



Harvard Pilgrim
Health Care *of New England*

Benefit Handbook

NH LOCAL CHOICE HSA HMO FOR INDIVIDUAL MEMBERS NEW HAMPSHIRE POLICY

Coverage under this Plan is provided in accordance with the New Hampshire Insurance law and under the jurisdiction of the New Hampshire Insurance Commissioner. Please read your Policy carefully. This is a legal document between you and Harvard Pilgrim Health Care of New England.

This policy may, at any time within 30 days after its receipt by the policyholder, be returned by delivering it or mailing it to the company or the agent through whom it was purchased. Immediately upon such delivery or mailing, the policy will be deemed void from the beginning, and any premium paid on it will be refunded.

Plan Coverage and Renewability: Coverage under this Policy is provided on a yearly basis from January 1st through December 31st and is guaranteed renewable. This Policy may only be cancelled, rescinded or non-renewed as allowed under state or federal law. You may renew this Policy by paying the renewal premium on the date your premium is due and you remain eligible for coverage.

Important Notice: This plan includes a limited provider network called the NH Local Choice Network. This network is smaller than Harvard Pilgrim Health Care of New England's full provider network. In this plan, Members have access to network benefits only from the providers in the NH Local Choice Network. Please consult the Provider Directory or visit the provider search tool at www.harvardpilgrim.org to determine which providers are included in the Network.

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.

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INTRODUCTION

Welcome to the NH Local Choice HSA HMO for Individual Members offered by Harvard Pilgrim Health Care of New England, Inc. Thank you for choosing us to help meet your health care needs.

The words “we,” “us,” and “our” used in this Handbook refer to Harvard Pilgrim Health Care of New England (HPHC-NE). The words “you” or “your” used in this Handbook refer to Members as defined in the Glossary.

The Plan is designed to meet Internal Revenue Service rules for a “High Deductible Health Plan.” You may be eligible for a Health Savings Account (HSA) with this High Deductible Health Plan. An HSA may be used to pay for Member Cost Sharing associated with Covered Benefits in addition to some health care services that are not covered by the Plan. An HSA may also provide you with generous tax advantages. It is important that you consult a qualified tax advisor for advice on whether you are eligible to contribute to an HSA and how an HSA may be used.

- Member Cost Sharing for Covered Benefits; and
- Some health care services that are not covered by the Plan.

An HSA may also provide tax advantages. Please consult a qualified tax advisor. He or she can advise if you are eligible for an HSA and how it works.

Your health care under the Plan is provided or arranged through the NH Local Choice Network. The NH Local Choice Network includes two tiers of providers: (1) Tier 1 Providers, and (2) Tier 2 Providers.

Tier 1 Providers: Tier 1 includes Primary Care Physicians (PCPs) and a variety of specialists, hospitals and other providers and facilities. Services from a Tier 1 Provider can be coordinated by Referral from your PCP. When you receive services from a Tier 1 Provider, you may have a lower out of pocket expense.

Tier 2 Providers: Tier 2 includes Primary Care Physicians (PCPs) and a variety of specialists, hospitals and other providers and facilities. Services from a Tier 2 Provider can be coordinated by Referral from your PCP. When you receive services from a Tier 2 Provider, you may have a higher out-of-pocket expense.

Please see your Schedule of Benefits to see the Member Cost Sharing applicable to your specific Plan.

You choose a PCP for yourself and each covered family member when you join the Plan. It is important to consider your PCP’s tier placement as your PCP will be providing or coordinating most of your care. If you choose a Tier 1 PCP, you will likely be referred to Tier 1 Providers. If you choose a Tier 2 PCP, you will likely be referred to Tier 2 Providers.

All Harvard Pilgrim providers meet our strict quality standards. Please refer to your Provider Directory to determine the tier placement of your provider.

Your Covered Benefits are described in this Handbook, the Schedule of Benefits, the Prescription Drug Brochure or amendments to those documents. Services under the Plan

must be provided or arranged by your PCP, except as described in section *I.D.1. Your PCP Manages Your Health Care*.

We provide helpful online tools and resources at www.harvardpilgrim.org. **Your secure online account** offers a safe place to help manage your health care. You can:

- check benefits,
- check Member Cost Sharing,
- view claims history,
- change your PCP,
- estimate costs for services from Plan Providers, and
- compare cost estimates between Plan Providers

For details on how to register **your secure online account**, log on to www.harvardpilgrim.org.

For any questions, call Member Services at **1-877-907-4742**. Member Services staff can help you with questions about the following:

- Selecting a PCP
- Your Benefit Handbook
- Your benefits
- Your enrollment
- Your claims
- Pharmacy management procedures
- Provider Information
- Requesting a Provider Directory
- Requesting a Member Kit
- Requesting ID cards
- Registering a complaint

We can help with questions from non-English speaking Members. We offer language interpretation services in more than 180 languages.

Deaf and hard-of-hearing Members may call Member Services at **711** for TTY service.

We value your input. We appreciate any comments or suggestions that will help us improve the quality of our services.

**Harvard Pilgrim Health Care of New England
Member Services Department**

**1 Wellness Way
Canton, MA 02021
1-877-907-4742**

www.harvardpilgrim.org

Medical Necessity Guidelines

We use evidence based clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for your care. To get Medical Necessity

Guidelines, you or your Provider may call Member Services at **1-877-907-4742** or go to **www.harvardpilgrim.org**.

Exclusions or Limitations for Preexisting Conditions. The Plan has no pre-existing condition restrictions, limitations or exclusions on your Covered Benefits.

Language Assistance Services

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-888-333-4742 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-888-333-4742 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-888-333-4742 (TTY: 711).

繁體中文 (Traditional Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-333-4742 (TTY: 711)。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quý vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quý vị miễn phí. Gọi số 1-888-333-4742 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-333-4742 (телетайп: 711).

العربية (Arabic)
إنتباه: إذا أنت تتكلم اللغة العربية، خدمات المساعدة اللغوية متوفرة لك مجاناً. إتصل على 1-888-333-4742 (TTY: 711)

ខ្មែរ (Cambodian) ចំពោះជនដំណឹង: បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-333-4742 (TTY: 711).

한국어 (Korean) '알림: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-333-4742 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्तमें उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા છે તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-888-333-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ຄ່າ, ມີຢູ່ສຳລັບທ່ານ. ໂທ 1-888-333-4742 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-333-4742 (TTY: 711).



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

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General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care and its affiliates as noted below ("HPHC") comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

HPHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact our Civil Rights Compliance Officer.

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with: Civil Rights Compliance Officer, 1 Wellness Way, Canton, MA 02021-1166, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@point32health.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



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

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I. How the Plan Works

This section describes:

- how to use your Benefit Handbook, and
- how your coverage works.

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 amendments make up the Evidence of Coverage (EOC). The EOC is the legal agreement stating the terms of the Plan. It constitutes the entire contract of insurance under this Policy.

The Benefit Handbook describes how your membership works. It's 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 EOC documents online with **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 describes some important sections of the Handbook.

We put the most important information first. For example, this section explains important requirements for coverage.

Benefit details are described in section *III. Covered Benefits* and in your Schedule of Benefits. Please review these together for a complete understanding of your benefits.

Section *VI. Appeals and Complaints* provides information on how to appeal a denial of coverage or file a complaint.

B. HOW TO USE YOUR PROVIDER DIRECTORY

This Plan includes a tiered provider network called the "NH Local Choice Network." You will pay different levels of Member Cost Sharing based on the tier placement, practice or location of the provider you use. Providers can change tier placement, practices and/or locations at any time during the year. When this happens, the tier of that Provider may also change. It is important to confirm the tier placement of your Provider before each visit.

The Provider Directory identifies the Plan's PCPs, specialists, hospitals and other providers you must use for most services under the Plan. Providers are listed by:

- state and town,
- specialty,
- languages spoken, and
- tier placement.

You can view the Provider Directory online at www.harvardpilgrim.org. Call Member Services at **1-877-907-4742** to get a free copy of the Provider Directory.

You can search the online Provider Directory for Plan Providers by:

- name,
- gender,
- specialty,
- hospital affiliations,
- languages spoken,
- office locations, and
- tier.

You can also get information about which Plan Providers are accepting new patients. The online directory is updated according to state and Federal laws. As a result, it is more current than the paper directory.

Please Note: Plan Providers are contracted to be part of our network. Contracts can be terminated either by a provider or by us. A Plan Provider may leave the network to retire, relocate or for other reasons. This means that we cannot guarantee your Plan Provider will

be in the network for the duration of your membership. If your PCP leaves the network, we will make every effort to tell you in advance. We will help you find a new Plan Provider. Under certain circumstances you may be eligible for transition services if your provider leaves the network. Please see section *I.F. SERVICES PROVIDED BY A DISENROLLED OR NON-PLAN PROVIDER* for details.

C. MEMBER OBLIGATIONS

1. Choose a Primary Care Provider (PCP)

Under this 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. You may choose a PCP from Tier 1 or Tier 2. It is important to consider the tier of the PCP you select. Your PCP will provide or coordinate most of your care. We will assign a Tier 1 PCP to you if:

- you do not choose a PCP when you first enroll, or
- if the PCP you select is not available.

A PCP may be a physician or an advanced practice registered nurse. A PCP may specialize in one or more of the following:

- internal medicine,
- adult medicine,
- adolescent medicine,
- geriatric medicine,
- pediatrics, or
- family practice.

PCPs are listed in the Provider Directory on our website. Call Member Services at **1-877-907-4742** to confirm that the PCP you choose is available.

We suggest calling your PCP for an appointment if you have not seen him/her before. **Please do not wait until you are sick.** Your PCP can take better care of you when he or she knows 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 using **your secure online account** or by calling Member Services at **1-877-907-4742**. The change is effective immediately.

2. Obtain Referrals to Specialists

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 before your appointment. Referrals to Tier 1 or Tier 2 Plan Providers must be given in writing. Please see the Provider Directory before receiving covered services to confirm the tier of the Plan Provider you will be seeing.

3. Show Your Identification Card

Please 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. You may be responsible for the cost of the service. You can order a new ID card online. Log in to **your secure online account** at www.harvardpilgrim.org or call Member Services at **1-877-907-4742**.

4. Share Costs

You must 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. This limits the amount of Member Cost Sharing you may be required to pay. Your specific Member Cost Sharing is listed in your Schedule of Benefits. See Section *I.E. MEMBER COST SHARING* for more information.

5. 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. These limits are needed to maintain reasonable premium rates for all Members. See your Schedule of Benefits for any 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) To receive Covered Benefits you must use Plan Providers, except as noted below in section *I.D.3. Using Plan Providers*.
- 3) When you use Tier 1 Providers, your Member Cost Sharing may be lower. When you use Tier 2 Providers, your Member Cost Sharing may be higher. See your Schedule of Benefits for your specific Member Cost Sharing.
- 4) Your Provider may move from Tier 1 to Tier 2 anytime during the year. It is important to confirm the tier of your Provider before each visit.
- 5) If you need care from a specialist, you must contact your PCP for a Referral. See *I.D.7. Services That Do Not Require a Referral* for exceptions.
- 6) If you have 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. Most services must be provided or arranged by your PCP. The only exceptions are:

- Care in a Medical Emergency.
- Care when you are temporarily outside of the state you live in. See section *I.D.6. Coverage for Services When You Are Temporarily Traveling Outside of the State Where You Live*.
- Mental health care. See section *III. Covered Benefits, Mental Health and Substance Use Disorder Treatment* for more information.
- Special services that do not require a Referral that are listed in section *I.D.7. Services That Do Not Require a Referral*.

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 who provides care after normal business hours. Some PCPs may have covering physicians after hours. Others may have extended office or clinic hours.

You may change your PCP at any time. Choose a new Tier 1 or Tier 2 PCP from the Provider Directory. It is

important to consider the tier placement of the PCP you select as he/she will be providing or coordinating most of your care. You can change your PCP online. Log in to **your secure online account** or call Member Services at **1-877-907-4742**. The change is effective immediately. If you choose a new PCP, you cannot use the Referrals from your prior PCP. Your new PCP will need to provide new Referrals.

2. Referrals for Hospital and Specialty Care

When you need hospital or specialty care, you must call your PCP first. Your PCP will arrange your care. This helps your PCP manage and maintain the quality of your care.

Plan Providers in Tier 1 or Tier 2 with recognized expertise in specialty pediatrics are covered with a Referral from your PCP.

You can view the Provider Directory online at **www.harvardpilgrim.org** before your services to confirm the tier of your provider or facility.

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

- 1) The PCP decides that the Referral is appropriate;
- 2) The specialist (i) agrees to a treatment plan for the Member, and (ii) 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.

You will be directed to a Center of Excellence for certain specialized services. See section *I.D.4. Centers of Excellence* for more information.

You do not need to ask your PCP to receive some specialty services. See section *I.D.7. Services That Do Not Require a Referral*.

3. Using Plan Providers

Under this Plan, you must get Covered Benefits from a Plan Provider. Covered Benefits from a provider who is not a Plan Provider are only covered if one of the following exceptions applies:

- 1) The service was received in a Medical Emergency. See section *I.D.5. Medical Emergency Services* for more information.
- 2) The service was received: (i) while you were outside of the state where you live; and (ii) meets the requirements for coverage under the temporary travel benefit. See section *I.D.6. Coverage for Services When You Are Temporarily*

Traveling Outside of the State Where You Live for more information.

- 3) There is no Plan Provider who has the professional expertise needed to provide the Medically Necessary Covered Benefit. Unless 1) or 2) above applies, services must be approved by us in advanced.
- 4) Your physician is disenrolled as a Plan Provider and exception applies as described in section *I.F. SERVICES PROVIDED BY A DISENROLLED OR NON-PLAN PROVIDER*.

To check a providers' status, see the Provider Directory online at www.harvardpilgrim.org or call Member Services at **1-877-907-4742**.

Please Note: When care cannot be provided by a Plan Provider, HPHC-NE will apply the highest Tier listed in your Schedule of Benefits for covered services.

4. Centers of Excellence

Plan Providers with special training, experience, facilities or protocols for certain specialized services are designated as "Centers of Excellence." These specialized services are only covered when received from a Center of Excellence.

We choose Centers of Excellence based on the findings of recognized specialty organizations or government agencies such as Medicare.

You must get care at a Center of Excellence for the following service:

- Weight loss surgery (bariatric surgery)

Important Notice: There is no coverage for the service listed above unless it is received from a Center of Excellence. To check a Provider's status, see your Provider Directory online at www.harvardpilgrim.org or call Member Services at **1-877-907-4742**.

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. See your Schedule of Benefits for your Member Cost Sharing. If you are admitted to the hospital, you must call the Plan at **1-877-907-4742** within 48 hours or as soon as you can. This phone number is on your ID card. If an attending emergency physician contacts us or your PCP, then no further notice is needed. Your PCP will help to arrange for any follow-up care you need. See the *Glossary* for more information on Medical Emergency Services.

6. Coverage for Services When You Are Temporarily Traveling Outside of the State Where You Live

When you are temporarily outside of the state where you live, 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 traveling outside of the state where you live;
- 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.

If you are admitted to the hospital, call the Plan at **1-877-907-4742** within 48 hours, or as soon as you can. This phone number is on your ID card. If an attending emergency physician contacts us or your PCP, then no further notice is needed. 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. See section *V. Reimbursement and Claims Procedures* for more information. Member Cost Sharing amounts will apply as listed in your Schedule of Benefits.

Please Note: We must have your current address on file to correctly process claims. To change your address, call Member Services at **1-877-907-4742**.

7. Services That Do Not Require a Referral

In most cases you need a Referral from your PCP to get care from any other Tier 1 or Tier 2 Provider. However, the services listed below do not require a referral when received from a Plan Provider. Plan Providers are listed in the Provider Directory. We urge you to keep your PCP informed about care you get without a Referral. This ensures your PCP is aware of your medical situation and keeps your medical records up-to-date.

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 OB/GYN for 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
- Chiropractic care
- Nutritional counseling
- Routine eye examination
- Urgent Care Services

E. MEMBER COST SHARING

Member Cost Sharing may include Copayments, Coinsurance and/or Deductible amounts. See your Schedule of Benefits for your specific Member Cost Sharing amounts. There may be two types of office visit cost sharing that apply to your Plan:

- a lower cost sharing known as “Level 1” and
- a higher cost sharing known as “Level 2.”

If a provider is listed as both a Tier 1 Provider and a Tier 2 Provider, your Member Cost Sharing will depend on the location or practice of the provider. For example: Your provider practices at two different locations. One of the locations is in Tier 1 and the other location is in Tier 2. The Provider Directory will list your provider twice, once for each location where he/she practices. Each listing will identify the location and the tier.

1. Copayment

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.

Your Plan may have other Copayment amounts. See your Schedule of Benefits for more information on your specific Copayments.

2. Deductible

A Deductible is a specific dollar amount that is paid by a Member for Covered Benefits received each Calendar Year. A Deductible is applied:

- before any benefits subject to the Deductible are paid by the Plan.
- on the date the benefit is received.

Your Plan will have one of the following types of Deductibles:

Individual Deductible An Individual Deductible will apply when you have Individual Coverage. Once you have met the individual Deductible, you will have no additional Deductible costs to pay for the rest of the Calendar Year. Note: An individual Deductible may also apply if you have Family Coverage. See Family Deductible with an embedded individual Deductible below.

Family Deductible A family Deductible applies when you have Family Coverage. This Deductible may be met by all family Members combined. For example, a family of four meets a \$4,000 family Deductible as follows:

- One covered family Member has \$3,000 in covered medical expenses; and
- Another covered family Member has \$1,000 in covered medical expenses.

In this example, the family Deductible is met for the entire family. This applies for the rest of the Calendar Year.

Family Deductible with an embedded individual Deductible A family Deductible with an embedded individual Deductible applies when you have Family Coverage. This Deductible can be met in one of two ways:

- A Member of a covered family meets an individual embedded Deductible. In this instance, that Member has no additional Deductible costs to pay for Covered Benefits for the rest of the Calendar Year.
- Any number of Members in a covered family collectively meet the family Deductible. In this instance, all Members of a covered family have no

additional Deductible costs to pay for Covered Benefits for the rest of the Calendar Year. No one family member may contribute more than the individual embedded Deductible amount to the family Deductible.

An embedded individual Deductible cannot be less than the minimum family Deductible required for a High Deductible Health Plan.

A Member may change from Family Coverage to Individual Coverage or from Individual Coverage to Family Coverage within a Calendar Year. In either case:

- costs the Member paid toward the Deductible under the prior coverage will apply toward the Deductible limit under their new coverage
- the Member or family will only need to pay the Copayment or Coinsurance amounts listed on the new Schedule of Benefits, if the previously paid Deductible amount is more than the new Deductible limit.

3. Coinsurance

After your Deductible is met, you may have to pay Coinsurance. Coinsurance is a percentage of the Allowed Amount, or the Recognized Amount, if applicable. For Plan Providers, the Allowed Amount is based on the contracted rate between HPHC-NE and the Provider. Coinsurance amounts are listed in your Schedule of Benefits.

4. Out-of-Pocket Maximum

Your coverage has an Out-of-Pocket Maximum. An Out-of-Pocket Maximum is the total amount of Member Cost Sharing you may pay in a Calendar Year. Once the Out-of-Pocket Maximum is reached, there is no additional Member Cost Sharing for the rest of the year. HPHC will pay 100% of the Allowed Amount for the remainder of the Calendar Year.

Charges above the Allowed Amount never apply to the Out-of-Pocket Maximum.

Individual Out-of-Pocket Maximum An Individual Out-of-Pocket Maximum applies when you have Individual Coverage. Once you have met the individual Out-of-Pocket Maximum, you will have no additional Member Cost Sharing for the rest of the Calendar Year. Note: An individual Out-of-Pocket Maximum may also apply if you have Family Coverage. See Family Out-of-Pocket Maximum with an embedded individual Out-of-Pocket Maximum below..

Family Out-of-Pocket Maximum A family Out-of-Pocket Maximum applies when you have Family Coverage. A family Out-of-Pocket Maximum can be met by all Members of the family combined. For example: a family of four meets a \$10,000 family Out-of-Pocket Maximum as follows:

- one covered family Member pays \$5,000 in Member Cost Sharing; and
- another family Member pays \$3,000 in Member Cost Sharing; and
- another covered family Member pays \$2,000 in Member Cost sharing.

In this example, the \$10,000 family Out-of-Pocket Maximum is met for the entire family for the rest of the Calendar Year.

Family Out-of-Pocket Maximum with an embedded individual Out-of-Pocket Maximum This family Out-of-Pocket Maximum may apply when you have Family Coverage. It can be met in one of two ways:

- a. A Member of a covered family meets an individual Out-of-Pocket Maximum. In this case, the Member has no additional Member Cost Sharing for the rest of the Calendar Year.
- b. Any number of Members in a covered family collectively meet the family Out-of-Pocket Maximum. In this case, all Members of the covered family have no additional Member Cost Sharing for the rest of the Calendar Year. Note: No one family member may contribute more than the individual Out-of-Pocket Maximum amount toward the family Out-of-Pocket Maximum.

See your Schedule of Benefits to determine which Out-of-Pocket Maximum applies to your Plan.

A Member may change from Family Coverage to Individual Coverage or from Individual Coverage to Family Coverage within a Calendar Year. In either case:

- costs the Member paid toward the Out-of-Pocket Maximum under the prior coverage will apply toward the Out-of-Pocket Maximum limit under their new coverage.
- the Member or family will have no additional Member Cost Sharing for that Calendar Year if the Out-of-Pocket Maximum amount paid is greater than the new Out-of-Pocket Maximum limit.

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

1. Disenrollment of a Plan Provider

If your Provider is disenrolled as a Plan Provider, we do our best to notify you in writing at least 60 days prior to the date of disenrollment. That notice will explain how to select a new Plan Provider. If disenrollment was not related to fraud or quality of care, you may be able to continue to receive Covered Benefits from the disenrolled Plan Provider, under the terms of this Handbook and your Schedule of Benefits, for at least 60 days after the disenrollment date.

You may also be eligible to continue to receive coverage for the following services from the disenrollment date or the date of the disenrollment member notice (whichever is later):

i. Active Course of Treatment

Except for pregnancy and terminal illness as described below, if you are undergoing an active course of treatment for an illness, injury or condition, we may approve additional coverage through the active course of treatment or up to 90 days (whichever is shorter). An active course of treatment is when you:

- have a “serious and complex condition.”
- are undergoing a course of institutional or inpatient care.
- have scheduled nonelective surgery including any related postoperative care.

The term “serious and complex condition” is an acute illness that requires specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or is a chronic illness that is (a) life-threatening, degenerative, potentially disabling, or congenital; and (b) requires specialized medical care over a prolonged period of time.

ii. Pregnancy

When you are pregnant, you may continue to receive Covered Benefits from your disenrolled provider. Coverage will be through delivery and up to 6 weeks of postpartum visits immediately following childbirth.

iii. Terminal Illness

When you have a terminal illness, you may continue to receive Covered Benefits from the disenrolled provider until death.

2. Mental Health Provider Continuation

If this Plan replaced your prior health plan and you were being treated by a mental health provider under the prior plan, you may be eligible to continue seeing your previous health care provider. See Section III. *Covered Benefits*, Mental Health and Substance Use Disorder Treatment for more information.

G. MEDICAL NECESSITY GUIDELINES

We use evidence based clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for your care. You or your Provider may get a copy of our Medical Necessity Guidelines. Call Member Services at **1-877-907-4742** or go to www.harvardpilgrim.org.

H. PROVIDER FEES FOR SPECIAL SERVICES (CONCIERGE SERVICES)

Certain physician practices charge extra fees for special services or amenities. 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;
- 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 not included as a Covered Benefit under your Plan.

In considering arrangements with physicians for special services, you should understand exactly what services are to be provided. You will need to decide if these 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.

I. BUNDLED PAYMENT ARRANGEMENTS

The Plan may participate in bundled payment arrangements with certain Providers. Under these arrangements, a specific service or treatment is paid for based on a fixed sum for all services you

receive. Member Cost Sharing for Covered Benefits under a bundled payment arrangement may be less than if the Covered Benefits were received without the bundled payment arrangement. Please refer to www.harvardpilgrim.org or call Member Services at **1-877-907-4742** for a list of Plan Providers with bundled payment arrangements and their corresponding services. We may revise the list of services or Plan Providers who have bundled payment arrangements upon 30 days notice to Members.

J. CARE MANAGEMENT PROGRAMS

The Plan provides care management programs for Members with certain illnesses and injuries. These programs are designed to encourage the use of the most appropriate and cost-effective treatment and to provide support for the Member's care. Care management may include programs for medical and behavioral health care including, but not limited to:

- cancer;
- lung and kidney diseases;
- severe traumatic injuries;
- behavioral health disorders;
- substance use disorders;
- high risk pregnancies and newborn care

The Plan may work with certain providers to establish care management programs. The Plan or providers affiliated with the care management program may contact Members that may be candidates for its programs. The Plan or providers may also contact Members to:

- assist with enrollment,
- develop treatment plans,
- establish goals,
- determine alternatives to a Member's current treatment plan.

Covered Benefits provided through a care management program may apply Member Cost Sharing.

II. Glossary

This section lists words with special meaning within the Handbook.

Glossary Term	Definition
<p>1 . Activities of Daily Living</p>	<p>The basic functions of daily life include bathing, dressing, and mobility, including, but not limited to, transferring from bed to chair and back, walking, sleeping, eating, taking medications and using the toilet.</p>
<p>2 . Allowed Amount</p>	<p>The Allowed Amount is the maximum amount the Plan will pay for Covered Benefits minus any applicable Member Cost Sharing.</p> <p>The Allowed Amount depends upon whether a Covered Benefit is provided by a Plan Provider or a Non-Plan Provider, as follows:</p> <ol style="list-style-type: none"> 1. Plan Providers. If a Covered Benefit is provided by a Plan Provider, the Allowed Amount is the contracted rate HPHC-NE has agreed to pay Plan Providers. The Plan Providers are not permitted to charge the Member any amount for Covered Benefits, except the applicable Member Cost Sharing amount for the service, in addition to the Allowed Amount. 2. Non-Plan Providers. Most services that are Covered Benefits under your Plan must be provided by a Plan Provider to be covered by HPHC-NE. However, there are exceptions. These include: (i) care in a Medical Emergency; and (ii) care while traveling outside of the state where you live. <p>If services provided by a Non-Plan Provider are Covered Benefits under your Plan, the Allowed Amount for such services depends upon where the Member receives the service, as explained below.</p> <ol style="list-style-type: none"> a. If a Member receives Covered Benefits from a Non-Plan Provider in the states of Massachusetts, New Hampshire, Maine, Rhode Island, or Vermont, the Allowed Amount is defined as follows: <p>The Allowed Amount is the lower of the Provider’s charge or a rate determined as described below:</p> <p>An amount that is consistent, in the judgment of the Plan, with the normal range of charges by health care Providers for the same, or similar, products or services provided to a Member. If the Plan has appropriate data for the area, the Plan will determine the normal range of charges in the geographic area where the product or services were provided to the Member. If the Plan does not have data to reasonably determine the normal range of charges where the products or services were provided, the Plan will utilize the normal range of charges in Boston, Massachusetts. Where services are provided by non-physicians but the data on provider charges available to the Plan is based on charges for services by physicians, the Plan will, in its discretion, make reasonable reductions in its determination of the allowable charge for such non-physician Providers.</p> b. If a Member receives Covered Benefits from a Non-Plan Provider outside of Massachusetts, New Hampshire, Maine, Rhode Island, or Vermont, the Allowed Amount is defined as follows: <p>The Allowed Amount is the lower of the Provider’s charge or a rate determined as described below:</p> <p>The Allowed Amount is determined based on 150% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.</p> <p>When a rate is not published by CMS for the service, we use other industry standard methodologies to determine the Allowed Amount for the service as follows:</p>

Glossary Term	Definition
Allowed Amount (Continued)	
	<p>For services other than Pharmaceutical Products, we use a methodology called a relative value scale, which is based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by Optuminsight, Inc. If the Optuminsight, Inc. relative value scale becomes no longer available, a comparable scale will be used.</p> <p>For Pharmaceutical Products, we use industry standard methodologies that are similar to the pricing methodology used by CMS and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.</p> <p>When a rate is not published by CMS for the service and no industry standard methodology applies to the service, or the provider does not submit sufficient information on the claim to pay it under CMS published rates or an industry standard methodology, the Allowed Amount will be 50% of the provider's billed charge, except that the Allowed Amount for certain mental health services and substance use disorder services will be 80% of the billed charge.</p> <p>Pricing of the Allowed Amount will be conducted by UnitedHealthcare, Inc. United Healthcare, updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.</p> <p>As stated above, the Allowed Amount is the maximum amount the Plan will pay for Covered Benefits minus any applicable Member Cost Sharing. Most Non-Plan Providers are permitted to charge amounts for Covered Benefits in excess of the Allowed Amount. In that event, the Plan is responsible for payment of the Allowed Amount, minus any applicable Member Cost Sharing. The Member is responsible for paying the applicable Member Cost Sharing amount and any additional amount charged by the Non-Plan Provider above the Allowed Amount.</p>
3 . Anniversary Date	
	<p>The date upon which the yearly premium rate is adjusted and benefit changes normally become effective. This Benefit Handbook, Schedule of Benefits, and Prescription Drug Brochure will terminate unless renewed on the Anniversary Date.</p>
4 . Benefit Handbook (or Handbook)	
	<p>This document that describes the terms and conditions of the Plan, including but not limited to, Covered Benefits and exclusions from coverage.</p>
5 . Benefit Limit	
	<p>The day, visit or any other limit maximum that applies to certain Covered Benefits. Once the Benefit Limit has been reached, no more benefits will be paid for such services or supplies. If you exceed the Benefit Limit, you are responsible for all charges incurred. The Benefit Limits applicable to your Plan are listed in your Schedule of Benefits.</p> <p>For Example: If your Plan offers 30 visits per Calendar Year for physical therapy services, once you reach your 30 visit limit for that Calendar Year, no additional benefits for that service will be covered by the Plan.</p>
6 . Calendar Year	
	<p>The one-year period beginning on January 1 for which benefits are purchased and administered. Benefits for which limited yearly coverage is provided renew at the beginning of the Calendar Year. Benefits for which limited coverage is provided every two years renew at the beginning of every second Calendar Year. Benefits under your plan are administered on a Calendar Year basis.</p>

NH LOCAL CHOICE HSA HMO FOR INDIVIDUAL MEMBERS - NEW HAMPSHIRE

Glossary Term	Definition
7 . Centers of Excellence	
	<p>Certain specialized services are only covered when received from designated providers with special training, experience, facilities or protocols for the service. Centers of Excellence are selected by us based on the findings of recognized specialty organizations or government agencies such as Medicare.</p>
8 . Coinsurance	
	<p>A percentage of the Allowed Amount, or Recognized Amount, if applicable, for certain Covered Benefits that must be paid by the Member. Coinsurance amounts applicable to your Plan are stated in your Schedule of Benefits.</p> <p>For Example: If the Coinsurance for a service is 20%, you pay 20% of the Allowed Amount while we pay the remaining 80%.</p>
9 . Copayment	
	<p>A fixed dollar amount you must pay for certain Covered Benefits. The Copayment is usually due at the time services are rendered or when billed by the provider.</p> <p>Your specific Copayment amounts, and the services to which they apply, are listed in your Schedule of Benefits.</p> <p>For Example: If your Plan has a \$20 Copayment for outpatient visits, you'll pay \$20 at the time of the visit or when you are billed by the provider.</p>
10 . Cosmetic Services	
	<p>Cosmetic Services are surgery, procedures or treatments that are performed primarily to reshape or improve the individual's appearance.</p>
11 . Covered Benefit(s)	
	<p>The products and services that a Member is eligible to receive, or obtain payment for, under the Plan.</p>
12 . Custodial Care	
	<p>Services provided to a person for the primary purpose of meeting non-medical personal needs (e.g., bathing, dressing, preparing meals, including special diets, taking medication, assisting with mobility).</p>
13 . Deductible	
	<p>A specific dollar amount that is payable by the Member for Covered Benefits received each Calendar Year before any benefits subject to the Deductible are payable by the Plan. There may be an individual Deductible and a family Deductible, and you may have different Deductibles that apply to different Covered Benefits under your Plan. If a family Deductible applies to your Plan, it will be stated in your Schedule of Benefits.</p> <p>For Example: If your Plan has a \$500 Deductible and you have a claim with the Allowed Amount of \$1,000, you will be responsible for the first \$500 to satisfy your Deductible requirement before the Plan begins to pay benefits.</p>
14 . Dental Care	
	<p>Any service provided by a licensed dentist involving the diagnosis or treatment of any disease, pain, injury, deformity or other condition of the human teeth, alveolar process, gums, jaw or associated structures of the mouth. However, surgery performed by an oral maxillofacial surgeon to correct positioning of the bones of the jaw (orthognathic surgery) is not considered Dental Care within the meaning of this definition.</p>
15 . Dependent	
	<p>A Member of the Subscriber's family who (1) meets the eligibility requirements as described in section <i>VIII.A.2. Dependent Eligibility</i> for coverage through a Subscriber and (2) is enrolled in the Plan.</p>
16 . Enrollment Area	
	<p>The geographic area in which you must live in order to be eligible to enroll as a Member under the Plan. The Enrollment Area is the state of New Hampshire.</p>

Glossary Term	Definition
17 . Evidence of Coverage (EOC)	
	The legal documents, including the Benefit Handbook, Schedule of Benefits, Prescription Drug Brochure and amendments which describe the services covered by the Plan, and other terms and conditions of coverage.
18 . Experimental, Unproven, or Investigational	
	Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests, will be deemed Experimental, Unproven, or Investigational by us under this Benefit Handbook for use in the diagnosis or treatment of a particular medical condition if any the following is true: a. The product or service is not recognized in accordance with generally accepted medical standards as being safe and effective for the use in the evaluation or treatment of the condition in question. In determining whether a service has been recognized as safe or effective in accordance with generally accepted evidence-based medical standards, primary reliance will be placed upon data from published reports in authoritative medical or scientific publications that are subject to established peer review by qualified medical or scientific experts prior to publication. In the absence of any such reports, it will generally be determined that a service, procedure, device or drug is not safe and effective for the use in question. b. In the case of a drug, the drug has not been approved by the United States Food and Drug Administration (FDA) (this does not include off-label uses of FDA approved drugs) or if approved for lawful marketing by the FDA and reliable scientific evidence does not support that the treatment is effective in improving health outcomes or that appropriate patient selection has not been determined.
19 . Family Coverage	
	Coverage for a Member and one or more Dependents.
20 . Habilitation Services	
	Health care services that help a person keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapies and speech-language services.
21 . Harvard Pilgrim Health Care of New England (HPHC-NE)	
	Harvard Pilgrim Health Care of New England is a Massachusetts corporation that is licensed as a Health Maintenance Organization (HMO) in the state of New Hampshire. HPHC-NE provides or arranges for health care benefits to Members through a network of Primary Care Providers, specialists and other providers.
22 . Health Savings Account or HSA	
	A tax-exempt trust or custodial account, similar to an individual retirement account (IRA), but established to pay qualified medical expenses. In order to establish a Health Savings Account an individual must: (1) be covered under a High Deductible Health Plan during the months in which contributions are made to the account; (2) not be covered by any other health plan that is not a High Deductible Health Plan (with certain limited exceptions established by law); (3) not be entitled to Medicare benefits; and (4) not be claimed as a dependent on another person's tax return. Members should consult a qualified tax advisor before establishing a Health Savings Account.
23 . High Deductible Health Plan	
	A health care plan that meets the requirements of Section 223 of the Internal Revenue Code with respect to Deductibles and Out-of-Pocket Maximums. A person who is enrolled in a High Deductible Health Plan and meets other requirements stated in that law may establish a Health Savings Account (or HSA) for the purpose of paying qualified medical expenses.
24 . Individual Coverage	
	Coverage for a Subscriber only.

Glossary Term	Definition
25 . Medical Drugs	<p>A prescription drug that is administered to you either (1) in a doctor’s office or other outpatient medical facility, or (2) at home while you are receiving home health care services or receiving drugs administered by home infusion services. Medical Drugs cannot be self-administered. The words “cannot be self-administered” mean that the active participation of skilled medical personnel is always required to take the drug. When a Member is receiving drugs in the home, the words “cannot be self-administered” will also include circumstances in which a family member or friend is trained to administer the drug and ongoing supervision by skilled medical personnel is required.</p>
26 . Medical Emergency	<p>A sudden and unexpected onset of a physical or mental health condition with symptoms of sufficient severity, including severe pain, that a prudent person with average knowledge of health and medicine would reasonably expect that failure to obtain immediate medical attention could result in serious impairment to bodily functions, serious dysfunction of bodily organ or part, or could place the person’s physical and/or mental health in serious jeopardy (or with respect to a pregnant woman, the health of the woman or her unborn child).</p> <p>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.</p>
27 . Medical Emergency Services	<p>Services provided during a Medical Emergency, including:</p> <ul style="list-style-type: none"> • A medical screening examination (as required under section 1867 of the Social Security Act or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital, or an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Medical Emergency, and • Further medical examination and treatment, within the capabilities of the staff and facilities available at the hospital or independent freestanding emergency department, as applicable, as are required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further exam or treatment is provided). • Items and services, otherwise covered under the Plan, that are provided by a Non-Plan Provider or facility (regardless of the department of the hospital in which the items and services are provided) after the Member is stabilized and as part of an inpatient stay or outpatient services that are connected to the original Medical Emergency, unless each of the following conditions are met: <ul style="list-style-type: none"> a. The Provider or facility, as described above, determines the Member is able to travel using non-medical transportation or non-emergency medical transportation. b. The Provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law. c. The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law. d. Any other conditions as specified by under sections 2799A-1 and 2799A-2 of the Public Service Act..

Glossary Term	Definition
28 . Medically Necessary or Medical Necessity	
	<p>Those medical services which are provided to a Member for the purpose of preventing, stabilizing, diagnosing or treating an illness, injury or disease, or the symptoms thereof, in a manner that is (a) consistent with generally accepted standards of medical practice, (b) clinically appropriate in terms of type, frequency, extent, location of service and duration, (c) demonstrated through scientific evidence to be effective in improving health outcomes, (d) representative of best practices in the medical profession, and (e) not primarily for the convenience of the enrollee or physician or other health care provider.</p> <p>Please Note: To determine coverage of Medically Necessary services, we use Medical Necessity Guidelines (MNG) created using 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 the Medical Necessity Guideline(s) applicable to a service or procedure for which coverage is requested by going online or by calling Member Services at 1-877-907-4742.</p>
29 . Member	
	Any Subscriber or Dependent covered under the Plan.
30 . Member Cost Sharing	
	<p>The responsibility of Members to assume a share of the cost of the benefits provided under the Plan. Member Cost Sharing may include Copayments, Coinsurance and Deductibles. There may be two types of office visit cost sharing that apply to your Plan: a lower cost sharing known as "Level 1" and a higher cost sharing known as "Level 2." Please refer to your Schedule of Benefits for the specific Member Cost Sharing that applies to your Plan.</p>
31 . Network	
	Providers of health care services, including but not limited to, physicians, hospitals and other health care facilities that are under contract with us to provide services to Members.
32 . Non-Plan Provider	
	Providers of health care services that are not under contract with us to provide care to Members.
33 . Out-of-Network Rate	
	<p>With respect to a Surprise Bill, the total amount paid by the Plan to a Non-Plan Provider for Covered Benefit under section 2799A-1 and 2799A-2 of the Public Service Act and their implementing regulations for: (1) Emergency Medical Services, (2) non-emergency ancillary services, (3) non-emergency, non-ancillary services, and (4) air ambulance services. The amount is based on (1) Applicable state law, (2) an All Payer Model Agreement if adopted, (3) the initial payment made by us or the amount subsequently agreed to by the Non-Plan Provider and us, or (4) the amount determined by Independent Dispute Resolution between us and the Non-Plan Provider.</p>

Glossary Term	Definition
34 . Out-of-Pocket Maximum	
	<p>An Out-of-Pocket Maximum is a limit on the amount of Copayments, Coinsurance and Deductibles that you must pay for Covered Benefits in a Calendar Year. The Out-of-Pocket Maximum is specified in your Schedule of Benefits.</p> <p>Please Note: Charges above the Allowed Amount never apply to the Out-of-Pocket Maximum.</p> <p>For Example: If your plan has an individual Out-of-Pocket Maximum of \$1,000, this is the most Member Cost Sharing you will pay for out-of-pocket costs for that Calendar Year. As an example, the Out-of-Pocket Maximum can be reached by the following: \$500 in Deductible expenses, \$400 in Coinsurance expenses and \$100 in Copayment expenses.</p>
35 . Physical Functional Impairment	
	<p>A condition in which the normal or proper action of a body part is damaged, and affects the ability to participate in Activities of Daily Living. Physical Functional Impairments include, but are not limited to, problems with ambulation, communication, respiration, swallowing, vision, or skin integrity.</p> <p>A physical condition may impact an individual's emotional well-being or mental health. However such impact is not considered in determining whether or not a Physical Functional Impairment exists. Only the physical consequences of a condition are considered.</p>
36 . Plan or Policy	
	<p>This package of health care benefits offered by Harvard Pilgrim Health Care of New England.</p>
37 . Plan Provider	
	<p>Providers of health care services in the Service Area that are under contract to provide care to Members of your Plan. Plan Providers include, but are not limited to hospitals, skilled nursing facilities, and medical professionals including: physicians, psychiatrists, psychiatrist-supervised physician assistants, naturopaths, acupuncturists, podiatrists, osteopaths, chiropractors, nurse practitioners, advanced practice registered nurses, physician assistants, certified midwives, certified registered nurse anesthetists, and licensed mental health professionals including psychologists, clinical social workers, marriage and family therapists, psychiatric/mental health advanced practice registered nurses, alcohol and drug counselors, clinical mental health counselors, optometrists, and pastoral psychotherapists/counselors (except when providing services to a Member of his church or congregation in the course of his or her duties as a pastor, minister or staff person). Services must be within the lawful scope of the licensing required for such Providers. Plan Providers are listed in the Provider Directory.</p>
38 . Premium	
	<p>A payment made to us for health coverage under the Plan.</p>
39 . Primary Care Provider (PCP)	
	<p>A Plan Provider designated to help you maintain your health and to provide and authorize your medical care under the Plan. A PCP may be a (1) physician or a (2) advanced practice registered nurse specializing in one or more of the following specialties: internal medicine, pediatrics or family practice. A PCP may designate other Plan Providers to provide or authorize a Member's care.</p>
40 . Prior Approval (also known as Prior Authorization)	
	<p>A program to verify that certain Covered Benefits are and continue to be, Medically Necessary and provided in an appropriate and cost-effective manner.</p>

Glossary Term	Definition
41 . Provider Directory	
	A directory that identifies Plan Providers. We may revise the provider directory from time to time without notice to Members. The most current listing of Plan Providers is available on www.harvardpilgrim.org .
42 . Recognized Amount	
	With respect to a Surprise Bill, the amount on which a Copayment, Coinsurance or Deductible is based for Medical Emergency Services and certain non-emergency Covered Benefits when provided by Non-Plan Providers. The amount under sections 2799A-1 and 2799A-2 of the Public Service Act and their implementing regulations is based on: (1) Applicable state law, (2) an All Payer Model Agreement if adopted, or (3) the lesser of the amount billed by the Provider or the qualifying payment amount as determined under applicable law. Please Note: Member Cost Sharing based on the Recognized Amount may be higher or lower than Member Cost Sharing based on the Allowed Amount.
43 . Referral	
	An instruction from your PCP that gives you the ability to see another Plan Provider for services that may be out of your PCP's scope of practice. For Example: If you need to visit a specialist, such as a dermatologist or cardiologist, you must contact your PCP first. Your PCP will refer you to a specialist who is a Plan Provider.
44 . Rehabilitation Services	
	Rehabilitation Services are treatments for a disease or injury that helps restore or move an individual toward functional capabilities he/she had prior to the disease or injury. For treatment of congenital anomalies with significant functional impairment, Rehabilitation Services improve functional capabilities to or toward normal function for age appropriate skills. Only the following are covered: cardiac rehabilitation therapy; occupational therapy; physical therapy; pulmonary rehabilitation therapy; speech therapy; or an organized program of these services when rendered by a health care professional licensed to perform these therapies.
45 . Serious Mental Illness	
	Serious Mental Illness means any of the following conditions: (a) schizophrenia and other psychotic disorders; (b) schizoaffective disorder; (c) bipolar disorders; (d) anorexia nervosa and bulimia nervosa; (e) major depressive disorder; (f) obsessive compulsive disorder; (g) panic disorder; (h) pervasive developmental disorder or autism; and (i) chronic post-traumatic stress disorder.
46 . Service Area	
	The geographic area where Plan Providers are available to manage a Member's care.
47 . Skilled Nursing Facility	
	An inpatient extended care facility, or part of one, that is operating pursuant to law and provides skilled nursing services.
48 . Subscriber	
	The person who meets the Subscriber eligibility requirements described in this Benefit Handbook and is enrolled in the Plan.
49 . Surgery - Outpatient	
	A surgery or procedure in a day surgery department, ambulatory surgery department or outpatient surgery center that requires operating room, anesthesia and recovery room services.

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Glossary Term	Definition
50 . Surprise Bill	An unexpected bill you may receive if: (1) You obtain services from a Non-Plan Provider in an emergency, (2) you obtain services from a Non-Plan Provider while you were receiving a service from a Plan Provider or facility, and you did not knowingly select the Non-Plan Provider, (3) you obtain air ambulance services from a Non-Plan Provider or (4) you obtain services from a Non-Plan Provider during and related to a service previously approved or authorized by HPHC where you did not knowingly select a Non-Plan Provider.
51 . 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.
52 . Tier 1 Provider	Certain Providers in the network through which you may receive your care. Tier 1 Providers include Primary Care Providers (PCPs), hospitals, specialists and other providers and facilities. When you receive Covered Benefits from a Tier 1 Provider, your Member Cost Sharing may be lower.
53 . Tier 2 Provider	Certain Providers in the network through which you may receive your care. Tier 2 Providers include Primary Care Providers (PCPs), hospitals, specialists and other providers and facilities. When you receive Covered Benefits from a Tier 2 Provider, your Member Cost Sharing may be higher.
54 . Urgent Care	Medically Necessary services for a condition that requires prompt medical attention but is not a Medical Emergency.

III. Covered Benefits

This Section contains detailed information on the benefits covered under your Plan. Member Cost Sharing information and any applicable benefit limitations that apply to your Plan are listed in your Schedule of Benefits. Benefits are administered on a Calendar Year basis.

Basic Requirements for Coverage

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

- Listed as a Covered Benefit in this section.
- Medically Necessary.
- Not excluded in section IV. *Exclusions*.
- Received while an active Member of the Plan.
- Provided by or upon Referral from your PCP. This requirement does not apply to care needed in a Medical Emergency. Please see section I.D.1. *Your PCP Manages Your Health Care* for other exceptions that apply.
- Provided by a Plan Provider. This requirement does not apply to care needed in a Medical Emergency. Please see I.D.3. *Using Plan Providers* for other exceptions that apply.

Benefit	Description
55 . Acupuncture Treatment	The Plan covers acupuncture treatment, including, electro-acupuncture, that is provided for the treatment of neuromusculoskeletal pain.
56 . Ambulance and Medical Transport	<p>Emergency Ambulance Transport</p> <p>If you have a Medical Emergency, your Plan covers ambulance transport to the nearest hospital that can provide you with Medically Necessary care.</p> <p>Non-Emergency Medical Transport</p> <p>You're also covered for non-emergency medical transport, including but not limited to ambulance and wheelchair vans, between hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary. Services must be arranged by a Plan Provider.</p>
57 . Autism Spectrum Disorders Treatment	<p>The Plan covers the following services for the treatment of autism spectrum disorders to the extent required by New Hampshire law:</p> <ul style="list-style-type: none"> • Services and treatment programs, including applied behavioral analysis, necessary to produce socially significant improvements in human behavior or to prevent loss of attained skill or function. To be covered by the Plan, applied behavior analysis must be provided by a person who is professionally certified by the National Behavior Analyst Certification Board or provides services under the supervision of a person professionally certified by the National Behavior Analyst Certification Board. • Direct or consultative services provided by a licensed Plan Provider including a licensed psychiatrist, licensed advanced practice registered nurse, licensed psychologist, or licensed clinical social worker. • Services provided by a licensed speech therapist, licensed occupational therapist, or licensed physical therapist. • Prescriptions drugs.

Benefit	Description
Autism Spectrum Disorders Treatment (Continued)	
	The Plan may require the submission of a treatment plan, including frequency and duration of treatment showing that the treatment is Medically Necessary and is consistent with nationally recognized treatment standards for autism spectrum disorders.
58 . Bariatric Surgery	
	<p>The Plan covers the surgical treatment of obesity and morbid obesity (bariatric surgery). Services are covered in accordance with the patient qualification and treatment standards set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons. Coverage may be limited or excluded under your Plan unless services are performed at a designated Center of Excellence. Please see the section <i>I.D.4. Centers of Excellence</i> for important information concerning your coverage for this service.</p> <p>Important Notice: We use clinical guidelines to evaluate whether bariatric surgery is Medically Necessary. If you are planning to receive bariatric surgery services we recommend that you review the Medical Necessity Guidelines. To obtain a copy, please call Member Services at 1-877-907-4742.</p>
59 . Chemotherapy and Radiation Therapy	
	The Plan covers outpatient chemotherapy administration and radiation therapy at a hospital or other outpatient medical facility. Covered Benefits include the facility charge, the charge for related supplies and equipment, and physician services for anesthesiologists, pathologists and radiologists.
60 . Chiropractic Care	
	The Plan covers musculoskeletal adjustment or manipulation.
61 . Clinical Trials for the Treatment of Cancer or Other Life-Threatening Diseases	
	<p>The Plan covers services for Members enrolled in a qualified clinical trial for the treatment, prevention or detection of any form of cancer or other life-threatening disease under the terms and conditions provided for under New Hampshire and federal law. A qualified clinical trial means any trial approved by: (1) a New Hampshire institutional review board; (2) a federal agency including the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control and Prevention, and the Department of Health and Human Services; or (3) any other state or federal agency authorized by law to approve clinical trials.</p> <p>All of the requirements for coverage under the Plan apply to coverage under this benefit. Coverage is provided under this benefit for services that are Medically Necessary for the treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the Plan. Coverage is not provided for the following: (1) the investigational item, device or service itself; or (2) for services, tests or items that are provided solely to satisfy data collection and analysis for the clinical trial and that are not used for the direct clinical management of your condition.</p>

Benefit	Description
<p>62 . Dental Services</p>	<p>Important Notice: The Plan does not provide dental insurance. It covers only the limited Dental Care described below. No other Dental Care is covered.</p> <p>Accidental Injury Dental Care:</p> <p>The Plan provides coverage for Medically Necessary Dental Care resulting from an accidental injury to sound natural teeth and gums. Coverage for Dental Care is subject to all other terms and conditions of this Evidence of Coverage. Dental Care required as a result of normal activities of daily living or extraordinary use of the teeth is not considered by the Plan to have occurred as the result of an accident. No coverage is provided under the Plan for repairs to teeth that are damaged as a result of such activities.</p> <p>Outpatient Surgery Expenses for Dental Care:</p> <p>The Plan covers the expenses of a hospital or outpatient surgery and expenses for general anesthesia administered by a licensed anesthesiologist or certified registered nurse anesthetist for the performance of Dental Care if:</p> <ul style="list-style-type: none"> • A Member is a child up to the age of 13 who is determined by a licensed dentist and his or her PCP to have a dental condition that is so complex as to require the necessary dental procedures be performed in a hospital or surgical day care facility; or • A Member (of any age) is determined by his or her PCP to require dental treatment in a hospital or surgical day care facility due to exceptional medical circumstances or a developmental disability, which places the Member at serious risk. <p>Your PCP must arrange for all hospital or outpatient surgery. The only expenses covered under this benefit are hospital charges, surgical day charges and anesthesia charges.</p> <p>Pediatric Dental Care:</p> <p>The Plan provides coverage for pediatric dental care for children until the end of the month in which the child turns 19. Please see the Pediatric Dental Benefit section of your Schedule of Benefits and Appendix B: Pediatric Dental Benefit (for children up to the age of 19) later in this Benefit Handbook for details.</p>
<p>63 . Diabetes Services and Supplies</p>	<p>Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care:</p> <p>The Plan covers outpatient self-management education and training for the treatment of diabetes, including medical nutrition therapy services, used to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes. Services must be provided on an individual basis and be provided by a Plan Provider. Benefits also include medical eye exams (dilated retinal exams) and preventive foot care. Diabetes equipment and supplies are also covered.</p> <p>Some equipment and supplies listed below may be furnished by a Durable Medical Equipment (DME) provider or a pharmacy. Your Member Cost Sharing is based on who furnishes the equipment and/or supplies.</p> <p>The following items are covered:</p>

Benefit	Description
	<p>Diabetes Services and Supplies (Continued)</p> <p>Diabetes Equipment (covered under your DME benefit):</p> <ul style="list-style-type: none"> • Blood glucose monitors • Continuous glucose monitors • Dosage gauges • Injectors • Insulin pumps (including supplies) and infusion devices • Lancet devices • Therapeutic molded shoes and inserts • Visual magnifying aids • Voice synthesizers <p>Please see the “Durable Medical Equipment (DME)” benefit for more information.</p> <p>Pharmacy Supplies (covered at a pharmacy):</p> <ul style="list-style-type: none"> • Blood glucose strips • Certain blood glucose monitors • Certain insulin pumps (including supplies) and infusion devices • Flash glucose monitors (including supplies) • Insulin, insulin needles and syringes • Lancets • Oral agents for controlling blood sugar • Urine and ketone test strips <p>Please see the “Drug Coverage” benefit for more information.</p> <p>For coverage of pharmacy items listed above, you must get a prescription from your Plan Provider and present it at a participating pharmacy. Member Cost Sharing for up to a 30 day supply of insulin will not exceed \$30 in accordance with state law. You can find participating pharmacies by logging into your secure online account at www.harvardpilgrim.org or by calling the Member Services Department at 1-877-907-4742.</p>
<p>64 . Dialysis</p>	<p>The Plan covers dialysis on an inpatient, outpatient or at home basis. When Medicare is the primary payer under federal law (or would be primary if the Member were timely enrolled), the Plan will cover only those costs that exceed what would be payable by Medicare.</p> <p>Coverage for dialysis in the home includes non-durable medical supplies, and drugs and equipment necessary for dialysis.</p> <p>We must approve dialysis services if you are temporarily traveling outside of the state where you live. We will cover dialysis services for up to 30 days of travel per Calendar Year. You must make arrangements in advance with your Plan Provider.</p>

Benefit	Description
<p>65 . Drug Coverage</p>	<p>You have limited coverage for drugs received during inpatient and outpatient treatment and also for certain medical supplies you purchase at a pharmacy under this Benefit Handbook. This coverage is described in Subsection 1, below. You also have coverage for outpatient prescription drugs you purchase at a pharmacy under the Plan’s outpatient prescription drug coverage. Subsection 2, below, explains more about this coverage.</p> <p>1. Drug Coverage under this Benefit Handbook</p> <p>a. Medical Drugs Received During Outpatient or Home Care. These drugs are known as “Medical Drugs.” A Medical Drug is administered to you either (1) in a doctor’s office or other outpatient medical facility, or (2) at home while you are receiving home care services or receiving drugs administered by home infusion services.</p> <p>Medical Drugs cannot be self-administered. The words “cannot be self-administered” mean that the active participation of skilled medical personnel is always required to take the drug. When a Member is receiving drugs in the home, the words “cannot be self-administered” will also include circumstances in which a family member or friend is trained to administer the drug and ongoing supervision by skilled medical personnel is required.</p> <p>An example of a drug that cannot be self-administered is a drug that must be administered intravenously. Examples of drugs that can be self-administered are drugs that can be taken in pill form and drugs that are typically self-injected by the patient.</p> <p>See your Schedule of Benefits for your Medical Drug Member Cost Sharing.</p> <p>b. Drugs and supplies required by law. Some drugs or supplies required by law may only be available through a pharmacy. These items will be covered under this Handbook even if your Plan does not include HPHC’s outpatient Prescription Drug rider. Coverage is provided for:</p> <ul style="list-style-type: none"> • Certain diabetes supplies See the “Diabetes Services and Supplies” benefit for details. • Certain prescribed, oral or self administered anticancer medication used to kill or slow the growth of cancerous cells are covered with no Member Cost Sharing after the Deductible has been met. • Certain antibiotic therapy for tick-borne illness. See “Medical Drug” above to details. <p>Note: If you are planning to receive antibiotic therapy to treat a tick-borne illness, we recommend that you review the current guidelines online at www.harvardpilgrim.org.</p> <p>No coverage is provided under this Benefit Handbook for: (1) drugs that have not been approved by the United States Food and Drug Administration; (2) drugs the Plan excludes or limits, including, but not limited to, drugs for cosmetic purposes; and (3) any drug that is obtained at an outpatient pharmacy except as explained above.</p> <p>2. Outpatient Prescription Drug Coverage</p> <p>In addition to the coverage provided under this Benefit Handbook, you also have coverage for outpatient prescription drugs. Your Plan provides coverage for most prescription drugs purchased at an outpatient pharmacy.</p>

Benefit	Description
Drug Coverage (Continued)	
	See the Prescription Drug Brochure for more information. See your ID card for your Member Cost Sharing.
66 . Durable Medical Equipment (DME)	
	<p>The Plan covers DME when Medically Necessary and ordered by a Plan Provider. We will rent or buy all equipment. The cost of the repair and maintenance of covered equipment is also covered.</p> <p>In order to be covered, all equipment must be:</p> <ul style="list-style-type: none"> • Able to withstand repeated use; • Not generally useful in the absence of disease or injury; • Normally used in the treatment of an illness or injury or for the rehabilitation of an abnormal body part ; and • Suitable for home use. <p>Coverage is only available for:</p> <ul style="list-style-type: none"> • The least costly equipment adequate to allow you to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports; and • One item of each type of equipment. 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. <p>Covered equipment and supplies include:</p> <ul style="list-style-type: none"> • Canes • Certain diabetes supplies and equipment (See the “Diabetes Services and Supplies” benefit for details.) • Certain types of braces • Crutches • Hospital beds • Oxygen and oxygen equipment • Respiratory equipment • Walkers • Wheelchairs <p>Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan.</p>
67 . Early Intervention Services	
	<p>The Plan covers early intervention services for children with an identified developmental disability or delay. Coverage is provided for children from birth up to the age of 3.</p> <p>Coverage under this benefit is only available for services rendered by the following types of providers:</p> <ul style="list-style-type: none"> • Occupational therapists • Physical therapists • Speech-language pathologists • Clinical social workers

Benefit	Description
<p>68 . Emergency Room Care</p>	<p>If you have a Medical Emergency, you are covered for care in a hospital emergency room. Please remember the following:</p> <ul style="list-style-type: none"> • If you need follow-up care after you are treated in an emergency room, you must call your PCP. Your PCP will provide or arrange for the care you need. • If you are hospitalized, you must call the Plan at 1-877-907-4742 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. • Services provided in an emergency room for conditions that do not meet the definition of Medical Emergency may apply a higher Member Cost Sharing. Examples of non-Medical Emergency services may include follow-up care, treatment for earaches, rashes, or sore throats, or suture removal. Please refer to your Schedule of Benefits to determine the applicable Member Cost Sharing for services provided in an emergency room. <p>Please Note: You may log into your secure online account for more information on lower cost options when you need Urgent Care. Whenever possible, you should also contact your PCP prior to obtaining Urgent Care, because your PCP may be able to provide the services you require at a lower out-of-pocket cost.</p>
<p>69 . Family Planning Services</p>	<p>The Plan covers family planning services, including the following:</p> <ul style="list-style-type: none"> • Contraceptive monitoring • Family planning consultation • Pregnancy testing • Genetic counseling • FDA approved birth control drugs, implants or devices • Professional services relating to the injection of birth control drugs and the insertion or removal of birth control implants or devices.
<p>70 . Gender Affirming Services</p>	<p>The Plan covers gender affirming services to the extent Medically Necessary and in accordance with Medical Necessity Guidelines. Coverage includes surgery, related physician and behavioral health visits, and outpatient prescription drugs, if you have the outpatient prescription drug coverage under this Plan. If you are planning to receive gender affirming services, you should review the current Medical Necessity Guidelines that identify covered services under this benefit. To receive a copy of the Medical Necessity Guidelines, please call Member Services at 1-877-907-4742 or go to our website at www.harvardpilgrim.org.</p> <p>Benefits for gender affirming services are in addition to other benefits provided under the Plan. HPHC-NE does not consider gender affirming surgery to be reconstructive surgery to correct a Physical Functional Impairment or Cosmetic Services. Coverage for reconstructive surgery or Cosmetic Services is limited to the services described under the Reconstructive Surgery benefit in this Benefit Handbook.</p> <p>Prior Approval or Notification Required: You must obtain prior approval for coverage under this benefit. If you use a Plan Provider, he/she will seek prior approval for you. The prior approval process is initiated by calling: 1-800-708-4414.</p>

Benefit	Description
<p>71 . Hearing Aids</p>	<p>The Plan covers hearing aids to the extent required by New Hampshire law. A hearing aid is defined as any instrument or device designed, intended or offered for the purpose of improving a person’s hearing.</p> <p>Coverage is only available for the least costly hearing aid when determined by a Provider to be Medically Necessary to correct a hearing impairment. The Plan will pay the Allowed Amount, minus any applicable Member Cost Sharing, for the least costly hearing aid. If you purchase a hearing aid that is more expensive than the least costly item adequate to correct a Medically Necessary hearing impairment, you will be responsible for any additional cost. Medically Necessary hearing impairments do not include special functions needed for occupational purposes or sports. No back-up hearing aids that serve a duplicate purpose are covered.</p> <p>Covered Benefits include the following:</p> <ul style="list-style-type: none"> • One hearing aid per hearing impaired ear • Any parts, attachments or accessories, including ear moldings • Services necessary to assess, select, fit or service the hearing aid that are provided by a licensed audiologist, hearing instrument specialist or licensed physician
<p>72 . Home Health Care</p>	<p>If you are homebound for medical reasons, you are covered for home health care services listed below. To be eligible for home health care, your Plan Provider must determine that skilled nursing care or physical therapy is an essential part of active treatment. There must also be a defined medical goal that your Plan Provider expects you will meet.</p> <p>When you qualify for home health care services as stated above, the Plan covers the following services:</p> <ul style="list-style-type: none"> • Durable medical equipment and supplies (must be a component of the home health care being provided) • Medical and surgical supplies • Medical social services • Nutritional counseling • Occupational therapy • Palliative care • Physical therapy • Services of a home health aide • Skilled nursing care • Speech therapy <p>Medically Necessary prenatal and postpartum homemaker services are covered when on the recommendation of her attending healthcare provider, a woman is confined to bed rest or her normal functions of daily life (including walking, speaking, sleeping, eating, drinking and using the toilet) are restricted.</p>

Benefit	Description
<p>73 . Hospice Services</p>	<p>The Plan covers hospice services for terminally ill Members who need the skills of qualified technical or professional health personnel for palliative care. Care may be provided at home or on an inpatient basis. Inpatient respite care is covered for the purpose of relieving the primary caregiver 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.</p> <p>Covered Benefits include:</p> <ul style="list-style-type: none"> • Care to relieve pain • Counseling • Drugs that cannot be self-administered • Durable medical equipment appliances • Home health aide services • Medical supplies • Nursing care • Physician services • Occupational therapy • Physical therapy • Speech therapy • Respiratory therapy • Respite care • Social services
<p>74 . Hospital – Inpatient Services</p>	<p>The Plan covers acute hospital care including, but not limited to, the following inpatient services:</p> <ul style="list-style-type: none"> • Semi-private room and board • Doctor visits, including consultation with specialists • Palliative care • Medications • Laboratory, radiology and other diagnostic services • Intensive care • Surgery, including related services • Anesthesia, including the services of a nurse-anesthetist • Radiation therapy • Physical therapy • Occupational therapy • Speech therapy <p>In order to be eligible for coverage, the following service must be received at a Center of Excellence:</p> <ul style="list-style-type: none"> • Weight loss surgery (bariatric surgery) <p>Please see the <i>I.D.4. Centers of Excellence</i> section for more information.</p>

Benefit	Description
75 . House Calls	The Plan covers house calls.
76 . Human Organ Transplant Services	The Plan covers human organ transplants, including bone marrow transplants for a Member with metastasized breast cancer in accordance with the criteria of the National Cancer Institute.
	<p>The Plan covers the following services when the recipient is a Member of the Plan:</p> <ul style="list-style-type: none"> • Care for the recipient • Donor search costs through established organ donor registries • Donor costs that are not covered by the donor's health plan <p>If a Member is a donor for a recipient who is not a Member, then the Plan will cover the donor costs for the Member when they are not covered by the recipient's health plan.</p>
77 . Infertility Services and Treatment	The Plan covers the following diagnostic services for infertility:
	<ul style="list-style-type: none"> • Consultation • Evaluation • Laboratory tests <p>Please Note: The Plan does not cover infertility treatment such as intra-cytoplasmic sperm injection (ICSI), intra-uterine insemination (IUI), and in-vitro fertilization (IVF), but coverage is provided for Medically Necessary services to treat underlying medical conditions that may cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency).</p>
78 . Laboratory, Radiology and Other Diagnostic Services	The Plan covers laboratory and radiology services (including Advanced Radiology), and other diagnostic services on an outpatient basis. The term "Advanced Radiology" means CT scans, PET Scans, MRI and MRA, and nuclear medicine services. Coverage includes:
	<ul style="list-style-type: none"> • The facility charge and the charge for supplies and equipment. • The charges of anesthesiologists, pathologists and radiologists. <p>In addition, the Plan also covers the following:</p> <ul style="list-style-type: none"> • Human leukocyte antigen testing or histocompatibility locus antigen testing for A, B or DR antigens. The Plan provides coverage up to \$150 toward the cost of human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish bone marrow transplant donor suitability. Services are subject to the Deductible. Testing must be performed at a facility accredited by the American Association of Blood Banks or its successors. At the time of testing the Member must complete and sign an informed consent form that authorizes the results of the test to be used for participation in the National Marrow Donor Program. NH Law prohibits Providers to bill, charge, collect a deposit from, seek payment for or reimbursement from, or have recourse against a Member for any portion of the HLA laboratory fee expenses. • Screening and diagnostic mammograms. This includes mammograms provided by breast tomosynthesis (3D mammographic imaging). • Allergy testing • Blood lead testing • Perfluoroalkyls (PFAS) and Perfluorinated Compound (PFC) blood testing

Benefit	Description
79 . Low Protein Foods	
	The Plan covers low protein foods for inherited diseases of amino and organic acids to the extent required by New Hampshire law.
80 . Maternity Care	
	<p>The Plan covers the following maternity services:</p> <ul style="list-style-type: none"> • Routine outpatient prenatal care, including evaluation and progress screening, physical exams, recording of weight and blood pressure monitoring. • Prenatal genetic testing (office visits require a referral). • 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. • Services by a certified midwife provided in a licensed health care facility or at a home. • Newborn care up to 31 days after birth. Coverage beyond 31 days will only be provided if the newborn is enrolled as a Dependent. Please see the section <i>VII. Eligibility</i> for information on adding new Dependents. • Routine outpatient postpartum care for the mother, up to six weeks after delivery. • Prenatal homemaker services (cooking, cleaning, laundry, shopping and other light housekeeping) for a woman who (1) is confined to bed rest or (2) whose normal functions of daily life (including walking, speaking, sleeping, eating, drinking and using the toilet) are restricted. Services must be Medically Necessary, as determined by your attending Plan Provider, who shall consult with the Plan case manager, when applicable. • A minimum of two postpartum homemaker visits, when Medically Necessary, as determined by your attending Plan Provider, who shall consult with the Plan case manager, when applicable.
81 . Medical Formulas	
	The Plan covers enteral formulas for inherited diseases of amino and organic acids and the treatment of impaired absorption of nutrients caused by disorders effecting the absorptive surface, functional length, or motility of the gastrointestinal tract to the extent required by New Hampshire law.
82 . Mental Health and Substance Use Disorder Treatment	
	<p>To be covered by the Plan, all mental health and substance use disorder treatment must be provided by contracted providers. The only exceptions apply to: (1) care required in a Medical Emergency, and (2) care when you are temporarily outside of the state where you live. These exceptions are described in the section <i>I. How the Plan Works</i>.</p> <p>Coverage for New Hampshire Parity Conditions: Under New Hampshire law, the Plan covers Medically Necessary treatment of Serious Mental Illness at the same level as for any other medical condition. Serious Mental Illnesses are the following diagnoses: schizophrenia and other psychotic disorders, schizoaffective disorder, bipolar disorder, anorexia nervosa and bulimia nervosa, major depressive disorder, panic disorder, pervasive developmental disorder or autism, chronic post-traumatic stress disorder and obsessive-compulsive disorder including pediatric autoimmune neuropsychiatric disorders (PANS/PANDAS). Treatment for PANS/PANDAS may include intravenous immunoglobulin therapy (IVIG) when ordered by a physician.</p>

Benefit	Description
	<p>Mental Health and Substance Use Disorder Treatment (Continued)</p> <p>Coverage for Other Conditions: In addition to the coverage discussed above, the Plan will provide coverage for the care of all other conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. Services for all other conditions not identified above will be covered to the extent Medically Necessary.</p> <p>Mental Health and Substance Use Disorder Treatment</p> <p>The Plan provides coverage for the following Medically Necessary mental health and substance use disorder treatment:</p> <p>a) Inpatient Services</p> <ul style="list-style-type: none"> • Mental health services • Substance use disorder treatment • Detoxification services <p>b) Intermediate Care Services</p> <ul style="list-style-type: none"> • Acute residential treatment (including detoxification) • Partial hospitalization programs • Intensive outpatient programs (IOP) • Mobile crisis intervention (MCI) <p>c) Outpatient Services</p> <ul style="list-style-type: none"> • Care by a licensed mental health professional (including online counseling through secure digital messaging) • Crisis intervention services (Crisis care stabilization) • In-home family stabilization • Substance use disorder treatment • Detoxification services • Medication management • Medication-assisted treatment • Methadone maintenance • Psychological and neuropsychological testing • eVisits (email consultations between a patient and a licensed mental health professional when there is an established relationship) <p>Please Note: A Member requesting mental health services will be referred for at least five (5) visits per Calendar Year to an HPHC-NE network mental health provider. The Plan will not review Medical Necessity of those five (5) visits.</p>

Benefit	Description
83 . Oral Surgery	<p>The Plan covers the following services when Medically Necessary:</p> <ul style="list-style-type: none"> • Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia • Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part • Oral/surgical correction of accidental injuries as described in the “Dental Services” benefit. • Surgical services for the treatment of Temporomandibular Joint Dysfunction (TMD) as described in the “Temporomandibular Joint Dysfunction (TMD)” benefit. • Treatment of non-dental lesions, such as removal of tumors and biopsies • Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses
84 . Observation Services	<p>The Plan covers observation services including short term treatment, assessment and reassessment for up to 48 hours in an acute care facility (i.e. hospital). Observation services determine if a Member needs to be admitted for additional treatment or if the Member is able to be discharged from the hospital.</p>
85 . Ostomy Supplies	<p>The Plan covers the following ostomy supplies:</p> <ul style="list-style-type: none"> • Irrigation sleeves, bags and catheters • Pouches, face plates and belts • Skin barriers
86 . Palliative Care	<p>The Plan covers palliative care in conjunction with inpatient, home health care, hospice and physician services. Member Cost Sharing for palliative care is included in the cost sharing associated with these services.</p> <p>Palliative care is a medical specialty that supports improved quality of life for Members with chronic or serious illness. Care is focused on providing relief from symptoms and the stress of illness. Palliative care can be provided at any stage of illness, along with treatment for your condition while remaining under the care of your regular provider. This care is offered alongside curative or other treatments you may be receiving.</p> <p>Palliative care may include physician services, nursing care, home health care, pain and symptom management, medication management, rehabilitation therapies (occupational, physical, speech and pulmonary), behavioral health services and durable medical equipment.</p>

Benefit	Description
<p>87 . Physician and Other Professional Office Visits</p>	<p>Physician services, including services of all covered medical professionals, can be obtained on an outpatient basis at a physician’s office or a hospital. These services may include:</p> <ul style="list-style-type: none"> • Routine physical examinations, including routine gynecological examination • Follow-up care provided by an obstetrician or gynecologist for obstetrical or gynecological conditions identified during maternity care or annual gynecological visit • Immunizations, including childhood immunizations as recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention and the American Academy of Pediatrics • Well baby and well child care • Health education and nutritional counseling • Sickness and injury care • Palliative care • Vision and Hearing screenings • Medication management • Chemotherapy • Radiation therapy • eVisits (email consultations between a patient and a physician or other medical professional when there is an established relationship)
<p>88 . Prosthetic Devices</p>	<p>The Plan covers prosthetic devices when ordered by a Plan Provider. The cost of the repair and maintenance of a covered device is also covered. In order to be covered, all devices must be able to withstand repeated use. Coverage is only available for:</p> <ul style="list-style-type: none"> • The least costly prosthetic device adequate to allow you to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports; and • One item of each type of prosthetic device. No back-up items or items that serve a duplicate purpose are covered. <p>Covered prostheses include:</p> <ul style="list-style-type: none"> • Breast prostheses, including replacements and mastectomy bras • Prosthetic arms and legs (including myoelectric and bionic arms and legs). A prosthetic device means an artificial limb device to replace, in whole or in part, an arm or leg. • Prosthetic eyes <p>Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan.</p>

Benefit	Description
<p>89 . Reconstructive Surgery</p>	<p>The Plan covers reconstructive and restorative surgical procedures as follows:</p> <ul style="list-style-type: none"> • Reconstructive surgery is covered when the surgery can reasonably be expected to improve or correct a Physical Functional Impairment resulting from an accidental injury, illness, congenital anomaly, birth injury or prior surgical procedure. If reconstructive surgery is performed to improve or correct a Physical Functional Impairment, as stated above, Cosmetic Services that are incidental to that surgery are also covered. After a Physical Functional Impairment is corrected, no further Cosmetic Services are covered by the Plan. • Restorative surgery is covered to repair or restore appearance damaged by an accidental injury. (For example, this benefit would cover repair of a facial deformity following an automobile accident.) <p>Benefits are also provided for post mastectomy care, including coverage for:</p> <ul style="list-style-type: none"> • Protheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient; • Reconstruction of the breast on which the mastectomy was performed; and • Surgery and reconstruction of the other breast to produce a symmetrical appearance. <p>Benefits include coverage for procedures that must be done in stages, as long as you are an active member. Membership must be effective on all dates on which services are provided.</p> <p>There is no coverage for Cosmetic Services or surgery except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, (3) post-mastectomy care as described above, and (4) gender affirming procedures and related services.</p> <p>Important Notice: We use clinical guidelines to evaluate whether different types of reconstructive and restorative procedures are Medically Necessary. If you are planning to receive such treatment, you may review the Medical Necessity Guidelines. To obtain a copy, please call Member Services at 1-877-907-4742.</p>
<p>90 . Rehabilitation – Hospital Care</p>	<p>The Plan covers care in a facility licensed to provide rehabilitative care on an inpatient basis. Coverage is provided when you need daily Rehabilitation Services that must be provided in an inpatient setting. Rehabilitation Services include cardiac rehabilitation therapy, physical therapy, pulmonary rehabilitation therapy, occupational therapy and speech therapy. The Benefit Limit is listed in the Schedule of Benefits.</p>

Benefit	Description
91 . Rehabilitation and Habilitation Services – Outpatient	
	<p>The Plan covers the following outpatient Rehabilitation and Habilitation Services:</p> <ul style="list-style-type: none"> • Cardiac rehabilitation therapy • Occupational therapy • Physical therapy • Pulmonary rehabilitation therapy • Speech therapy <p>Outpatient Rehabilitation and Habilitation Services are covered up to the Benefit Limit listed in the Schedule of Benefits. Services are covered only:</p> <ul style="list-style-type: none"> • If, in the opinion of your Plan Provider, there is likely to be significant improvement in your condition within the period of time benefits are covered; and • When needed to improve your ability to perform Activities of Daily Living. <p>Activities of Daily Living do not include special functions needed for occupational purposes or sports.</p> <p>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 the Plan.</p> <p>Rehabilitation and Habilitation Services are also covered under your inpatient hospital and home health benefits. When such therapies are part of an approved home care treatment plan they are available as described in section <i>III. Covered Benefits, Home Health Care.</i></p>
92 . Scopic Procedures – Outpatient Diagnostic	
	<p>The Plan covers diagnostic scopic procedures and related services received on an outpatient basis.</p> <p>Diagnostic scopic procedures are those for visualization, biopsy and/or polyp removal. Scopic procedures are:</p> <ul style="list-style-type: none"> • Colonoscopy • Endoscopy • Sigmoidoscopy
93 . Skilled Nursing Facility Care	
	<p>The Plan covers care in a health care facility operated pursuant to law that provides skilled nursing care on an inpatient basis. Coverage is provided only when you need daily skilled nursing care that must be provided in an inpatient setting. The Benefit Limit is listed in the Schedule of Benefits.</p>
94 . Surgery - Outpatient	
	<p>The Plan covers outpatient surgery, including related services. Outpatient surgery is defined as any surgery or procedure in a day surgery department, ambulatory surgery department or outpatient surgery center.</p> <p>There are certain specialized services for which you will be directed to a Center of Excellence for care. See the section <i>I.D.4. Centers of Excellence</i> for more information.</p>

Benefit	Description
<p>95 . Telemedicine Virtual Visit Services</p>	<p>The Plan covers Medically Necessary telemedicine virtual visit services for the purpose of diagnosis, consultation or treatment. Telemedicine virtual visit services are limited to the use of real-time interactive audio, video or other electronic media telecommunications, telemonitoring, and telemedicine services involving stored images forwarded for future consultations, i.e. "store and forward" telecommunication as a substitute for in-person consultation with Providers. Your Plan Provider must be appropriately licensed in the state in which you are located when receiving telemedicine services.</p> <p>Member Cost Sharing for telemedicine virtual visit services is the same as the Member Cost Sharing for the same type of service if it had been provided through an in-person consultation. Please refer to your Schedule of Benefits for specific information on Member Cost Sharing you may be required to pay.</p>
<p>96 . Temporomandibular Joint Dysfunction Services</p>	<p>The Plan covers medical treatment of Temporomandibular Joint Dysfunction (TMD). Only the following services are covered:</p> <ul style="list-style-type: none"> • Consultation with a physician • Physical therapy, (subject to the visit limit for outpatient physical therapy listed in the Schedule of Benefits) • Surgery • X-rays • Removable appliances for Temporomandibular Joint (TMJ) repositioning (Please Note: This service can be provided by a dental or medical provider.) <p>Covered Benefits for TMD do not include fixed or removable appliances that involve movement or repositioning of teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).</p> <p>Important Notice: No other Dental Care is covered for the treatment of Temporomandibular Joint Dysfunction (TMD).</p>
<p>97 . Urgent Care Services</p>	<p>The Plan covers Urgent Care services that you receive at (1) a convenience care clinic, (2) an urgent care center, or (3) a hospital urgent care center.</p> <p>(1) Convenience care clinics: Convenience care clinics provide treatment for minor illnesses and injuries. They are usually staffed by non-physician providers, such as advanced practice registered nurses, and are located in stores, supermarkets or pharmacies. To see a list of convenience care clinics covered by the Plan, please refer to your Provider Directory and search under "convenience care".</p> <p>(2) Urgent care centers: Urgent care centers provide treatment for illnesses and injuries that require urgent attention but are not life threatening. Urgent care centers are independently owned and operated centers that are considered standalone facilities, not departments of a hospital. They are staffed by doctors, advanced practice registered nurses and physician assistants. To see a list of urgent care centers covered by the Plan, please refer to your Provider Directory and search under "urgent care".</p> <p>(3) Hospital urgent care centers: Some hospitals provide treatment for urgent care services as part of the hospital's outpatient services. A hospital urgent care center may be located within a hospital, or at a satellite location separate from the hospital. These urgent care centers are owned and operated by the hospital and are considered a department of the hospital. They are staffed by doctors, nurse practitioners, and physician assistants and provide treatment for illnesses and injuries that require urgent attention but are not</p>

Benefit	Description
<p>Urgent Care Services (Continued)</p>	<p>life threatening. Because the services provided are considered outpatient hospital services, only the hospitals are listed in the Provider Directory. These services may require higher Member Cost Sharing than urgent care services received at independent urgent care centers. Please note: Hospital urgent care center services are treated differently than similar services received in a hospital emergency room. For information on services received in a hospital emergency room, please see the Emergency Room Care benefit above and your Schedule of Benefits.</p> <p>Please refer to your Schedule of Benefits for the Member Cost Sharing applicable to each type of Urgent Care service.</p> <p>Coverage for Urgent Care is provided for services that are required to prevent deterioration to your health resulting from an unforeseen sickness or injury. Covered Benefits include, but are not limited to the following:</p> <ul style="list-style-type: none"> • Care for minor cuts, burns, rashes or abrasions, including suturing • Treatment for minor illnesses and infections, including earaches • Treatment for minor sprains or strains <p>You do not need to obtain a referral from your PCP to be covered for Urgent Care. Whenever possible, you should contact your PCP prior to obtaining Urgent Care. Your PCP may be able to provide the services you require at a lower out-of-pocket cost. In addition, your PCP is responsible for coordinating your health care services and should know about the services you receive.</p> <p>Important Notice: Urgent Care is not emergency care. You should call 911 or go directly to a hospital emergency room if you are having a Medical Emergency. These include heart attack or suspected heart attack, shock, major blood loss, or loss of consciousness. Please see the section <i>I.D.5. Medical Emergency Services</i> for more information.</p>
<p>98 . Vision Services</p>	<p>Routine Eye Examinations:</p> <p>The Plan covers routine eye examinations.</p> <p>Pediatric Vision Care:</p> <p>The Plan covers pediatric vision care. Please see the Pediatric VisionCare section of your Schedule of Benefits for details.</p> <p>Vision Hardware for Special Conditions:</p> <p>The Plan provides coverage for contact lenses or eyeglasses needed for the following conditions:</p> <ul style="list-style-type: none"> • Keratonconus. One pair of contact lenses is covered per Calendar Year. The replacement of lenses, due to a change in the Member's condition, is limited to 3 per affected eye per Calendar Year. • Post cataract surgery with an intraocular lens implant (pseudophakes). Coverage is provided 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. • Post cataract surgery without lens implant (aphakes). One pair of eyeglass lenses or contact lenses is covered per Calendar Year. Coverage is also provided for the purchase of eyeglass frames. The replacement of lenses

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Benefit	Description
Vision Services (Continued)	
	<p>due to a change in the Member's condition is also covered. Replacement of lenses due to wear, damage, or loss, is limited to 3 per affected eye per Calendar Year.</p> <ul style="list-style-type: none"> • Post retinal detachment surgery. For a Member who wore eyeglasses or contact lenses prior to retinal detachment surgery, the Plan covers the full cost of one lens per affected eye up to one Calendar Year after the date of surgery. For Members who have not previously worn eyeglasses or contact lenses, the Plan covers either (1) a pair of eyeglass lenses and frames, or (2) a pair of contact lenses.
99 . Voluntary Sterilization	
	The Plan covers voluntary sterilization, including tubal ligation and vasectomy.
100 . Voluntary Termination of Pregnancy	
	The Plan covers voluntary termination of pregnancy when the life of the mother is endangered or when the pregnancy is a result of rape or incest.
101 . Wigs and Scalp Hair Protheses	
	<p>Wigs and scalp hair protheses when needed for hair loss suffered as a result of the treatment for any form of cancer or leukemia or for a certain pathologic condition such as alopecia areata, alopecia totalis, alopecia medicamentosa or permanent loss of scalp hair due to injury.</p> <p>Please Note: No coverage is provided for back-up wigs or scalp hair prosthetics or items that serve a duplicate purpose.</p>

IV. Exclusions

The exclusions headings in this section are intended to group together services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath the headings. A heading does not create, define, modify, limit or expand an exclusion.

The services listed in the table below are not covered by the Plan:

Exclusion	Description
1 . Alternative Treatments	<ol style="list-style-type: none"> 1. Acupuncture services that are outside the scope of standard acupuncture care. 2. Alternative or holistic services and all procedures, laboratories and nutritional supplements associated with such treatments. 3. Aromatherapy, treatment with crystals and alternative medicine. 4. Any of the following types of programs: Health resorts, spas, recreational programs, camps, outdoor skills programs, therapeutic or educational boarding schools, relaxation or lifestyle programs, and wilderness programs (therapeutic outdoor programs). 5. Massage therapy when performed by anyone other than a licensed physical therapist, physical therapy assistant, occupational therapist, or certified occupational therapy assistant. 6. Myotherapy. 7. Services by a Naturopath that are not covered by other Plan Providers under the Plan.
2 . Dental Services	<ol style="list-style-type: none"> 1. Dental Care, except the specific dental services listed in this Benefit Handbook and your Schedule of Benefits. 2. Temporomandibular Joint Dysfunction (TMD) care, except the specific medical treatments listed as Covered Benefits in this Benefit Handbook. 3. Extraction of teeth.
3 . Durable Medical Equipment and Prosthetic Devices	<ol style="list-style-type: none"> 1. Any devices or special equipment needed for sports or occupational purposes. 2. Any home adaptations, including, but not limited to home improvements and home adaptation equipment. 3. Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. 4. Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.
4 . Experimental, Unproven or Investigational Services	<ol style="list-style-type: none"> 1. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.

Exclusion	Description
5 . Foot Care	<ol style="list-style-type: none"> 1. Foot orthotics, except for the treatment of severe diabetic foot disease or systemic circulatory diseases. 2. Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members diagnosed with diabetes or systemic circulatory diseases.
6 . Maternity Services	<ol style="list-style-type: none"> 1. Delivery outside the Service Area after the 37th week of pregnancy, or after you have been told that you are at risk for early delivery. 2. Routine pre-natal and post-partum care when you are traveling outside the Service Area. 3. Services provided by a Doula
7 . Mental Health Care	<ol style="list-style-type: none"> 1. Educational services or testing. No benefits are provided: (1) for educational services intended to enhance educational achievement; or (2) to resolve problems of school performance. 2. Sensory integrative praxis tests. 3. Mental health care that is (1) provided to Members who are confined or committed to a jail, house of correction, or prison, or (2) provided by the Department of Youth Services or Department of Mental Health. 4. Services or supplies for the diagnosis or treatment of mental health and substance use disorder treatment that, in the reasonable judgment of the Plan, are any of the following: <ul style="list-style-type: none"> • Not consistent with prevailing national standards of clinical practice for the treatment of such conditions. • Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome. • Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
8 . Physical Appearance	<ol style="list-style-type: none"> 1. Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, (3) post-mastectomy care and (4) gender affirming procedures and related services. 2. Electrolysis or laser hair removal, except for what is Medically Necessary as part of gender affirming services. 3. Hair removal or restoration, including, but not limited to, transplantation or drug therapy. 4. Liposuction, except for what is Medically Necessary as part of gender affirming services, or removal of fat deposits considered undesirable. 5. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). 6. Skin abrasion procedures performed as a treatment for acne.

Exclusion	Description
Physical Appearance (Continued)	
	<ol style="list-style-type: none"> 7. Treatments and procedures related to appearance including but not limited to abdominoplasty; chemical peels; collagen injections; dermabrasion; implantations (e.g. cheek, calf, pectoral, gluteal); lip reduction/enhancement; panniculectomy; removal of redundant skin; and silicone injections (e.g. for breast enlargement), except for what is Medically Necessary as part of gender affirming services or another Covered Benefit. 8. Treatment for skin wrinkles and skin tags or any treatment to improve the appearance of the skin. 9. Treatment for spider veins. 10. Wigs and scalp hair prostheses when hair loss is due to male pattern baldness, female pattern baldness, or natural or premature aging.
9 . Procedures and Treatments	
	<ol style="list-style-type: none"> 1. Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care. 2. Commercial diet plans, weight loss programs and any services in connection with such plans or programs. 3. If a service is listed as requiring that it be provided at a Center of Excellence, no coverage will be provided under this Handbook if that service is received from a Provider that has not been designated as a Center of Excellence. Please see the Handbook section <i>I.D.4. Centers of Excellence</i> for more information. 4. Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). 5. Physical examinations and testing for insurance, licensing or employment. 6. Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. 7. Testing for central auditory processing. 8. Group diabetes training, educational programs or camps.
10 . Providers	
	<ol style="list-style-type: none"> 1. Charges for services which were provided after the date on which your membership ends. 2. 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. 3. Charges for missed appointments. 4. Concierge service fees. (See the Handbook section <i>"Providers Fees for Special Services"</i> for more information.) 5. Follow-up care after an emergency room visit, unless provided or arranged by your PCP. 6. Inpatient charges after your hospital discharge.

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Exclusion	Description
Providers (Continued)	
	<ol style="list-style-type: none"> 7. Provider's charge to file a claim or to transcribe or copy your medical records. 8. Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
11 . Reproduction	
	<ol style="list-style-type: none"> 1. Infertility drugs. 2. Infertility treatment including, but not limited to, therapeutic donor insemination, including related sperm procurement and banking; donor egg procedures, including related egg and inseminated egg procurement, processing and banking; assisted hatching; gamete intrafallopian transfer (GIFT); intra-cytoplasmic sperm injection (ICSI); intra-uterine insemination (IUI); in-vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT); preimplantation genetic testing (PGT); microsurgical epididymal sperm aspiration (MESA); and testicular sperm extraction (TESE). 3. Any form of Surrogacy or services for a gestational carrier other than covered maternity services. 4. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). 5. The following fees: wait list fees, non-medical costs, shipping and handling charges, etc. 6. Voluntary termination of pregnancy (except in cases of rape, incest, or when the life of the mother is endangered).
12 . Services Provided Under Another Plan	
	<ol style="list-style-type: none"> 1. Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. 2. Costs for services for which payment is required to be made by a Workers' Compensation plan (unless the Member has waived Workers Compensation) or under state or federal law.
13 . Telemedicine	
	<ol style="list-style-type: none"> 1. Telemedicine services involving fax.. 2. Provider fees for technical costs for the provision of telemedicine services.
14 . Types of Care	
	<ol style="list-style-type: none"> 1. Custodial Care. 2. Rest or domiciliary care. 3. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. 4. Pain management programs or clinics. 5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. 6. Private duty nursing. 7. Sports medicine clinics. 8. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.

Exclusion	Description
15 . Vision and Hearing	<ol style="list-style-type: none"> 1. Eyeglasses, contact lenses and fittings, except as listed in this Benefit Handbook and in your Schedule of Benefits. 2. Deluxe or designer frames. 3. Hearing aid batteries, cords, and individual or group auditory training devices and any instrument or device used by a public utility in providing telephone or other communication services. 4. Over the counter hearing aids. 5. Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism.
16 . All Other Exclusions	<ol style="list-style-type: none"> 1. Any service or supply furnished in connection with a non-Covered Benefit. 2. Any service or supply (with the exception of contact lenses) purchased from the internet. 3. Any service, supply or medication when there is a less intensive Covered Benefit or more cost-effective alternative that can be safely and effectively provided, in accordance with applicable Medical Necessity Guidelines. 4. Any service, supply or medication that is required by a third party that is not otherwise Medically Necessary (examples of a third party are an employer, an insurance company, a school or court). 5. Beauty or barber service. 6. Any drug or other product obtained at an outpatient pharmacy, except for pharmacy supplies covered under the benefit for diabetes services, unless your Plan includes outpatient pharmacy coverage. 7. Diabetes equipment replacements when solely due to manufacturer warranty expiration. 8. Donated or banked breast milk. 9. Externally powered exoskeleton assistive devices and orthoses. 10. Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law and prescribed for Members who meet HPHC policies for enteral tube feedings. 11. Guest services. 12. Medical equipment, devices or supplies except as listed in this Benefit Handbook. 13. Medical services that are provided to Members who are confined or committed to a jail, house of correction, or prison, or (2) provided by the Department of Youth Services. 14. Reimbursement for travel expenses. 15. Services for non-Members. 16. Services for which no charge would be made in the absence of insurance. 17. Services for which no coverage is provided in this Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure.

Exclusion	Description
All Other Exclusions (Continued)	
	<p>18. Services provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under than IEP purchased from a contractor or vendor.</p> <p>19. Services that are not Medically Necessary.</p> <p>20. Services your PCP or a Plan Provider has not provided, arranged or approved except as described in the Handbook sections <i>"Your PCP Manages Your Health Care"</i> and <i>"Using Plan Providers"</i>.</p> <p>21. Taxes or governmental assessments on services or supplies.</p> <p>22. Transportation, except for emergency ambulance transport, and non-emergency medical transport needed for transfer between hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary.</p> <p>23. Voice modification surgery, except when Medically Necessary for gender affirming services.</p> <p>24. The following products and services:</p> <ul style="list-style-type: none"> • Air conditioners, air purifiers and filters, dehumidifiers and humidifiers. • Car seats. • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners. • Electric scooters. • Exercise equipment. • Home modifications including but not limited to elevators, handrails and ramps. • Hot tubs, jacuzzis, saunas or whirlpools. • Mattresses. • Medical alert systems. • Motorized beds. • Pillows. • Power-operated vehicles. • Stair lifts and stair glides. • Strollers. • Safety equipment. • Vehicle modifications including but not limited to van lifts. • Telephone. • Television.

V. Reimbursement and Claims Procedures

The information in this section applies when you receive services from a non-Plan Provider.

This should happen only when you get care:

- In a Medical Emergency; or
- When you are temporarily traveling outside of the state where you live.

In most cases, you should not receive bills from a Plan Provider.

A. BILLING BY PROVIDERS

If you get a bill for a Covered Benefit you may ask the provider to:

- 1) Bill us on a standard health care claim form (such as the CMS 1500 or the UB-04 form); and
- 2) Send it to HPHC-NE Claims, P.O. Box 699183, Quincy, MA 02269-9183.

If you receive a Surprise Bill, you are only responsible for the applicable Member Cost Sharing based on the Recognized Amount. HPHC-NE will reimburse Non-Plan Providers at the Out-of-Network Rate unless otherwise agreed to by the Provider and HPHC-NE. You will not be billed for any charges other than the applicable Member Cost Sharing based on the Recognized Amount. All Member Cost Sharing will apply to the Out-of-Pocket Maximum. You are not responsible, and a Non-Plan Provider cannot bill you for:

- Amounts in excess of your Member Cost Sharing, based on the Recognized Amount, for non-emergency ancillary Covered Benefits received at certain In-network facilities by a Non-Plan Provider.
- Amounts in excess of your Member Cost Sharing, based on the Recognized Amount, for non-emergency, non-ancillary Covered Benefits received at certain In-network facilities from a Non-Plan Provider who has not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act.
- Amounts in excess of your Member Cost Sharing, based on the Recognized Amount, for Covered Benefits that are Medically Emergency Services provided by a Non-Plan Provider.
- Amounts in excess of your applicable Member Cost Sharing, based on the rates that would apply if the service was provided by a Plan Provider, for

Covered Benefits that are air ambulance services provided by a Non-Plan Provider.

If you have any questions, call Member Services at **1-877-907-4742**.

B. REIMBURSEMENT FOR BILLS YOU PAY

If you pay a provider who is not a Plan Provider for a Covered Benefit, we will reimburse you less your applicable Member Cost Sharing. Claim reimbursements must be submitted to the following addresses:

Pharmacy Claims:

**OptumRx
Manual Claims
P.O. Box 650334
Dallas, TX 75265-0334**

All Other Claims:

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

To obtain reimbursement for a bill you have paid, other than for pharmacy items, you must submit an HPHC-NE healthcare reimbursement form with the provider or facility information. If you request a healthcare reimbursement claim form from HPHC-NE, one will be provided within 15 days of your request. A legible claim form from the provider or facility that provided your care may also be included but is not required. The form must include all of the following information:

- The Member's full name and address
- The Member's date of birth
- The Member's Plan ID number (on the front of the Member's Plan ID card)
- The Member's signature
- The name and address of the person or facility providing the services for which a claim is made and their Tax Identification Number (TIN) or National Provider Identification (NPI) number
- The Member's diagnosis description, diagnosis code or ICD 10 code
- The date the service was rendered
- The CPT code (or a brief description of the illness or injury) for which payment is sought

- The amount of the provider's charge
- Proof that you have paid the bill
- Other insurance information

Important Notice: We may need more information for some claims. If you have any questions about claims, please call our Member Services Department at **1-877-907-4742**.

A healthcare reimbursement form can be obtained online at www.harvardpilgrim.org or by calling Member Services at **1-877-907-4742**.

1. International Claims

If you are requesting reimbursement for services received while outside of the United States, you must submit an HPHC-NE healthcare reimbursement form along with an itemized bill and proof of payment. We may also require you to provide additional documentation, including, but not limited to: (1) records from financial institutions clearly demonstrating that you have paid for the services that are the subject of the claim; (2) the source of funds used for payment; and (3) an English translated description of the services received.

2. Pharmacy Claims

To obtain reimbursement for pharmacy bills you have paid, you must submit a Prescription Claim Form. The form can be obtained online at www.harvardpilgrim.org or by calling Member Services at **1-877-907-4742**.

In addition to the Prescription Claim Form you must send a drug store receipt showing the items for which reimbursement is requested.

The following information must be on the Prescription Claim Form:

- The Member's name and Plan ID number
- The name of the drug or medical supply
- The quantity
- The number of days supply of the medication provided
- The date the prescription was filled
- The prescribing Provider's name
- The pharmacy name and address
- The amount you paid

If you have a question regarding your reimbursement, you should contact Member Services at **1-877-907-4742**.

C. LIMITS ON CLAIMS

To be eligible for payment, we must receive claims (proof of loss) within one year of the date care was received or as soon as reasonably possible. In accordance with New Hampshire law, we will send you reimbursement within 30 days of receipt of all information needed to process your claims or within 15 days upon receipt of a clean, electronic claim.

We limit the amount we will pay for services that are not rendered by Plan Providers. The most we will pay for such services is the Allowed Amount, unless it is a Surprise Bill. You may have to pay the balance if the claim is for more than the Allowed Amount, unless it is a Surprise Bill.

D. MISCELLANEOUS CLAIMS PROVISIONS

Generally, benefits will be paid to the Member who received the services for which a claim is made or directly to the health care provider whose charge is the basis for the claim.

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

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

VI. Appeals and Complaints

This section explains how we process appeals and complaints. It explains your options if an appeal is denied.

A. BEFORE YOU FILE AN APPEAL

If a claim is denied as a result of a claims processing error, or a misunderstanding with a provider, please call Member Services at **1-877-907-4742**. Member Services will investigate the claim and either (i) resolve the problem, or (ii) explain why the claim was denied. If you are dissatisfied with the response from Member Services, you may file an appeal. See section *VI.B. MEMBER APPEAL PROCEDURES* for more information.

B. MEMBER APPEAL PROCEDURES

You may file an appeal when coverage is denied. This includes either:

- the denial of a health service you requested; or
- the denial of payment for a health service you already received.

Appeals may also be filed by your representative or a provider acting on a your behalf. Our staff can help you file an appeal. For help, call **1-877-907-4742**.

You can also get help from the New Hampshire Insurance Department. They can be reached at **1-603-271-2261** or **1-800-852-3416**. For TDD access, call Relay NH at **1-800-735-2964**. Members may also write the Department at:

**New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301**

If we do not provide you with a timely appeal or expedited appeal in accordance with the time limits stated below, we will promptly notify you of your right to proceed to external review by the New Hampshire Insurance Department without having received a decision from us. Please see below for information on external review

1. Initiating Your Appeal

To begin, you may file your appeal:

- in person,
- by mail,
- by fax,
- by telephone, or

- electronically via the secure online member portal.

You should explain what coverage you are requesting and why you feel it should be granted. If your appeal qualifies as an expedited appeal, you may contact us by telephone. See the section *VI.B.3. Expedited Review Procedure* for information on that process.

Please be as specific as possible in your appeal request. We need all the details in order to make a fair decision, including pertinent medical records and itemized bills. You must submit this information within 180 days of the denial of coverage.

If you have a representative (including a medical provider) submit an appeal on your behalf, you must also include a statement signed by you. This statement should authorize the representative to act on your behalf. HPHC-NE may refuse to provide any information to the representative, until we receive the signed authorization.

A request for appeal must be filed within 180 days of the date a service, or payment for a service, when denied.

For all appeals, please send your request to the following address:

**HPHC-NE Appeals and Grievances Department
Harvard Pilgrim Health Care of New England,
Inc.**

**1 Wellness Way
Canton, MA 02021
Telephone: 1-877-907-4742
Fax: 1-617-509-3085**

After an appeal is filed, we assign an Appeals and Grievances Analyst. This analyst will be responsible for your appeal during the appeals process. We will send you a letter that will:

- identify your Appeals and Grievance Analyst, and
- provide detailed information on the appeals process.

2. Appeal Process

Your Appeals and Grievances Analyst will review appeal. The analyst will let you know if more information is needed. This information may include:

- medical records,
- statements from doctors, and
- bills and receipts for services you have received.

You may also provide us with any written comments, documents, records or other information related to your claim. If we need more information to decide your appeal, your analyst will notify you. You will have 45 days to provide the information. After 45 days, your appeal may be closed. However, the appeal may be reopened if the information is submitted within 180 days of the denial of coverage.

We will review your appeal and send you a written decision within 30 days of receiving your appeal. If we need additional information from you, the 30-day time period will not run while we wait for the information. After we receive all information needed to make a decision, your Appeals and Grievances Analyst will inform you in writing if your appeal has been approved or denied. The written decision will include:

- the titles and qualifying credentials of your Appeals and Grievances Analyst and any other person reviewing your appeal;
- a summary of the facts and issues in the appeal;
- a summary of the documentation relied upon; and
- the specific reasons for the decision, including the clinical rationale, if any

This decision is our final decision under the appeal process. If our decision is not fully in your favor, the decision will also include other options for further review of your appeal. See section VI.C. *OPTIONS FOR FURTHER REVIEW IF YOUR APPEAL IS DENIED* for details.

Appeals that involve Medical Necessity decisions will be reviewed by a qualified physician or other medical specialist. No one involved in the initial decision to deny a claim under appeal will be a decision-maker in any stage of the appeal process. Upon request, we will provide you with:

- any written Medical Necessity Guidelines used to decide your appeal,
- the physician (or other medical specialist) consulted concerning the decision,
- all documents, records or other information relevant to the initial denial and your appeal.

This information will be provided free of charge.

3. Expedited Review Procedure

We will provide you with an expedited review if your appeal involves services which:

- 1) if delayed, could seriously jeopardize your life or health or ability to regain maximum function,

- 2) in the opinion of a physician with knowledge of your medical condition, would result in severe pain that cannot be adequately managed without the care or treatment, or
- 3) involves the continuation of inpatient services following emergency care.

If your appeal involves services that meet one of these criteria, please inform us and we will provide an expedited review.

You, your representative or a provider acting on your behalf may request an expedited appeal by phone or fax. Please see section VI.B.1. *Initiating Your Appeal* for phone and fax numbers. We will investigate and respond to your request within 72 hours. We will notify you of the decision on your appeal by telephone and then send you a written decision within two business days.

If you request an expedited appeal of a decision to discharge you from a hospital, we will continue to pay for your hospitalization until we notify you of our decision.

If you are filing an expedited appeal with us, you may also file a request for expedited external review with the New Hampshire Insurance Department at the same time. You do not have to wait until we complete your expedited appeal to file for expedited external review. Please see the Section C.2.VI.C.2. *Independent External Review of Appeals* for information on how to file for external review.

To enable us to conduct such a quick review of the expedited appeal, we must limit the expedited appeal process to the circumstances listed above. Your help in promptly providing all necessary information is essential for us to provide you with this quick review. If we do not have sufficient information necessary to decide your appeal, we will notify you that additional information is required within 24 hours after receipt of your appeal.

C. OPTIONS FOR FURTHER REVIEW IF YOUR APPEAL IS DENIED

If you disagree with the decision of your appeal, you may have more options. These options are (1) Reexamination of appeals that are subject to clinical review for Medical Necessity by HPHC-NE, and (2) external review by an Independent Review Organization (IRO) appointed by the New Hampshire Insurance Department.

1. Reexamination

If you disagree with a decision concerning an appeal that is subject to clinical review for medical necessity, you may request reexamination of such appeal if there is additional clinical documentation that hasn't previously been reviewed by HPHC-NE. You must request reexamination within 45 days of the date of your denial letter.

Reexamination is not available for the following types of appeals:

- Decisions involving a benefit limitation where the limit is stated in the Handbook
- Decisions involving excluded services, except Experimental, Unproven, or Investigational services
- Decisions concerning Member Cost Sharing requirements; or
- Decisions that do not involve clinical review for Medical Necessity.

Our reexamination process is voluntary and optional. A member may request reexamination by HPHC-NE before seeking external review from the New Hampshire Insurance Department, as discussed below, or you may proceed directly to external review. You may also request such reexamination if the Insurance Department has determined that your appeal is not eligible for external review. However, we will not reexamine an appeal that has been accepted for external review by the Insurance Department.

2. Independent External Review of Appeals

The New Hampshire Insurance Department has prepared a publication that explains your rights to appeal certain health care service denials to an Independent Review Organization selected by the Department. The Department has also issued a form for requesting an external appeal. This form is included with clinical denial letters and can be found at the end of this Handbook. The following text is the Insurance Department's Managed Care Consumer Guide to External Appeal:

i. MANAGED CARE CONSUMER GUIDE TO EXTERNAL APPEAL

a. What is an External Appeal?

New Hampshire law gives individuals who are covered by fully-insured, health or dental insurance plans the right to have a nationally-accredited, independent, medical review organization (IRO), which is not affiliated with his/her insurance company, review and assess whether the company's denial of a specific

claim or requested service or treatment is justified. This type of review is available when a recommended service or treatment is denied on the basis that it does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, and level of care or effectiveness. This review is often called Independent External Appeal, External Appeal, External Health Review or simply External Review.

b. What are the eligibility requirements for External Appeal?

To be eligible for External Appeal the following conditions must be met:

- The patient must have a fully-insured health or dental insurance plan.
- The service that is the subject of the appeal request must be either a) a covered benefit under the terms of the insurance policy or b) a treatment that may be a covered benefit.
- Unless the patient meets the requirements for Expedited External Review (see below), the patient must have completed the Internal Appeal process provided by the insurer and have received a final, written decision from the insurer relative to its review.

Exception #1: The patient does not need to meet this requirement, if the insurer agrees in writing to allow the patient to skip its Internal Appeal process.

Exception #2: If the patient requested an internal appeal from the insurer, but has not received a decision from the insurer within the required time frame, the patient may apply for External Appeal without having received the insurer's final, written decision.

- The patient must submit the request for External Appeal to the Department within 180 days from the date appearing on the insurance company's letter, denying the requested treatment or service at the final level of the company's Internal Appeals process.
- The patient's request for External Appeal may not be submitted for the purpose of pursuing a claim or allegation of healthcare provider malpractice, professional negligence, or other professional fault.

c. What types of health insurance are excluded from External Appeal?

In general, External Appeal is available for most health insurance coverage. Service denials relating to the following types of insurance coverage or health benefit

programs are not reviewable under New Hampshire’s External Appeal law:

- Medicaid (except for coverage provided under the NH Premium Assistance Program)
- The New Hampshire Children’s Health Insurance Program (CHIP)
- Medicare
- All other government-sponsored health insurance or health services programs
- Health benefit plans that are self-funded by employers

Note: Some self-funded plans provide external appeal rights which are administered by the employer.

d. Can someone else represent me in my External Appeal?

Yes. A patient may designate an individual, including the treating health care provider, as his/her representative. To designate a representative, the patient must complete Section II of the External Review Application Form entitled “Appointment of Authorized Representative.”

e. Submitting the External Appeal:

To request an External Appeal, the patient or the designated representative must complete and submit the External Review Application Form, available on the Department’s website (https://www.nh.gov/insurance/consumers/documents/ex_rev_app.pdf), and all supporting documentation to the New Hampshire Insurance Department. There is no cost to the patient for an External Appeal.

Please submit the following documentation:

- The completed External Review Application Form — signed and dated on page 6.
The Department cannot process this application without the required signature(s)
- A photocopy of the front and back of the patient’s insurance card or other evidence that the patient is insured by the insurance company named in the appeal.
- A copy of the insurance company’s letter, denying the requested treatment or service at the final level of the company’s internal appeals process.
- Any medical records, statements from the treating health care provider(s) or other information that you would like the review organization to consider in it’s review.

- If requesting an Expedited External Appeal, the Provider’s Certification Form.

If you have questions about the application process or the documentation listed above, please call the Insurance Department at **1-800-852-3416**.

Mailing Address:

**New Hampshire Insurance Department
Attn: External Review Unit
21 South Fruit Street, Suite 14
Concord, NH 03301**

Expedited External Review Applications

- May be faxed to **(603) 271-1406**, or
- Sent by overnight carrier to the Department’s mailing address.

f. What is the Standard External Appeal Process and Time Frame for receiving a Decision?

It may take up to 60 days for the Independent Review Organization (IRO) to issue a decision in a Standard External Appeal.

- Within 7 business days after receiving your application form, the Insurance Department (the Department) will complete a preliminary review of your application to determine whether your request is complete and whether the case is eligible for external review.

If the request is not complete, the Department will inform the applicant what information or documents are needed in order to process the application. The applicant will have 10 calendar days to supply the required information or documents.

- If the request for external appeal is accepted, the Department will select and assign an IRO to conduct the external review and will provide a written notice of the acceptance and assignment to the applicant and the insurer.
- Within 10 calendar days after assigning your case to an IRO, the insurer must provide the applicant and the IRO a copy of all information in its possession relevant to the appeal.
- If desired, the applicant may submit additional information to the IRO by the 20th calendar day after the date the case was assigned to the selected IRO. During this period, the applicant may also present oral testimony via telephone conference to the IRO. However, oral testimony will be permitted only in cases where the Insurance Commissioner determines that it would not be

feasible or appropriate to present only written information.

To request a “teleconference,” complete Section VII of the application form entitled “Request for Telephone Conference” or contact the Department no later than 10 days after receiving notice of the acceptance of the appeal.

- By the 40th calendar day after the date the case was assigned to the selected Independent Review Organization, the IRO shall A) review all of the information and documents received, b) render a decision upholding or reversing the determination of the insurer, and c) notify in writing the applicant and the insurer of the IRO’s review decision.

g. What is an Expedited External Appeal?

Whereas a Standard External Appeal may take 60 days, Expedited External Appeal is available for those persons who would be significantly harmed by having to wait. An applicant may request expedited review by checking the appropriate box on the External Review Application Form and by providing a Provider’s Certification Form, in which the treating provider attests that in his/her medical opinion adherence to the time frame for standard review would seriously jeopardize the patient’s life or health or would jeopardize the patient’s ability to regain maximum function. Expedited reviews must be completed in 72 hours.

If the applicant is pursuing an internal appeal with the insurer and anticipates requesting an Expedited External Appeal, please call the Department at **1-800-852-3416** to speak with a consumer services officer, so that accommodations may be made to receive and process the expedited request as quickly as possible.

Please note a patient has the right to request an Expedited External Appeal simultaneously with the insurer’s Expedited Internal Appeal.

h. What happens when the Independent Review Organization makes its decision?

- If the appeal was an Expedited External Appeal, in most cases the applicant and insurer will be notified of the IRO’s decision immediately by telephone or fax. Written notification will follow.
- If the appeal was a Standard External Appeal, the applicant and insurer will be notified in writing.
- The IRO’s decision is binding on the insurer and is enforceable by the Insurance Department. The

decision is also binding on the patient except that it does not prevent the patient from pursuing other remedies through the courts under federal or state law.

Have a question or need assistance?

Staff at the New Hampshire Insurance Department is available to help.

Call **1-800-852-3416** to speak with a consumer services officer.

Note: Payment disputes are not eligible for external review, except when the appeal is filed to determine if Surprise Bill protections are applicable.

D. MEMBER COMPLAINTS

If you have any Complaints about your care under the Plan or about our service, we want to know about it. We are here to help. For all complaints, please call or write to us at:

**HPHC-NE Member Services Department
Harvard Pilgrim Health Care of New England,
Inc.
Attention: Appeals and Grievances Department
1 Wellness Way
Canton, MA 02021
Telephone: 1-877-907-4742**

We will respond to you as quickly as we can. Member complaints sent to us in writing will be investigated and responded to within 30 days of request.

VII. Eligibility

This section describes eligibility rules under the Plan.

A. MEMBER ELIGIBILITY

1. General Eligibility Requirements

To be eligible for coverage under this Plan, you must:

- Live and keep a permanent residence in the Enrollment Area at least 6 months of the year;
- Agree to pay the monthly premium for coverage under the Plan; and
- Not be entitled to or enrolled under Medicare Parts, A, B or D.

HPHC-NE reserves the right to request proof of residency at any time. Call Member Services at **1-877-907-4742** with questions. They can give you a current list of the cities and towns in the Enrollment Area.

2. Dependent Eligibility

To be covered as a Dependent under the Plan, an individual must be one of the following:

- 1) The Subscriber's legal spouse.
- 2) For members enrolled through New Hampshire's Federally Operated Health Insurance Marketplace, a child (including an adopted child) of the Subscriber or spouse of the Subscriber until the end of the year in which the child turns 26.
- 3) For members enrolled directly through HPHC-NE, a child (including an adopted child) of the Subscriber or spouse of the Subscriber until the end of the month in which the child turns 26.
- 4) A child (including an adopted child) of the Subscriber or spouse of the Subscriber, who is no longer eligible under paragraph 2), above, and meets each of the following requirements: (a) is currently disabled; (b) became disabled while enrolled as a dependent under paragraph 2), above; and (c) remains chiefly financially dependent on the Subscriber. An individual will be determined to be "disabled" by HPHC-NE only if he or she: is mentally or physically incapable of earning his or her own living. In the event of a dispute concerning eligibility under this paragraph, HPHC-NE shall apply the standard for determining disability under Title II of the Social Security Act.

HPHC-NE will require proof of such disability within 31 days following the date the individual would no longer be eligible due to age as described under Paragraph 2), above.

- 5) A child under 18 years of age, for whom the Subscriber or Subscriber's spouse is the court appointed legal guardian. Proof of guardianship must be submitted to HPHC-NE prior to enrollment.
- 6) The child of an eligible Dependent of the Subscriber until such time as the parent is no longer a Dependent.

Evidence of eligibility may be required from time to time.

B. EFFECTIVE DATE - NEW AND EXISTING 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.

Please see section VII.E. *SPECIAL ENROLLMENT RIGHTS* for more information.

C. 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 petition to adopt is filed. An adoptive child who has not been living with you may be covered from the date of placement in your home for purposes of adoption by a licensed adoption agency.

We must receive notice of the addition within 31 days of the effective date. The addition of a new Dependent may change the Subscriber's membership for Individual Coverage to Family Coverage. If we are not notified within 31 days of the effective date, Dependents may only be added on the next effective date.

D. CHANGE IN STATUS

It is your responsibility to inform us of all changes that affect Member eligibility. These changes include address changes, new Dependents, marriage of a Dependent; death of a Member and loss of Dependent eligibility as described above. If you purchased coverage through New Hampshire's federally operated health insurance marketplace, please see section *VII.H. MARKETPLACE MEMBERSHIP* below for information applicable to your plan.

Please Note: We must have your current address on file in order to correctly process claims.

E. SPECIAL ENROLLMENT RIGHTS

A special enrollment period is a period during which an eligible individual or enrollee, or Dependent where applicable, experiences certain qualifying events or changes in eligibility that permit enrollment, or a change in enrollment, outside of the annual open enrollment period. Unless specifically stated otherwise, an eligible individual or enrollee, or Dependent where applicable, must select a plan within sixty (60) days of the following triggering events:

- Loss of minimum essential coverage or other qualifying health coverage*
- Change in primary place of living*
- Gains access to an individual coverage Health Reimbursement Account (ICHRA) or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)*
- Change in eligibility for Marketplace coverage*
- Change in eligibility for the Premium Tax Credit or other cost sharing reductions*
- Gains a new Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption
- If you purchased coverage through the Marketplace, you may have additional special enrollment rights as determined by the Marketplace, including but not limited to:
 - Change in eligibility for Medicaid or the Children's Health Insurance Program (CHIP)
 - Gaining or maintaining status as a member of a federally recognized tribe or a shareholder in Alaska Native Corporation
 - Gains status as a U.S. citizen, national, or lawfully present individual

- Meets eligibility guidelines for Exceptional Circumstances as determined by the Marketplace

*An eligible individual or enrollee, or a Dependent where applicable, may have sixty (60) days before or after the triggering event to select a plan.

These special enrollment rights comply with the Affordable Care Act (45 CFR 155.420) and New Hampshire state law (RSA 420-G:8,V).

F. HOW YOU'RE COVERED IF MEMBERSHIP BEGINS WHILE YOU'RE HOSPITALIZED

If your membership happens to begin while you are hospitalized, coverage starts on the day membership is effective. To obtain coverage, you must call both your PCP and the Plan and allow us to manage your care. This may include transfer to a Plan affiliated facility, if medically appropriate. All other terms and conditions of coverage under this Handbook will apply.

G. 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, including Medical Emergency Services. No coverage is provided after the 31-day period, unless the Subscriber obtains coverage for the newborn within 60 days of the date of birth. Please see section *VII.E. SPECIAL ENROLLMENT RIGHTS* for additional rights upon the birth of a child.

H. MARKETPLACE MEMBERSHIP

Individuals purchasing coverage through New Hampshire's Federally Operated Health Insurance Marketplace must submit their application and enroll directly through the Marketplace. Administrative changes concerning coverage under this plan, including changes in address, effective dates of coverage or termination of coverage must be made through the Marketplace.

VIII. Premiums

A. PREMIUM AMOUNT

You are responsible for paying the premium for Covered Benefits under the Policy. Your initial premium payment for January 1st coverage under this policy is due by January 10th. If you purchase coverage through a Special Enrollment Period (SEP) through New Hampshire's Federally Operated Health Insurance Marketplace, your initial premium payment is due 30 days from the day we receive your enrollment application from the Marketplace or the effective date of coverage period, whichever is later. Premium payment for coverage thereafter is due by the date stated on your invoice which is generally the 1st day of the month.

Any misrepresentation or omission on your application may cause HPHC-NE to change your premium retroactive back to the effective date. If the age of a Member under this Policy has been misstated, all amounts payable under the Policy shall be such as the premium paid that the Member would have purchased at the current age.

The rates provided are guaranteed for the twelve (12) month period following the 1st day of your effective date or renewal date, except that the premium will change when you add or remove a Member from the Plan or when you change your coverage.

B. GRACE PERIOD

If you are a Subscriber who does not receive Advance Premium Tax Credit (APTC) assistance, this Policy has a 31 day grace period in which to pay your premium following the due date. This means that if any premium is not paid by the due date, it may be paid during the next 31 days. During the grace period, this Policy will remain in force. If the premium is not paid before the grace period ends, this Policy will lapse and will be terminated as of the paid through date.

If you are a Subscriber who receives APTC assistance and at least one month's premium has been paid, HPHC-NE will provide a grace period of at least three consecutive months (90 days). During the grace period, HPHC-NE must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC from the federal government. If full premium is not received during the 90-day grace period, the policy will be terminated retroactively back to the last day of the first month of the three consecutive month grace period.

HPHC-NE must pay claims during the first month of the grace period but may pend claims in the second and third months subject to our right to cancel the Policy as described in this Policy. You will be liable for the premium payment due including those for the grace period and for any claims payments made for services incurred after the date through which the premium is paid.

IX. Termination of Coverage

A. TERMINATION BY THE SUBSCRIBER

You may cancel your Policy at any time and for any reason. To cancel your Policy, contact HPHC-NE. Your Policy will be cancelled on the date we receive your request or on a future date of your choosing. Any premiums paid beyond your termination date will be sent back to you within 30 days of receiving notice of cancellation. Cancellation will not affect payment of Covered Benefits while a member of the Plan.

If you have coverage through New Hampshire's Federally Operated Health Insurance Marketplace, you must contact the Health Insurance Marketplace to cancel your policy. Termination may be processed for the same day that you notify the Health Insurance Marketplace or a later date of your choosing.

B. TERMINATION OF POLICY

Your Policy may be terminated. HPHC-NE may cancel coverage as follows:

- for any Member who no longer meets eligibility requirements under the Plan (except for Medicare eligibility); or
- if you do not pay your premium. Please see Section VIII. *Premiums* for more information.

C. MEMBERSHIP TERMINATION FOR CAUSE

We may end your coverage for any of the following reasons:

- Providing false or misleading information on your membership application or in an attempt to obtain benefits for which you or a Dependent are not eligible within 2 years from the date this policy was issued;
- Committing, or attempting to commit, misrepresentation or fraud against the Plan;
- Obtaining, or attempting to obtain, benefits under the EOC for a person who is not a Member; or
- Committing acts of physical or verbal abuse that pose a threat to providers, the Plan, or other Members, which are unrelated to your physical or mental condition.

Termination will be effective immediately upon notice from the Plan. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company.

You will be refunded any premiums paid for periods after the termination date.

D. TERMINATION DUE TO PRODUCT DISCONTINUANCE

We may terminate this coverage by giving you written notice at least 90 days prior to the date we will stop offering the Plan in New Hampshire. In the event of termination due to the product discontinuance, you may purchase another individual health plan we offer in New Hampshire.

E. TERMINATION DUE TO WITHDRAWAL FROM MARKET

HPHC-NE may terminate this Agreement by giving you written notice at least 180 days prior to the date we stop offering coverage in the individual (nongroup) market in New Hampshire.

F. EFFECT OF TERMINATION

If your Policy is cancelled, you cannot reapply until the next annual open enrollment period unless you qualify for enrollment under a special enrollment right.

G. MEMBERS WHO MOVE OUT OF THE ENROLLMENT AREA

Your coverage will end if you move out of the Enrollment Area. You may be eligible to enroll for coverage under another health plan. HPHC-NE offers individual health plans for Massachusetts, Maine, and New Hampshire residents. You may only enroll in a plan offered in the state you live and must satisfy all eligibility guidelines. Your state of residence will have specific rules about eligibility and the new coverage may differ from the coverage under your previous Plan. Call Member Services at **1-877-907-4742** for more information.

H. REINSTATEMENT

If you're purchasing coverage through New Hampshire's Federally Operated Health Insurance Marketplace there is no reinstatement of this policy unless the coverage was terminated due to an error on the part of HPHC-NE or New Hampshire's Federally Operated Health Insurance Marketplace.

If your premium is not paid before the grace period ends (90 days for Members with APTC assistance and 31 days for all other Members), this Policy will lapse.

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Later acceptance of premium, along with a required reinstatement fee of up to \$50, by HPHC-NE or by an agent duly authorized by HPHC-NE to accept such premium, without requiring an application for reinstatement, shall reinstate this Policy. If HPHC-NE requires an application for reinstatement, it must be submitted to HPHC-NE along with the required premium payment. Reinstatement of the Policy is subject to approval by HPHC-NE. If the application is disapproved, this Policy will not be reinstated. If the application and the applicable premium payment are received by HPHC-NE and the application is not disapproved in writing, this Policy will be reinstated upon the date of the receipt of the application. A reinstated Policy will provide coverage for services you incurred after the date of reinstatement. In all other respects your rights and the rights of HPHC-NE will remain the same, subject to any provisions noted on or attached to the reinstated Policy.

X. When You Have Other Coverage

This section explains how Plan benefits will be paid when another company or individual must also pay for health services a Member has received. This can happen when:

- other insurance, in addition to this Plan, is available to pay for health services.
- a third party is legally responsible for a Member's injury or illness.

Nothing in this section should be interpreted as:

- providing coverage for any service or supply that is not expressly covered under the EOC; or
- increasing the level of coverage provided.

A. INSURANCE WITH OTHER INSURERS

If you have other valid insurance not with HPHC-NE that provides benefits for the same loss on a provision of service basis for an expense incurred basis, coverage under your HPHC-NE plan will not be prorated or reduced. When you have coverage under HPHC-NE and another plan, you are entitled to coverage from both insurers. This coverage does not apply when you have coverage under Worker's Compensation or a governmental program as described below.

B. BENEFITS IN THE EVENT OF OTHER INSURANCE

Coordination of benefits will be based on the Allowed Amount, or Recognized Amount. This applies 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, the reasonable value of these services will be used as the basis for coordination. This also applies if a provider of services is paid under a capitation arrangement. No duplication in coverage of services among Health Benefit Plans is permitted. Notwithstanding the foregoing and if applicable, HPHC shall comply with NH law under RSA 415:6 (II) subsections (3) & (4) as follows:

1. When a Member is enrolled in multiple HPHC health plans, and coverage is limited to one of those plans elected by the member or their Dependents, HPHC shall return premiums paid for all other such HPHC health plans not elected;
2. When a Member is enrolled in health plan coverage with another carrier that is not HPHC, and that other coverage provides benefits for the same Covered Services on a provision of service basis or an expense incurred basis, payment shall not be prorated or reduced and the Member shall

be entitled to payment from both carriers, and HPHC may apply Deductible.

For prescription drug claims, we will coordinate benefits pursuant to our secondary payer Allowed Amount In all cases.

C. WORKER'S COMPENSATION/GOVERNMENT PROGRAMS

HPHC-NE may have information that shows the services provided to you are covered under (i) Worker's Compensation, or (ii) by a federal, state or other government agency. In this case, HPHC-NE may hold payment for such services until a determination is made whether payment will be made by such program. If HPHC-NE provides or pays for services for an illness or injury covered under Worker's Compensation or by a federal, state or other government agency, HPHC-NE will be entitled to recovery of its expenses. Recovery will be from the provider of services or the party or parties legally obligated to pay for such services.

D. SUBROGATION AND REIMBURSEMENT

If you have an injury or illness legally caused by a third party, we have a right to be reimbursed by the third party for claims we pay for Covered Benefits you need. This is called subrogation.

Specifically:

- HPHC-NE will be subrogated and succeed to all rights to recover against such person or entity up to the value of the services paid for or provided by the Plan.
- HPHC-NE 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
 - the Member's own auto insurance carrier, in cases of uninsured or underinsured motorist coverage.
- HPHC-NE recovery will be made from any recovery the Member receives from an insurance company or any third party.
- HPHC-NE will have the right to take legal action, with or without the Member's consent, against any party to secure recovery of the value of services

provided or paid for by HPHC-NE for which such party is, or may be, liable.

E. MEMBER COOPERATION

You agree to cooperate with HPHC-NE in exercising its rights of subrogation and coordination of benefits under this Handbook. Such cooperation will include, but not be limited to:

- the provision of all information and documents requested by HPHC-NE
- the execution of any instruments deemed necessary by HPHC-NE to protect its rights
- the prompt assignment to HPHC-NE of any monies received for services provided or paid for by HPHC-NE, and
- the prompt notification to HPHC-NE of any instances that may give rise to HPHC-NE's rights

You further agree to do nothing to prejudice or interfere with HPHC-NE's rights to subrogation or coordination of benefits.

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

F. HPHC-NE'S RIGHTS

Nothing in this Handbook shall be construed to limit HPHC-NE's right to utilize any remedy provided by law to enforce its rights to subrogation under this agreement.

XI. Plan Provisions and Responsibilities

A. IF YOU DISAGREE WITH RECOMMENDED TREATMENT

Plan Providers are responsible for determining treatment appropriate to your care. You:

- may disagree with the treatment recommended by Plan Providers for personal or religious reasons.
- may demand treatment or seek of treatment that Plan Providers judge to be incompatible with proper medical care.
- have the right to refuse the recommendations of Plan Providers.

In this case, HPHC-NE shall have no further obligation to provide coverage for the care in question. If you obtain care from Non-Plan Providers because of the disagreement, HPHC-NE has no obligation for the cost or outcome of such care. You have the right to appeal benefit denials.

B. LIMITATION ON LEGAL ACTIONS

Any legal action against HPHC-NE for failing to provide Covered Benefits must be brought:

- 60 days after proof of claim has been filed with HPHC-NE; and
- within 3 years of the date the notice or proof of claim has or should have been given to HPHC-NE.

C. ACCESS TO INFORMATION

You agree that we may have access to the following (except where restricted by law):

- all health records and medical data from Providers of Covered Benefits.
- information concerning health coverage or claims from all providers of:
 - motor vehicle insurance.
 - medical payment policies.
 - home-owners' insurance.
 - all types of health benefit plans.

We will comply with all laws that restrict access to special types of medical information. This includes, but is not limited to:

- HIV test data,
- substance use disorder treatment, and
- mental health care records.

You can get a copy of the Notice of Privacy Practices on our website at www.harvardpilgrim.org. You can also call Member Services at **1-877-907-4742**.

D. SAFEGUARDING CONFIDENTIALITY

HPHC-NE values your privacy rights. We are committed to safeguarding protected health information (PHI) and personal information (PI). Our Privacy and Security policies include:

- how HPHC-NE administers privacy and security programs;
- staff training, and
- how PHI and PI can be used and disclosed.

We may collect, use, and disclose financial and medical information about you when doing business with you or others. We follow our privacy policies and state and federal laws. Our business partners administer your health care coverage on our behalf. We require our partners to protect your information according to state and federal laws.

For a copy of our Notice of Privacy Practices, go to www.harvardpilgrim.org or call Member Services at **1-877-907-4742**.

E. NOTICE

Member mailings are sent to your last address that we have on file. Mailings may include:

- plan documents,
- invoices,
- activity statements, and
- letters

Be sure to let us know of an address change. This ensures mailings go to the right address. We are not responsible for mail you don't receive if you have not sent an address change.

Notice to HPHC-NE, other than a request for Member appeal, should be sent to:

HPHC-NE Member Services Department
1 Wellness Way
Canton, MA 02021
1-877-907-4742
www.harvardpilgrim.org

See section VI. *Appeals and Complaints* for the addresses and phone numbers to file an appeal.

F. MODIFICATION OF THIS HANDBOOK

We may amend the EOC. We will provide sixty (60) days written notice to you.

The EOC is the entire contract between you and the Plan. HPHC-NE's responsibilities to the Member are stated in the EOC. The EOC can only be modified in writing by an authorized Plan officer. No other action by us will waive or alter any part of the EOC.

G. OUR RELATIONSHIP WITH PLAN PROVIDERS

Separate agreements govern our relationship with Plan Providers. Plan Providers:

- are independent contractors.
- may not modify the EOC.
- may not create any obligation for HPHC-NE.

We are not liable for their statements about the EOC. This includes their employees or agents. We may change our arrangements with service Providers, including the addition or removal of Providers.

H. PROVIDER COMPENSATION ARRANGEMENTS

Under New Hampshire law HPHC-NE must tell you about the types of financial arrangements within the provider contracts. They are described below.

HPHC-NE's compensation programs are designed to reward providers for the delivering cost effective services. This includes Medically Necessary services provided on referral. Providers may also receive compensation when set goals for quality and Member satisfaction are met.

There are two main types of HPHC-NE Provider payment arrangements, as follows:

1. **Capitation.** One of the ways that HPHC-NE pays providers is through a method called "capitation." Under a capitation arrangement a provider organization receives a set dollar amount for each HPHC-NE patient they are responsible for. Sometimes capitation is paid on a monthly basis. Other times the capitation payment is based on a budget. In a budgeted capitation arrangement, claims are paid at contracted rates minus a percentage. This percentage is withheld by HPHC-NE. At the end of the year, claims payments are reconciled against a budget. All or part of the amount that had been withheld is returned to the provider organization or retained by HPHC-NE based on that reconciliation. Providers receive a share in

any surplus after reconciliation. Some capitation arrangements only apply to professional services. Others apply to professional, hospital and ancillary services.

2. **Fee-for-Service.** Under certain circumstances, HPHC-NE pays a contracted rate for the services provided. This arrangement could include additional payments or bonuses as agreed to by the parties. Fee-for-service payment is usually used for specialty care and ancillary services.

In the capitation method above, HPHC-NE provides financial protection, ("stop-loss" insurance) from excessive costs in providing medical care to HPHC-NE patients. This means that HPHC-NE Providers are responsible only up to a certain dollar amount for the care of an individual Member. As a result, the compensation of HPHC-NE Providers' is not unduly affected by an unusually large medical expense that might be necessary for care of an individual Member.

I. WELLNESS INCENTIVES

A Member may be able to receive incentives for taking part in health and wellness programs. Incentives may include reimbursement for certain fees you pay for taking part in:

- fitness programs,
- weight loss programs, or
- other wellness programs.

Receiving an incentive does not depend upon the outcome of the program. Go to www.harvardpilgrim.org for more information. See your EOC for any incentive amounts included with your Plan. For tax information, please consult with your tax advisor.

J. IN THE EVENT OF A MAJOR DISASTER

We will try to provide or arrange for services in the case of a major disaster. This might include war, riot, epidemic, public emergency, or natural disaster. Other causes include:

- the partial or complete destruction of our facility(ies).
- the disability of service providers.

We may not be able to provide or arrange services in a major disaster. We are not responsible for the costs or outcome of this inability. However, HPHC-NE will refund premium to the extent covered benefits were not provided solely as a result of the major disaster.

K. EVALUATION OF NEW TECHNOLOGY

We have a dedicated team that evaluates new:

- diagnostics;
- testing;
- interventional treatment;
- therapeutics;
- medical/behavioral therapies;
- surgical procedures;
- medical devices and drugs; and
- new applications of the above.

The team manages an evidence-based evaluation process. This process recommends a status of (i) an accepted standard of care; or (ii) Experimental, Unproven or Investigational. The team researches the safety and effectiveness of these new technologies by:

- reviewing published peer reviewed medical reports and literature,
- consulting with expert practitioners, and
- benchmarking.

The team makes recommendations to internal policy committees. These committees make final policy decisions for new technology coverage. The policy evaluation process includes:

- determining the FDA approval status of the device/product/drug in question;
- reviewing relevant clinical literature, and
- consulting actively practicing specialists about current practice standards.

L. GOVERNING LAW

This Evidence of Coverage is governed by New Hampshire law.

M. CONFORMITY WITH STATE STATUTES

If a state law is passed and is in conflict with this EOC, the state law will take precedent.

N. UTILIZATION REVIEW PROCEDURES

We use the following utilization review procedures to evaluate the Medical Necessity of certain services. We use clinical criteria to ensure your care is clinically appropriate and cost-effective. This applies to both physical and mental health services.

- **Prospective Utilization Review (Prior Approval).** We review certain services before they are provided. This review determines if

the proposed services meet Medical Necessity Guidelines. Services include:

- elective inpatient admissions;
- surgical day care;
- outpatient/ambulatory procedures; and
- Medical Drugs.

Prospective utilization review decisions will be made within two working days of obtaining all necessary information.

1. For notice of a decision to approve an admission, procedure or service:
 - we will send notice in the HPHC-NE provider portal within 24 hours of the decision.
 - we will send written notice to you and the Provider within two working days.
2. For notice of a decision to deny or reduce benefits (“an adverse determination”):
 - we will call your Provider within 24 hours of the decision.
 - we will send you and your Provider written or electronic notice within one working day after the call.

- **Concurrent Utilization Review.** We review ongoing admissions for certain services. These reviews are to ensure that the services provided meet Medical Necessity Guidelines. These services may be at:
 - hospitals, including acute care hospitals;
 - rehabilitation hospitals;
 - skilled nursing facilities;
 - skilled home health providers; and
 - behavioral health and substance use disorder treatment facilities.

Concurrent review decisions are made within one working day of receiving all necessary information.

For either a decision to approve or deny additional services, we will call your provider within 24 hours of the decision. We will send you and your provider written or electronic notice within one working day. For ongoing services, coverage will continue without liability to you until you are notified of an adverse determination.

Concurrent review includes active case management and discharge planning. Your provider may request these services.

- **Retrospective Utilization Review.** We may review services that were provided before Prior Approval was obtained. This includes review of emergency medical admissions for appropriate level of care.

To find the status of a clinical review decision, call Member Services at **1-877-907-4742**.

For an adverse determination involving clinical review, your provider may discuss your case with a physician reviewer. Your provider may ask us to reconsider our decision. We will reconsider the decision within one working day of your provider's request. If the adverse determination is not reversed, you may appeal. Your appeal rights are described in section VI. *Appeals and Complaints*. Your right to appeal does not depend on your provider making a request to reconsider our decision.

O. QUALITY ASSURANCE PROGRAMS

HPHC-NE has quality controls in place guided by the National Committee for Quality Assurance (NCQA). Our Quality Assurance programs are designed to ensure consistently excellent health plan services. Key Quality Assurance programs include:

- **Verifying Provider Credentials** - HPHC-NE obtains, verifies and assesses Plan Provider qualifications to provide care or services. This involves gathering evidence of licensure, education, training and other experience and/or qualifications.
- **Verifying Facility Credentials** - HPHC-NE reviews and confirms licensures and certifications based on facility type.
- **Quality of Care Complaints** – HPHC-NE follows a process to investigate, resolve and monitor Member complaints about care received by a Plan Provider.
- **Evidence Based Practice** – HPHC-NE compiles Medical Necessity Guidelines. These guidelines are based on the most current evidence-based standards. They provide an analytical framework for clinicians to evaluate and treat common health conditions.
- **Performance monitoring** – HPHC-NE collects data to measure outcomes. This data is related to the Health Care Effectiveness Data and Information Set (HEDIS). It is used to monitor health care quality across various domains of evidence-based care and practice.

- **Quality program evaluation**- Annually HPHC-NE develops, plans and implements initiatives to improve clinical service and quality. The Quality Program is documented, tracked and evaluated against milestones and objectives. See and review the full program description at <https://www.harvardpilgrim.org/public/about-us/quality>.

P. PROCEDURES USED TO EVALUATE EXPERIMENTAL/INVESTIGATIONAL DRUGS, DEVICES, OR TREATMENTS

We use a standard process to assess coverage questions and requests. These may come to us from internal or external sources. The process includes:

- Determining FDA approval status of the device, product, or drug in question,
- Reviewing relevant clinical literature, and
- Consulting with actively practicing specialists about current practice standards.

Decisions are developed into policy change recommendations. These are then sent to our management for review and final approval.

Q. PROCESS TO DEVELOP MEDICAL NECESSITY GUIDELINES AND UTILIZATION REVIEW CRITERIA

We use Medical Necessity Guidelines to make fair and consistent utilization management decisions. Medical Necessity Guidelines are developed according to NCQA standards. Guidelines are reviewed (revised, if needed) at least annually. Review may occur more often to include updates in practice standards. This process applies to criteria for both physical and mental health services.

For example, we use the nationally recognized InterQual criteria to review (i) elective surgical day procedures, and (ii) services provided in acute care hospitals. InterQual criteria are developed from current national standards of medical practice. Physicians and clinicians in academic medicine and all areas of active clinical practice provide input. InterQual criteria are reviewed and revised annually.

Medical Necessity Guidelines are also used to review other services. Physicians and other clinicians with relevant clinical expertise provide input. The development includes review of relevant clinical literature and local practice standards.

R. NON-ASSIGNMENT OF BENEFITS

You may not assign or transfer your rights to benefits, monies, claims or causes of action provided under this Plan to:

- any person;
- health care provider;
- company; or
- other organization.

You must have our written consent to assign any benefits, monies, claims, or causes of action that result from a benefit denial.

S. NEW TO MARKET DRUGS

New to market prescription drugs are reviewed by the Plan prior to coverage. This ensures that the drug is safe and effective. New to market drugs are reviewed by HPHC-NE's

- Medical Policy Department;
- New Technology Assessment Committee or Pharmacy Services Department; and
- the Pharmacy and Therapeutics Committee.

The review will take place within the first 180 days of their introduction to the market. Coverage for a new to market drug may apply Prior Approval and coverage limitations.

T. PAYMENT RECOVERY

We may determine that a mistake was made paying benefits. We reserve the right to:

- recover such payments from the Provider or Member.
- offset later benefit payments to a Provider (regardless of payment source) or a Member by any such overpayment amount.

XII. Information on Patient Rights

The following information is provided to inform you of your rights under New Hampshire law.

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

1. The patient shall be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care and including being informed of the name, licensure status, and staff position of all those with whom the patient has contact, pursuant to RSA 151:3-b.
2. The patient shall be fully informed of a patient's rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in writing before or at admission, except for emergency admissions. Receipt of the information must be acknowledged by the patient in writing. When a patient lacks the capacity to make informed judgments, the signing must be by the person legally responsible for the patient.
3. The patient shall be fully informed in writing in language that the patient can understand, before or at the time of admission and as necessary during the patient's stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. A statement of services that are not normally covered by Medicare or Medicaid shall also be included in this disclosure.
4. The patient shall be fully informed by a health care provider of his or her medical condition, health care needs, and diagnostic test results, including the manner by which such results will be provided and the expected time interval between testing and receiving results, unless medically inadvisable and so documented in the medical record, and shall be given the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment, and to be involved in experimental research upon the patient's written consent only. For the purposes of this paragraph "health care provider" means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing health care services, including, but not limited to, a physician, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist, and any officer, employee, or agent of such provider acting in the course and scope of employment or agency related to or supportive of health care services.
5. The patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for the patient's welfare or that of other patients, if the facility ceases to operate, or for nonpayment for the patient's stay, except as prohibited by Title XVIII or XIX of the Social Security Act. No patient shall be involuntarily discharged from a facility because the patient becomes eligible for Medicaid as a source of payment.
6. The patient shall be encouraged and assisted throughout the patient's stay to exercise the patient's rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination, or reprisal.
7. The patient shall be permitted to manage the patient's personal financial affairs. If the patient authorizes the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with the patient's rights under this subdivision and in conformance with state law and rules.
8. The patient shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion.
9. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.
10. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to

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be the property of the patient. The patient shall be entitled to a copy of such records, for a reasonable cost, upon request. The charge for the copying of a patient's medical records shall not exceed \$15 for the first 30 pages or \$.50 per page, whichever is greater; provided, that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.

11. The patient shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by the patient, such services may be included in a plan of care and treatment.
12. The patient shall be free to communicate with, associate with, and meet privately with anyone, including family and resident groups, unless to do so would infringe upon the rights of other patients. The patient may send and receive unopened personal mail. The patient has the right to have regular access to the unmonitored use of a telephone.
13. The patient shall be free to participate in activities of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients.
14. The patient shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients.
15. The patient shall be entitled to privacy for visits and, if married, to share a room with his or her spouse if both are patients in the same facility and where both patients consent, unless it is medically contraindicated and so documented by a physician. The patient has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.
16. The patient shall not be denied appropriate care on the basis of age, sex, gender identity, sexual orientation, race, color, marital status, familial status, disability, religion, national origin, source of income, source of payment or profession.
17. The patient shall be entitled to be treated by the patient's physician of choice, subject to reasonable rules and regulations of the facility regarding the facility's credentialing process.
18. The patient shall be entitled to have the patient's parents, if a minor, or spouse, or next of kin, unmarried partner, or a personal representative chosen by the patient, if an adult, visit the facility, without restriction, if the patient is considered terminally ill by the physician responsible for the patient's care.
19. The patient shall be entitled to receive representatives of approved organizations as provided in RSA 151:28.
20. The patient shall not be denied admission to the facility based on Medicaid as a source of payment when there is an available space in the facility.
21. Subject to the terms and conditions of the patient's insurance plan, the patient shall have access to any provider in his or her insurance plan network and referral to a provider or facility within such network shall not be unreasonably withheld pursuant to RSA 420-J:8, XIV.
22. The patient shall not be denied admission, care, or services based solely on the patient's vaccination status.
23. (a) In addition to the rights specified in #18 above, the patient shall be entitled to designate a spouse, family member, or caregiver who may visit the facility while the patient is receiving care. A patient who is a minor may have a parent, guardian, or person standing in loco parentis visit the facility while the minor patient is receiving care.
(b) (1) Notwithstanding (a) above, a health care facility may establish visitation policies that limit or restrict visitation when:
 - (A) The presence of visitors would be medically or therapeutically contraindicated in the best clinical judgement of health care professionals;
 - (B) The presence of visitors would interfere with the care of or rights of any patient;
 - (C) Visitors are engaging in disruptive, threatening, or violent behavior toward any staff member, patient, or another visitor, or
 - (D) Visitors are noncompliant with written hospital policy.

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(2) Upon request, the patient or patient's representative, if the patient is incapacitated, shall be provided the reason for denial or revocation of visitation rights under this paragraph.

(c) a health care facility may require visitors to wear personal protective equipment provided by the facility, or provided by the visitor and approved by the facility. A health care facility may require visitors to comply with reasonable safety protocols and rules of conduct. The health care facility may revoke visitation rights for failure to comply with this subparagraph.

(d) Nothing in this paragraph shall be construed to require a health care facility to allow a visitor to enter an operating room, isolation room, isolation unit, behavioral health setting or other typically restricted area or to remain present during the administration of emergency care in critical situations. Nothing in this paragraph shall be construed to require a health care facility to allow a visitor access beyond the rooms, units, or wards in which the patient is receiving care or beyond general common areas in the health care facility.

(e) The rights specified in this paragraph shall not be terminated, suspended, or waived by the health care facility, the department of health and human services, or any governmental entity, notwithstanding declarations of emergency declared by the governor or the legislature. No health care facility licensed pursuant to RSA 151:2 shall require a patient to waive the rights specified in this paragraph.

(f) Each health care facility licensed pursuant to RSA 151:2 shall post on its website: (1) informational materials explaining the rights specified in this paragraph; (2) the patients' bill of rights which applies to the facility on its website; and (3) hospital visitation policy detailing the rights and responsibilities specified in this paragraph, and the limitations placed upon those rights by written hospital policy on its website.

(g) Unless expressly required by federal law or regulation, the department or any other state agency shall not take any action arising out of this paragraph against a health care facility for: (1) giving a visitor individual access to a property or location controlled by the health care facility; (2) failing to protect or otherwise ensure the safety or comfort of a visitor given access to a property or location controlled by the health care facility; (3) the acts or omissions of any visitor who is given access to a property or location controlled by the health care facility.

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

**HPHC-NE Member Services Department
Harvard Pilgrim Health Care of New England
Attn: Appeals and Grievances Department
1 Wellness Way
Canton, MA 02021
1-877-907-4742
www.harvardpilgrim.org**

For Massachusetts Physicians:

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

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

For New Hampshire Physicians:

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

**State of New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301**

For Maine Physicians:

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

**Maine Bureau of Insurance
34 State House Street
Augusta, ME 04333**

For Vermont Physicians:

**Vermont Board of Medical Practice
109 State Street
Montpelier, VT 05609-1106**

**Director of Consumer Services
89 Main Street, Drawer 20
Montpelier, VT 05620-3101**

XIII. MEMBER RIGHTS & RESPONSIBILITIES

You have a right to receive information about:

- HPHC-NE, its services,
- Plan practitioners and providers
- your rights and responsibilities

You have a right:

- to privacy.
- to be treated with dignity and respect.
- to participate in decision-making regarding your health care.
- to a candid discussion of appropriate treatment options for your condition, regardless of the cost or benefit coverage.
- to voice a complaint or appeal about HPHC-NE or the care provided.
- to suggest changes to HPHC-NE members' right and responsibilities policies.

You have a responsibility to:

- provide, to the extent possible, information that the Plan and Plan Providers need to manage your care.
- to follow your Providers plans an instructions for care.
- to understand your health problems.
- participate in developing mutually agreed upon treatment goals to manage your health.

APPENDIX A: NEW HAMPSHIRE EXTERNAL APPEAL REVIEW FORMS



The State of New Hampshire
Insurance Department

21 South Fruit Street, Suite 14; Concord, NH 03301
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

EXTERNAL REVIEW APPLICATION FORM
Request for Independent External Appeal of a Denied Medical or Dental Claim

Section I – Applicant Information

Patient's Name: _____ Patient's Date of Birth: _____
Applicant's Name: _____ Applicant's Email: _____
Applicant's Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Applicant's Phone Number(s): Daytime: (____) _____ Evening: (____) _____

Section II – Appointment of Authorized Representative

**** Complete this section, only if someone else is representing the patient in this appeal ****

You may represent yourself or you may ask another person, including your treating health care provider, to act as your personal representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

Signature of Enrollee (or legal representative – Please specify relationship or title) Date

Representative's Mailing Address: _____
City: _____ State: _____ Zip Code: _____

Representative's Phone Number(s): Daytime: (____) _____ Evening: (____) _____

Section III - Insurance Plan Information

Member's Name: _____ Relationship to Patient: _____

Member's Insurance ID #: _____ Claim/Reference #: _____

Health Insurance Company's Name: _____

Insurance Company's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Company's Phone Number: (____) _____

Name of Insurance Company representative handling appeal: _____

Is the member's insurance plan provided by an employer? Yes ___ No ___

- Name of employer: _____
- Employer's Phone Number: (____) _____
- Is the employer's insurance plan self-funded? Yes* ___ No ___

*** If you are not certain, please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may provide external review, but may have different procedures.**

New Hampshire Premium Assistance Program

Is the patient's health insurance provided through the Medicaid Premium Assistance Program, which is administered by the NH Department of Health and Human Services?

Yes ___ No ___

If yes, please provide the Medicaid ID number & complete the following records release:

Medicaid ID Number: _____

I, _____, hereby authorize the New Hampshire Insurance Department to release my external review file to the New Hampshire Department of Health and Human Services (DHHS), if I request a Medicaid Fair Hearing following my independent external review. I understand that DHHS will use this information to make a Fair Hearing determination and that the information will be held confidential.

Section IV – Information about the Patient’s Health Care Providers

Name of Primary Care Provider (PCP): _____

PCP’s Mailing Address: _____

City: _____ State: _____ Zip Code: _____

PCP’s Phone Number: (____) _____

Name of Treating Health Care Provider: _____

Provider’s clinical specialty: _____

Treating Provider’s Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Treating Provider’s Phone Number: (____) _____

Section V – Health Care Decision in Dispute

Describe the health insurer company’s decision in your own words. Include any information you have about the health care services, supplies or drugs being denied, including dates of service or treatment and names of health care providers. Explain why you disagree.

Please **attach** the following:

- Additional pages, if necessary;
- Pertinent medical records;
- If possible, a statement from the treating health care provider indicating why the disputed service, supply, or drug is medically necessary.

Continued on next page

VIII – Authorization and Release of Medical Records

I, _____, hereby request an external review and authorize the patient’s insurance company and the patient’s health care providers to release all relevant medical or treatment records to the Independent Review Organization (IRO) and the New Hampshire Insurance Department. I understand that the IRO and the Department will use this information to make a determination to either reverse or uphold the insurer’s denial. I also understand that the information will be kept confidential. I further understand that neither the Commissioner nor the IRO may authorize services in excess of those covered by the patient’s health care plan. This release is valid for one year.



Signature of Enrollee (or legal representative – Please specify relationship or title)

Date

Before submitting this application, please verify that you have ...

- Completed all relevant sections of the External Review Application Form
 - If appointing an authorized representative, the patient must complete Section II.
 - If requesting an Expedited External Review, Section VI must be completed and the Provider Certification Form must be submitted.
 - If requesting a telephone conference, Section VII must be completed.
- Signed and dated the External Review Application Form in Section VIII.
- Attached the following documents:
 - A photocopy of the front and back of the patient’s insurance card or other evidence that the patient is insured by the health or dental insurance company named in the appeal.
 - A copy of the Health Insurance Company’s letter, denying the requested treatment or service at the final level of the company’s internal appeals process.
 - Any medical records, statements from the treating health care provider(s) or other information that you would like the Independent Review Organization to consider in its review.
 - If requesting an Expedited External Review, the treating Provider’s Certification Form.

APPENDIX B: PEDIATRIC DENTAL BENEFIT (for children up to the age of 19)

Dependents up to the age of 19 are eligible for the Covered Dental Services listed in the Schedule of Benefits when such Dental Services are Necessary and are provided by or under the direction of a Dental Provider. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease does not mean that the procedure or treatment is a Covered Dental Service.

Covered Benefits are available only for the least costly clinically appropriate Dental Services. Clinical

situations that can be effectively treated by a less costly, clinically appropriate alternative procedure will be covered based on the least costly procedure.

Coverage under this benefit terminates at the end of the month in which the Dependent turns 19.

Certain capitalized words in this section have special meanings. We have defined these words either above in *Section II: Glossary* of the Benefit Handbook or below in *Section II. Defined Terms For Pediatric Dental Services* of Appendix B.

I. Accessing Pediatric Dental Services

A. NETWORK BENEFITS

These Covered Benefits apply when you choose to obtain Covered Dental Services from a Plan Dental Provider. You generally are required to pay less to the provider than you would pay for services from a Non-Plan Dental Provider. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Plan Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

In order for Covered Dental Services to be paid as Network Benefits, you must obtain all Covered Dental Services directly from or through a Plan Dental Provider.

You must always verify the participation status of a Plan Dental Provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling us and/or the provider. If necessary, we can provide assistance in referring you to a Plan Dental Provider.

A *Directory of Network Dental Providers* is available online at <https://www.harvardpilgrim.org/public/pediatric-dental-coverage.com>. You can also call *Customer Service* at **1-800-460-0315** to determine which providers participate in the Network. The telephone number for *Customer Service* is also listed on your ID card.

B. NON-PLAN DENTAL PROVIDERS

If you are unable to find a Plan Dental Provider to render your care, you can obtain Covered Dental Services from a Non-Plan Dental Provider. Non-Plan Dental Providers are reimbursed at the Usual and Customary fee for similarly situated Plan Dental Providers for each Covered Dental Service. The actual charge made by a Non-Plan Dental Provider for a Covered Dental Service may exceed the Usual and Customary fee. As a result, you may be required to pay a Non-Plan Dental Provider an amount for a Covered Dental Service in excess of the Usual and Customary fee. In addition, when you obtain Covered Dental Services from Non-Plan Dental Providers you must file a claim with us to be reimbursed for Eligible Dental Expenses.

Covered Dental Services received from a Dental Provider outside of the United States will be reimbursed at the same level as a Non-Plan Dental Provider.

C. PRE-TREATMENT ESTIMATE

If the charge for a Dental Service is expected to exceed \$300 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information

necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of Covered Benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

A pre-treatment estimate of Covered Benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

D. PRE-AUTHORIZATION

Pre-authorization is required for all Orthodontic Services. Speak to your Dental Provider about obtaining a pre-authorization before Dental Services are rendered. You or your Dental Provider can request Pre-authorization for these services by contacting us at **1-800-460-0315**. If you do not obtain a pre-authorization, we have a right to deny your claim for failure to comply with this requirement.

If a treatment plan is not submitted, you will be responsible for payment of any dental treatment not approved by us. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a Benefit based on the less costly procedure.

II. Defined Terms For Pediatric Dental Services

The following definitions are in addition to those listed in *Section II: Glossary of the Benefit Handbook*:

Covered Dental Service – a Dental Service or Dental Procedure for which Benefits are provided under this benefit.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to a Dependent up to the age of 19 while the Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the Policy is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Plan Dental Providers, Eligible Dental Expenses are our contracted fee(s) for Covered Dental Services with that provider.
- For Non-Network Benefits, when Covered Dental Services are received from Non-Plan Dental Providers, Eligible Dental Expenses are the lesser of the Usual and Customary fees, as defined below or the billed charges.

Necessary - Dental Services and supplies under this benefit which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Dependent up to the age of 19.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of

national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.

- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Dependent or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
 - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
 - Safe with promising efficacy
 - Provided in a clinically controlled research setting.
 - Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this section. The definition of Necessary used in this section relates only to Benefits under this section and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Usual, Customary and Reasonable Charge - Usual, Customary and Reasonable Charge is the maximum amount that we will pay for services from Dental Providers. The Usual, Customary and Reasonable Charge is calculated using the 80th percentile of provider reimbursement for services in the same geographic area under the FAIR Health database.

III. Pediatric Dental Exclusions

Unless specifically listed as a Covered Benefit in your Schedule of Benefits, the following services are excluded from coverage:

1. Any Dental Service or Procedure not listed as a Covered Dental Service in your Schedule of Benefits.

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2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental, Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Covered Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Dependent becoming enrolled for coverage provided under this benefit.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as a Dependent or who is a member of a Dependent's family, including spouse, brother, sister, parent or child.
18. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
19. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

IV. Claims For Pediatric Dental Services

When obtaining Dental Services from a Non-Plan Dental Provider, you will be required to pay all billed charges directly to your Dental Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities listed below apply to Covered Dental Services provided under this benefit, except that when you submit your claim, you must provide us with all of the information identified below.

REIMBURSEMENT FOR DENTAL SERVICES

You are responsible for sending a request for a claim for reimbursement (proof of loss) to our office, on a form provided by or satisfactory to us.

Claim Forms. It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

- Dependent's name and address
- Dependent's identification number
- The name and address of the provider of the service(s)
- A diagnosis from the Dental Provider including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports.
- Casts, molds or study models

- Itemized bill which includes the CPT or ADA codes or description of each charge.
- The date the dental disease began
- A statement indicating that you are or you are not enrolled for coverage under any other health or dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

If you would like to use a claim form, you can request one be mailed to you by calling *Customer Service* at **1-800-460-0315**. This number is also listed on your ID Card. If you do not receive the claim form within 15 calendar days of your request, send in the proof of loss with the information stated above.

Please mail your request for reimbursement to the following address:

**Claims – Harvard Pilgrim Health Care
P.O. Box 30567
Salt Lake City, UT 84130-0567**

Written proof of loss should be given to the Company within 90 days after the date of the loss. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service.

V. Appeals and Grievances

APPEALS

If you are dissatisfied with a decision on our coverage of services, you may appeal. Appeals may also be filed by a Member's representative or a provider acting on a Member's behalf and must be received within 180 days of the initial denial. Our staff is available to assist you in filing an appeal. If you'd like assistance, please call *Customer Service* at **1-800-460-0315**.

To initiate your appeal, you or your representative should write a letter to us about the coverage you are requesting and why you feel it should be granted. Please be as specific as possible in your appeal request. We need all the important details in order to make a

fair decision. Please send your request to the following address:

Harvard Pilgrim Health Care

**Attention: Appeals
P.O. Box 30569
Salt Lake City, UT 84130-0569**

You may also contact us at **1-800-460-0315** to initiate your appeal.

GRIEVANCES

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If you have a complaint about your care under the Plan or about our service, we want to know about it. For all grievances, please call or write to us at:

Harvard Pilgrim Health Care

**Attention: Grievances
P.O. Box 30569
Salt Lake City, UT 84130-0569
Telephone: 1-800-460-0315**

For additional information on the Appeals and Grievance process, please refer to your Benefit Handbook.

Harvard Pilgrim Health Care of New England, Inc.
1 Wellness Way
Canton, MA 02021-1166
1-888-333-4742
www.harvardpilgrim.org