Medical Emergency Services
In a Medical Emergency, including an emergency mental health condition, you should go to the nearest emergency facility or call 911 or other local emergency number. A Referral from your PCP is not needed. Your emergency room Member Cost Sharing is listed in your Schedule of Benefits. Please remember that if you are hospitalized, you must call the Plan at **1–888–333–4742** within 48 hours or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to the Plan or PCP by an attending emergency physician no further notice is required. Your PCP will help to arrange for any follow-up care you may need.

6. Coverage for Services When You Are Temporarily Traveling Outside the Service Area
When you are temporarily traveling outside the Service Area the Plan covers urgently needed Covered Benefits for sickness or injury. You do not have to call your PCP before getting care. However, the following services are not covered:

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

The "Service Area" is the state in which you live.

If you are hospitalized, you must call the Plan at **1-888-333-4742** within 48 hours, or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to the Plan or PCP by an attending emergency physician no further notice is required. Your PCP will help to arrange for any follow-up care you may need.

You must file a claim whenever you obtain services from a Non-Plan Provider. For more information, please see section *VI. Reimbursement and Claims Procedures*. Member Cost Sharing amounts will be applied as listed in your Schedule of Benefits.

Please Note: We must have your current address on file in order to correctly process claims for care outside the Service Area. To change your address, please call our Member Services Department at **1-888-333-4742**.

7. Services That Do Not Require a Referral
While in most cases you will need a Referral from your PCP to get covered care from any other Plan Provider, you do not need a Referral for the services listed below. However, you must get these services from a Plan Provider. Plan Providers are listed in the Provider Directory. We urge you to keep your PCP informed about such care so that your medical records are up-to-date and your PCP is aware of your entire medical situation.

i. Family Planning Services:

- Contraceptive monitoring
- Family planning consultation, including pregnancy testing

- Tubal ligation
- Voluntary termination of pregnancy

ii. Outpatient Maternity Services

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

iii. Gynecological Services

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

iv. Dental Services:

- Accidental injury dental care
- Pediatric dental services

v. Other Services:

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

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

1. Disenrollment of Primary Care Provider (PCP)
If your PCP is disenrolled as a Plan Provider for reasons unrelated to fraud or quality of care, we will use our best efforts to provide you with written notice at least 60 days prior to the date of your PCP's disenrollment. That notice will also explain the process for selecting a new PCP. You may be eligible to continue to receive coverage for services provided by the disenrolled PCP, under the terms of this Handbook and your Schedule of Benefits, for at least 30 days after the disenrollment date. If you are undergoing an active course of treatment for an illness, injury or condition, we may authorize additional coverage through the acute phase of illness, or for up to 90 days (whichever is shorter).

2. Pregnancy
If you are a female Member in your second or third trimester of pregnancy and the Plan Provider you are seeing in connection with your pregnancy is involuntarily disenrolled, for reasons other than fraud or quality of care, you may continue to receive coverage for services delivered by the disenrolled provider, under the terms of this Handbook and your Schedule of Benefits, for the period up to, and including, your first postpartum visit.

3. Terminal Illness
A Member with a terminal illness whose Plan Provider in connection with such illness is involuntarily disenrolled, for reasons other than fraud or quality of care, may continue to receive coverage for services delivered by the disenrolled provider, under the terms of this Handbook and the Schedule of Benefits, until the Member's death.

F. CLINICAL REVIEW CRITERIA

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

G. PROVIDER FEES FOR SPECIAL SERVICES (CONCIERGE SERVICES)

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

In considering arrangements with physicians for special services, you should understand exactly what services are to be provided and whether those services are worth the fee you must pay. For example, the Plan

does not require participating providers to be available by telephone 24-hours a day. However, the Plan does require PCPs to provide both an answering service that can be contacted 24-hours a day and prompt appointments when Medically Necessary.

H. BUNDLED PAYMENT ARRANGEMENTS

The Plan may participate in bundled service arrangements with certain Providers under which a specific service or treatment is paid for based on a fixed sum for all of the Covered Benefits you receive. Member Cost Sharing for Covered Benefits under a bundled service arrangement may be less than if the Covered Benefits were received without the bundled payment arrangement. Please refer to **www.harvardpilgrim.org** or call the Member Services Department at **1-888-333-4742** for a list of Providers who have bundled payment arrangements with Harvard Pilgrim and their corresponding services. We may revise the list of Providers or services who have bundled payment arrangements upon 30 days notice to Members.