



Harvard Pilgrim
Health Care

Administrative Guide for Employers, Brokers and Third Party Administrators (TPAs)

Including Information on:

- Important contacts
- Enrolling employees and dependents
- Reading your premium invoice
- Legislation

Making Great Health Care a Little Easier

Thank you for choosing a longtime leader in quality and customer service. For more than 30 years, Harvard Pilgrim Health Care (HPHC) has built a reputation for outstanding clinical quality and customer service. Harvard Pilgrim was the first health insurer in the region to cover preventive measures like immunizations and routine health screenings, and we were the first in the country to cover heart transplants.

Harvard Pilgrim has developed special **clinical outreach** and **educational programs** for individuals at high risk for serious illness and hospitalization, as well as for people with asthma, diabetes, high-risk pregnancies, coronary artery disease, and congestive heart failure. In addition, Harvard Pilgrim has implemented nationally recognized prevention and wellness programs, including one of the nation's leading programs to help women manage menopause. Harvard Pilgrim is consistently among the nation's highest-rated health plans.

Harvard Pilgrim's mission is to improve the quality and value of health care for the people and the communities we serve.

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Introduction

Welcome

Thank you for selecting Harvard Pilgrim Health Care (HPHC) for your employees' health benefits. This *Administrative Guide* is designed to answer your most common questions and to assist you with the completion of membership transactions, including instructions on enrollment procedures and premium payments.

Important Notice to Employers, Brokers and Third-Party Administrators

In order for HPHC to administer your plan effectively, it is important that employer groups, brokers and third-party administrators (TPAs) notify HPHC of enrollments, changes in membership status and terminations. In Rhode Island, Maine and Massachusetts notification must be made within 60 days of the qualifying event. In New Hampshire notification must be made within 30 days from the qualify event.

Enrolling employees **prior to the effective date of their coverage** allows HPHC to send identification (ID) cards and other membership materials that inform members about their health benefits prior to their use of health services. Enrollments and changes received by HPHC more than **60 days** after the effective date of coverage will be denied by HPHC.

HPHC requires immediate notification of employee and dependent terminations. Certain participating providers are paid monthly based on current membership. Therefore, HPHC will continue payments to providers until you notify HPHC of the termination of a member's coverage. HPHC will process terminations retroactively to **no more than 60 days in Rhode Island, Massachusetts and Maine, and no more than 30 days for New Hampshire**, beginning on the date of receipt of the termination. **Employers are required to pay the applicable monthly premium due for coverage provided prior to the termination effective date.**

Timely communication from employer groups and third-party administrators allows HPHC to better manage membership information, delivery of care and your premium rates.

To access details about your company's specific benefit plan(s), please log in to your secure *Employer Account* on harvardpilgrim.org to obtain a copy of your Plan Documents. The Plan Documents will include the *Benefit Handbook*, *Schedule of Benefits*, *Prescription Drug Coverage Brochure* and any rider information. For a general overview of plans and plans descriptions, please go to harvardpilgrim.org/broker.

Employer Materials

Upon the employer group's enrollment with HPHC, the designated benefits administrator will receive the *Employer Agreement*, including the Group Information Form and the dependent eligibility exhibit (additional Information available in the member portal):

- *Benefit Handbook*, *Schedule of Benefits* and any rider information
- *Prescription Drug Coverage Brochure* (included if the group elects prescription drug coverage)
- Monthly premium invoices listing each employee and the corresponding premium
- Enrollment and marketing materials
- *Administrative Guide* (available online at harvardpilgrim.org)
- Correspondence about administrative news or specific events

Additional information on this product may be received through your Sales Account Executive or Sales Department at **800-848-9995**

Subscriber Materials

Upon receipt of complete and accurate enrollment information, the following will be available on the member portal:

- An ID card for each covered individual
- *Benefit Handbook, Schedule of Benefits* and any rider information
- *Prescription Drug Coverage Brochure* (included if the group elects prescription drug coverage)
- *Your Member Savings* brochure with information about discounts and programs for fitness, weight loss, eyewear and more
- *Interpretation Services* flyer with information about translation services
- *Preventative Care Recommendations*
- Online and phone services information
- *Healthy + Informed* newsletter with articles on healthy lifestyles and HPHC updates
- Benefit update notifications describing significant benefit changes, as mandated by law or as agreed upon by the employer group and HPHC
- *Notice of Privacy Practices*

HPHC Contacts

HPHC's administrative departments are available to help when you have a question or need a particular service. This section outlines the departments to contact for assistance.

Sales Department

The Sales Department has overall responsibility for the employer group. You should contact your Sales Account Executive when you need:

- Information about your *Employer Agreement* or premium rates
- Information about your HPHC benefits plan
- HPHC forms or brochures

Sales Department Contact Information

Maine

Harvard Pilgrim Health Care
Sales Department
80 Exchange Street, Suite 200
Portland, Maine 04101

Phone: 888-476-2463

Fax: 207-761-0194

Fax: 800-592-2570

Massachusetts

Harvard Pilgrim Health Care
Sales Department
1 Wellness Way
Canton, MA 02021-1166

Phone: 800-848-9995

Phone: 617-509-2500

Fax: 617-509-2515

New Hampshire

Harvard Pilgrim Health Care
Sales Department
650 Elm Street, Suite 203
Manchester, NH 03101-2596

Phone: 800-544-9759

Phone: 603-656-9500

Fax: 603-656-9560

Rhode Island

Harvard Pilgrim Health Care
Sales Department
75 Fountain St, First Floor
Providence, RI 02902

Phone: 800-637-4751

Broker/Employer Services Team

This team provides overall customer service for issues related to enrollment processing, premium invoicing and eligibility. You should contact the Broker/Employer Services Team when you have questions about:

- Submitting the enrollment/change forms through the *Employer Account*, *Express Enrollment*, EDI (Electronic Data Interchange), or an enrollment/change form.
- Eligibility
- Premium invoices
- Group administrative services

Broker/Employer Services is located at:

Harvard Pilgrim Health Care **Phone:** 800-637-4751
Broker/Employer Services Team
1 Wellness Way
Canton, MA 02021-1166

Enrollments, changes and terminations may be submitted online through the *Employer Account*. Please send the **Enrollment/Change Form** and other related correspondence to:

Harvard Pilgrim Health Care
PO Box 9185
Quincy, MA 02269

Please send **Premium Payments** to:

Harvard Pilgrim Health Care
PO Box 970050
Boston, MA 02297-0050

Member Services Department

The Member Services Department is available to serve HPHC members directly. Member Services representatives answer questions about benefits, policies and procedures. Your employees should call Member Services when they have questions about:

- Benefits and coverage
- Eligibility
- Claims
- ID cards (i.e., new or replacement) and member materials
- Nongroup eligibility
- Primary care physician (PCP) changes (applies to Harvard Pilgrim HMOs and Harvard Pilgrim POS)*

**Subscribers and members, 18 years of age and older can access their member portal to order ID cards, make PCP changes, view a summary of benefits and print a copy of their specific Schedule of Benefits and Member Handbook for easy reference.*

Member Services also investigates and responds to inquiries and concerns and advises members on the process for appealing coverage decisions.

Harvard Pilgrim Health Care **Phone:** 888-333-4742
Member Services Department **Fax:** 617-509-1050
1 Wellness Way
Canton, MA 02021-1166

Members may also use HPHC's Interactive Voice Response System (IVR) for certain transactions. Your employees may call Member Services and use this automatic system to:

- Order materials
- Order ID cards
- Order drug/mail order brochure
- Check eligibility
- Request free language interpretation services in many languages through Pacific Interpreters. Deaf and hard-of-hearing members may call Member Services toll-free at **800-637-8257** for TTY service.

Insurance Liability Recovery (ILR)

The ILR Department coordinates with third parties to determine primary and secondary payment responsibilities when other insurance benefits exist and when a third party may be responsible for claims payment. Attorneys, employers, insurance carriers, members and providers may contact ILR with questions or to submit information relating to third party liability.

Send to this address using the appropriate P.O. Box listed below:

Harvard Pilgrim Health Care
Quincy, MA 02269

- Coordination of Benefits: PO Box 699180
- Motor Vehicle Accidents: PO Box 699187
- Workers' Compensation: PO Box 699218

Phone: 888-888-4742, ext. 38999 or 617-509-8999

Online Resources

Harvard Pilgrim's website, harvardpilgrim.org, contains a wide range of educational and interactive information about HPHC benefits, services and health programs. It is organized into four sections:

- Employers
- Brokers
- Members
- Providers

The most current version of this *Administrative Guide* is available in the Employers and Brokers sections of the website.

Employer Resources

Employers are encouraged to manage their membership enrollment via their *Employer Account*. Employer groups are provided with a username and password that gives you online access to your membership roster 24 hours a day, 7 days a week. Through the *Employer Account*, employers can:

- Download a roster of enrollees awaiting approval, denied enrollees or active enrollees (rosters can be saved to a spreadsheet and sorted as needed).
- Compare the membership roster with HPHC's enrollment using an online roster verification tool.
- Verify new enrollee's information and then approve, deny or hold applications for later action.
- Add or terminate subscribers and their dependents.
- Edit subscriber and dependent information.
- View the *Schedule of Benefits*.
- View and pay your premium invoice online.
- Set up administrative access for benefits representatives at their company.

Broker Resources

Brokers are encouraged to manage their account's enrollments via the Internet by establishing online access with HPHC through the *Employer Account*. Brokers are provided with a Username and Password that gives them online access to their accounts' rosters 24 hours a day, 7 days a week. Through their *Employer Account* access, brokers can:

- Download a roster of enrollees awaiting approval, denied enrollees or active enrollees (rosters can be saved to a spreadsheet and sorted as needed).
- Compare their account's membership roster with HPHC's enrollment using an online roster verification tool.
- Verify a new enrollee's information and then approve, deny or hold applications for later action.
- Add or terminate subscribers and their dependents.
- Edit subscriber and dependent information.
- View the *Schedule of Benefits*.
- Set up administrative access for the benefits representatives at their company.

The *Employer Account* puts you in control of enrollments, changes and terminations and ensures that the changes you enter are reflected in time for HPHC to produce an accurate monthly invoice. Enrollment policies and eligibility requirements must be followed to ensure coverage. Contact your Broker/Employer Services coordinator for more information at **800-637-4751**.

Member Resources

Members have access to a wide variety of online programs and services:

- An alphabetized database of health-related topics for members to research specific conditions, symptoms, treatment options and more.
- HPHC's *Provider Directory* provides information that allows members to choose their PCP. Maps and directions to the locations of providers are also provided. The online *Provider Directory* is updated weekly; therefore, the information on the website is more current than printed copies.
- HPHC's 5 Tier Pharmacy Program provides the names of medications that are available in Tier 1, Tier 2, Tier 3, Tier 4 and Tier 5.
- Through their secure *Member Account*, members can enroll online, add or remove dependents during qualifying events, update their PCP information, and review their *Summary of Benefits*, addresses or phone numbers.

There is also a public website that includes:

- Comprehensive listings of health education classes available to both HPHC members and the general community.
- Guidelines for better health and safety.
- Information on wellness and seasonal health issues.

Provider Resources

Providers can get a wide range of important information online at harvardpilgrim.org:

- HPHC's formulary
- News and information, including the *Insights and Updates for Providers* newsletter
- Updates and advisories
- Links to medical resources from
 - General health sites
 - Medical journals
 - Medical schools and other educational sources

Currently, providers have the ability to perform the following secure functions through the *Employer Account*

- Patient eligibility
- Claims submissions
- Claims status
- Specialty referrals
- Notifications/authorizations

Setting up your Account

HPHC establishes account structures to ensure that the receipt and processing of enrollment transactions and the collection, application and reconciliation of premium are accurate, timely and efficient. HPHC reserves the right to establish an account structure that is beneficial solely for the administration of eligibility. HPHC will set up your account as follows:

Standard Account Structure

Group Number: The employer group will be assigned a group number for each health benefits plan purchased. For example, if a customer purchases an HMO and a POS product, two group numbers will be assigned. Additional group numbers may be established by HPHC when system constraints or legal mandates deem it necessary.

Customer Account Number: Each group number will be assigned a single customer account number. HPHC reserves the right to establish separate customer account numbers to administer benefits for COBRA members if applicable. Additional customer account numbers may be established by HPHC when systems constraints or legal mandates deem it necessary.

Customized Account Structure

HPHC will make every effort to accommodate an employer group's proposed account structure, as long as the following requirements are met:

- The employer group must be in good standing, which means:
 - HPHC's policies are followed on a routine basis
 - Premium due is remitted in total and on time
 - Requests for changes to enrollment are communicated in a clear and timely manner according to HPHC's policies
- The effort associated with the setup and administration is deemed reasonable by HPHC staff
- When an employer group's request for a proposed account structure is granted, the employer group must provide a complete and detailed accounting of the payment for each group and customer account number with the premium payment
- The Broker/Employer Services Team manager must approve the employer group's requested customized account structure

Failure to meet ANY of these requirements will result in the establishment of a standard account structure.

Eligibility

HMO Residency Requirement

To be eligible for coverage under an HMO plan, a member must live and maintain a permanent residence within HPHC's enrollment area at least nine months per year. From time to time, HPHC may change the cities and towns in the enrollment area. A current list of cities and towns by ZIP code is available online at harvardpilgrim.org.

The residency requirement does not apply to:

- Dependents up to the age of 26 end of month.*
- Children covered under a Qualified Medical Support Order (QMSO).
- Members temporarily residing outside HPHC's enrollment area for no more than 12 months (for reasons such as non-recurring travel, sabbatical or work-related project) with HPHC approval.

** Please note: New Hampshire Federal Exchange out-of-area dependents are covered until the Anniversary Date following the child's 26th birthday. If the child's birthday falls on the Anniversary Date, eligibility will end that day. For dependents outside the enrollment area, coverage differs slightly from the coverage received in the enrollment area (emergency services only). Please see the Harvard Pilgrim Benefit Handbook for details.*

We provide limited out-of-area dependent coverage (Emergency services only, unless additional rider) because many dependent children attend schools or colleges outside of the enrollment area where plan providers are not available to provide care. However, a dependent under age 26 does not have to be a student to be eligible. All enrolled dependent children under age 26 who live outside of the enrollment area are eligible for this benefit.

All the rules and limits for coverage of out-of-area dependents are listed in the *Benefit Handbook*, the *Schedule of Benefits* and the *Prescription Drug Coverage Brochure*. Coverage may vary by employer group, based on what the employer has elected for coverage.

Members temporarily traveling outside the enrollment area may obtain covered services from any qualified provider. **(This is known as the "travel benefit.")** However, no coverage is provided under this benefit for the following:

- Services that the member could have foreseen the need for before leaving the area
- Routine care
- Delivery outside the service area beyond the 37th week of pregnancy or after the member has been told that she is at risk for early delivery, and
- Follow-up care that can wait until the member's return to the HPHC enrollment Area.

If you have questions about these requirements, please call the Broker/Employer Services Team at **800-637-4751**.

POS and PPO Residency Requirement

Members in a POS or PPO plan are not required to reside in the HPHC enrollment area in order to be eligible for enrollment. However, both small employer groups and large employer groups must comply with HPHC's eligibility requirements in order for the employer group to be eligible for POS or PPO coverage.

Subscriber Eligibility

An employee is eligible for group coverage when the employee meets the following:

Maine

- Is a permanent employee who normally works 30 or more hours a week and, if coverage is also offered to part-time employees, is:
 - For a large employer group, a part-time employee who normally works at least 20 hours per week and is hired for a period of at least five months.
 - For a small employer group, a part-time employee who works 10 hours a week and 26 weeks per year, provided that the employer has one other employee who works 30 or more hours a week and 26 weeks per year.
- Is enrolled through an employer group that is current in the payment of the applicable premium for coverage.

A bona-fide employer/employee relationship must exist. Persons who are not bona-fide employees may be enrolled as subscribers under the following circumstances:

- When continuation of coverage is required by the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) or other applicable law; and
- When an employer allows an early retiree (or his or her dependents) to continue the HPHC coverage the early retiree received as an active employee and meets all HPHC underwriting guidelines, including payment of the same employer contribution as is paid for active employees.

Other categories of non-employees may be enrolled as subscribers with the written approval of HPHC.

Massachusetts

- Is a full-time employee who normally works 30 or more hours a week, and
- If coverage is also offered to part-time employees, is a part-time employee who works at least 20 hours per week, and is hired for a period of at least five consecutive months, and
- Is enrolled through an employer group that is current in the payment of the applicable premium for coverage.

A bona-fide employer/employee relationship must exist. Persons who are not bona-fide employees may be enrolled as subscribers under the following circumstances:

- When continuation of coverage is required by the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) or other applicable law; and
- When an employer allows an early retiree (or his or her dependents) to continue the HPHC coverage the early retiree received as an active employee and meets all HPHC underwriting guidelines, including payment of the same employer contribution as is paid for active employees.

Unless otherwise agreed to by HPHC, a temporary or seasonal employee, as defined below, is not eligible for coverage.

A **“temporary employee”** is an employee who works for an employer on either a full-time or parttime basis, whose employment is explicitly temporary in nature and does not exceed 12 consecutive weeks during the period from October 1 through September 30.

A **“seasonal employee”** is an employee (1) who is hired to perform services for wages by a seasonal employer under M.G.L. c. 151A during the seasonal period in Employer’s seasonal operations for a specific temporary seasonal period, (2) that has been notified by the Division of Unemployment Assistance that the employee is performing services in a seasonal employment for a seasonal employer, and (3) whose employment is limited to the beginning and ending dates of the employer’s seasonal period and does not exceed 16 weeks.

Other categories of non-employees may be enrolled as subscribers with the written approval of HPHC.

New Hampshire

- Is a permanent employee who normally works 30 or more hours a week. If coverage is also offered to part-time employees, is a part-time employee who normally works at least half of the weekly hours of a full-time employee or 15 hours per week, whichever is greater.
- Is enrolled through an employer group that is current in the payment of the applicable premium for coverage.

A bona-fide employer/employee relationship must exist. Persons who are not bona-fide employees may be enrolled as subscribers under the following circumstances:

- When continuation of coverage is required by the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) or other applicable law; and
- When an employer allows an early retiree (or his or her dependents) to continue the HPHC coverage the early retiree received as an active employee and meets all HPHC underwriting guidelines, including payment of the same employer contribution as is paid for active employees.

Other categories of non-employees may be enrolled as subscribers with the written approval of HPHC.

Rhode Island

- An employee who works on a full-time basis at least 30 hours a week; or
- At Employer's sole discretion, works on a full-time basis with a normal work week of between at least seventeen and one-half (17.5) and thirty (30) hours, so long as this criteria is applied uniformly among all of Employer's eligible employees; and
- Is enrolled through an employer group that is current in the payment of the applicable premium for coverage.

A bona-fide employer/employee relationship must exist. Persons who are not bona-fide employees may be enrolled as subscribers under the following circumstances:

- When continuation of coverage is required by the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) or other applicable law; and
- When an employer allows an early retiree (or his or her dependents) to continue the HPHC coverage the early retiree received as an active employee and meets all HPHC underwriting guidelines, including payment of the same employer contribution as is paid for active employees.

Dependent Eligibility

Below are the standard eligibility criteria for dependents enrolled through employer groups offering an HPHC plan. Employers may purchase additional coverage for dependents and may select different ages for the termination of dependents with the written approval of HPHC.

Unless an employer group has purchased coverage for additional categories of dependents, a dependent must be one of the following to be eligible for enrollment in the Plan:

Maine

1. The legal spouse of the subscriber, including a domestic partner.
2. A child (including an adopted child or stepchild) of the subscriber or spouse of the subscriber until the end of the month of the child's 26th birthday. Coverage through the Federal Exchange extends to the end of the plan year that the child's turns age 26.

3. A child (including an adopted child or stepchild) of the subscriber or spouse of the subscriber, age 26* years or older who meets each of the following requirements: (a) is currently disabled; (b) was disabled on his or her 26th birthday (c) lives either with the subscriber or spouse or in a licensed institution; and (d) remains financially dependent on the subscriber. The term "disabled" means unable to engage in any substantial gainful activity by reason of a specific medically determinable physical or mental impairment that can be expected to last, or has lasted, for at least 12 months or result in death.
4. A child who is under the age of 19* for whom the subscriber or subscriber's spouse is the court-appointed legal guardian. Proof of guardianship must be submitted to HPHC prior to enrollment.

Massachusetts

1. The legal spouse of the subscriber. A legal spouse means the same-sex or opposite-sex spouse of the subscriber who has entered into a legally valid marriage or civil union in a jurisdiction where such marriage or civil union is legal. HPHC recognizes same-sex spouses and partners in a civil union subject to the employer's eligibility policies.
2. The former spouse of the subscriber, until either the subscriber or the former spouse remarries, or until the divorce judgment between them no longer requires the subscriber to provide health coverage to the former spouse, whichever comes first. (Please note: after the remarriage of the subscriber, a former spouse may continue coverage through an individual contract if the provision of such coverage is (a) required by the divorce judgment and (b) the applicable premium for such coverage is paid to HPHC. There is no coverage for the former spouse after he or she remarries.)
3. A child (including an adopted child or stepchild) of the subscriber or spouse of the subscriber until the end of the month of the child's 26th birthday.
4. A child (including an adopted child) of the Eligible Participant or spouse of the Eligible Participant, who meets each of the following requirements: (a) is currently Disabled; (b) lives either with the Eligible Participant or spouse, in a licensed institution, or group home; and (c) remains financially dependent on the Eligible Participant.
5. A child who is under the age of 19* for whom the subscriber or subscriber's spouse is the court appointed legal guardian. Proof of guardianship must be submitted to HPHC prior to enrollment.
6. The child of an enrolled dependent child of the Subscriber (or the subscriber's enrolled spouse) until (a) the child's parent is no longer an eligible dependent, or (b) the child reaches age 19*, whichever occurs first. There is no coverage under this paragraph unless the enrolled dependent parent has legal custody of the child. The employer is responsible for managing dependent eligibility and removing them when they are no longer eligible (within the groups retroactive policy).

New Hampshire

1. The legal spouse of the subscriber, including a partner in a legal civil union.
2. A child (including an adopted child) of the subscriber or spouse of the subscriber until the end of the month of the child's 26th birthday. Coverage through the Federal Exchange extends to the end of the plan year that the child's turns age 26.
3. 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 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 shall apply the standard for determining disability under Title II of the Social Security Act. HPHC 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.

4. A child who is under the age of 19* for whom the subscriber or subscriber's spouse is the court appointed legal guardian. Proof of guardianship must be submitted to HPHC prior to enrollment.
5. The child of an eligible dependent of the subscriber until such time as the parent is no longer a dependent. The employer is responsible for managing dependent eligibility and removing them when they are no longer eligible (within the groups retroactive policy).

Please note that a divorced or separated spouse of the subscriber may be eligible for coverage under New Hampshire law in accordance with RSA 415:18 VII (g) (i). An individual who is totally disabled and whose coverage is terminated is eligible to obtain new coverage through the New Hampshire Health Insurance Marketplace.

Rhode Island

1. The legal spouse of the Eligible Participant.
2. The former spouse of the Eligible Participant, if such order is included in the divorce judgment, until either the Eligible Participant or the former spouse remarries or until the divorce judgment between them no longer requires the Eligible Participant to provide health coverage to the former spouse. If the former spouse of the Eligible Participant becomes eligible to participate in a comparable plan through his or her own employment, continuation of the plan coverage through the Eligible Participant will end.
3. A child (including an adopted child or stepchild) of the Eligible Participant or spouse of the Eligible Participant until the end of the month in which the child turns 26.
4. A child (including an adopted child or stepchild) of the Eligible Participant or spouse of the Eligible Participant, age 26* years or older who meets each of the following requirements: (a) is currently Disabled; (b) was Disabled on his or her 26th birthday; (c) lives either with the Eligible Participant or spouse or in a licensed institution; and (d) remains financially dependent on the Eligible Participant. The term "Disabled" means unable to engage in any substantial gainful activity by reason of a specific medically determinable physical or mental impairment which can be expected to last, or has lasted, for at least 12 months or result in death.
5. An unmarried child for whom the Eligible Participant or Eligible Participant's spouse is the court appointed legal guardian for the duration of the guardianship or until the end of the month in which the child turns 26, whichever occurs first. Proof of guardianship must be submitted to Harvard Pilgrim prior to enrollment.
6. The unmarried child of an eligible dependent of an Eligible Participant until such time as the parent is no longer a dependent.

** Age requirements may vary among employer groups provided that they are adjusted upward. Please refer to the dependent eligibility exhibit in your Employer Agreement or your Group Information Form for the age requirements that apply to your group.*

All States

The following categories of dependents are eligible **only if coverage is elected** by the employer and approved by HPHC:

- The subscriber's former spouse until either the subscriber or the former spouse remarries, unless the divorce judgment specifically states otherwise.
- The subscriber's sole domestic partner in accordance with HPHC's eligibility guidelines. HPHC may request evidence of domestic partnership, including an affidavit attesting that the eligibility criteria for domestic partnership are met.
- A dependent child of the subscriber's sole domestic partner under the terms and conditions described above as if such sole domestic partner were the subscriber's spouse.

Note: HPHC reserves the right to request payroll records, copies of birth certificates, marriage certificates or other documents as may be necessary to verify members' eligibility and employer contributions under this Agreement.

Disabled Dependents

HPHC provides continued coverage for child dependents who qualify as disabled dependents as detailed in the Dependent Eligibility section above.

Maine

The term “disabled” means unable to engage in any substantial gainful activity by reason of a specific medically determinable physical or mental impairment that can be expected to last or has lasted for at least 12 months or result in death. A person who is capable of working at any job in the economy will generally not be deemed “disabled” under this definition.

At the time of initial enrollment, or when the dependent reaches the age maximum while covered as an eligible dependent under the subscriber’s HPHC policy, HPHC requires a statement from the treating physician attesting to the dependent’s disability. Periodic recertification is required for disabled dependents that have been approved for a limited time period. Dependents verified as “permanently disabled” are eligible for the duration of the condition, until they lose eligibility. Eligibility may be lost by (1) ceasing to be financially dependent on the subscriber, or (2) termination of the subscriber’s contract.

It is the subscriber’s responsibility to notify HPHC of changes in status that affect a dependent’s eligibility. HPHC must receive notification of such changes within 60 days of the effective date of the change.

Massachusetts

The term “disabled” means unable to engage in any substantial gainful activity by reason of a specific medically determinable physical or mental impairment that can be expected to last or has lasted for at least 12 months or result in death.

At the time of initial enrollment, or when the dependent reaches the age maximum while covered as an eligible dependent under the subscriber’s HPHC policy, HPHC requires a statement from the treating physician attesting to the dependent’s disability. Periodic recertification is required for disabled dependents that have been approved for a limited time-period.

Dependents verified as “permanently disabled” are eligible for the duration of the condition, until they lose eligibility. Eligibility may be lost by (1) ceasing to be financially dependent on the subscriber, or (2) termination of the subscriber’s contract.

It is the subscriber’s responsibility to notify HPHC of changes in status that affect a dependent’s eligibility. HPHC must receive such changes within 60 days of the effective date of the change.

New Hampshire

An individual will be determined to be “disabled” by HPHC 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 shall apply the standard for determining disability under Title II of the Social Security Act. Harvard Pilgrim will require proof of such disability within 31 days following the date the individual would no longer be eligible due to age as described in the “Eligible Dependents” section above.

At the time of initial enrollment, or when the dependent reaches the age maximum while covered as an eligible dependent under the subscriber’s HPHC policy, HPHC requires a statement from the treating physician attesting to the dependent’s disability. Periodic recertification is required for disabled dependents that have been approved for a limited time period. Dependents verified as “permanently disabled” are eligible for the duration of the condition, until they lose eligibility. Eligibility may be lost by (1) ceasing to be financially dependent on the subscriber, or (2) termination of the subscriber’s contract.

It is the subscriber's responsibility to notify HPHC of changes in status that affect a dependent's eligibility. HPHC must receive notification of such changes within 60 days of the effective date of the change for additions and within 30 days of the effective date of the change for termination.

Rhode Island

The term "disabled" means unable to engage in any substantial gainful activity by reason of a specific medically determinable physical or mental impairment that can be expected to last or has lasted for at least 12 months or result in death. A person who is capable of working at any job in the economy will generally not be deemed "disabled" under this definition.

At the time of initial enrollment, or when the dependent reaches the age maximum while covered as an eligible dependent under the subscriber's HPHC policy, HPHC requires a statement from the treating physician attesting to the dependent's disability. Periodic recertification is required for disabled dependents that have been approved for a limited time period. Dependents verified as "permanently disabled" are eligible for the duration of the condition, until they lose eligibility. Eligibility may be lost by (1) ceasing to be financially dependent on the subscriber, or (2) termination of the subscriber's contract.

It is the subscriber's responsibility to notify HPHC of changes in status that affect a dependent's eligibility. HPHC must receive notification of such changes within 60 days of the effective date of the change.

Enrollment Effective Dates

Notification of Enrollment

Employers, brokers and TPAs should be aware that HPHC must be notified of enrollment requests within 60 days of the qualifying event to ensure enrollees of their coverage rights established for them by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other applicable law.

Notification of enrollments must be received by HPHC within 60 days of the effective date of coverage. If HPHC does not receive notification of enrollment within 60 days, the employee and/or the dependent(s) cannot be enrolled until the next open enrollment period or until a subsequent qualifying event. Please refer to the "Continuation Coverage" section for specific timeframes regarding COBRA.

Enrolled members who are contained in the HPHC membership data files are considered covered members for whom a premium is due. In addition, employers are required to pay monthly premiums for any member not properly terminated.

Qualifying Events: When Employees and Dependents May Enroll and Effective Dates of Coverage

Your eligible employees and their eligible dependents may enroll in the HPHC health plan(s) at the following times:

- During your company's annual open enrollment, or during a special open enrollment for your group as approved by HPHC. The effective date of coverage is the date stated on the *Group Information Form* or a date agreed upon by the employer group and HPHC.
- When an employee is newly hired or initially eligible under your company's policy. Your employer group may require a new employee to satisfy a probationary period before health care coverage begins. This policy must be specified on your *Group Information Form* and must be agreed to by HPHC. If your company does not require a probationary period, enrollment must become effective within 30 days of the date of hire, provided that proper enrollments are received by HPHC within 60 days of the effective date*. If rehire occurs within thirteen consecutive weeks after a break in employment, the waiting period will be waived. As part of the ACA Employer Responsibility provision, employers are potentially subject to penalties if they impose waiting periods for employees who have breaks in coverage of less than thirteen weeks.
- Upon a change in employment status making the employee eligible for coverage. For example, an existing employee may become newly eligible for coverage by increasing his hours from part-time to full-time. Coverage is effective either on the status change date or in accordance with the employer group's probationary period.
- Upon moving into the HPHC Enrollment Area as a permanent resident. Coverage is effective on the date permanent residency is established. (This requirement applies to The Harvard Pilgrim HMO only.)
- Pursuant to a court order. An employee may enroll a dependent child when a judgment, decree or order including a Qualified Medical Support Order (QMSO) is issued requiring health coverage for a child. Coverage is effective on the date specified in the court order. The employee is required to enroll in order to add his/her dependent.

For enrollment to cover a domestic partner, coverage will be effective on the last day the affidavit requirements have been fulfilled.

** Changes in probationary periods may be made no more than twice within two contract years. Requests must be submitted in writing to your Account Executive and approved by HPHC prior to the submission of an enrollment requests reflecting this new probationary period.*

Newborn Coverage

A newborn infant of a member is eligible for coverage under the Plan from the moment of birth. Coverage for a newborn child is effective from the moment of birth. In Maine, Rhode Island and New Hampshire, this coverage is effective for up to 31 days without additional premium. Coverage includes the Covered Benefits in this Handbook. 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. HPHC must receive notice and enroll the plan, additional premium may be required. HPHC must receive notice and the child must be enrolled in the Plan, if additional premium is required.

Please Note:

Generally newborn coverage is bundled with the mother's maternity coverage. When the mother is not an HPHC member, HPHC needs to be put on notice of delivery in order to cover the newborn's care. In addition, HPHC requires employers to offer special enrollment periods for eligible employees and their dependents as applicable in the following circumstances:

- When an employee and/or his dependents previously declined coverage with your employer group because other coverage was available, and subsequently lost such coverage involuntarily (including COBRA) or lose employer contributions. In this instance, the employee must request coverage from the employer group no later than 30 days from the date of loss or exhaustion of prior coverage. The effective date of coverage must be no later than the first day of the first calendar month following the request for coverage. (Documentation of loss of coverage must be provided with enrollments.)
- When an employee gains a new dependent due to marriage, birth or adoption. In these instances, the employee must request coverage from the employer group no later than 30 days after the marriage, birth, adoption or placement for adoption. Both the new dependent(s) and the employee may enroll pursuant to such event. Only the employee, his/her spouse and newborn are eligible to be added for this special qualifying event.
 - For new enrollment due to marriage, the coverage effective date is the date of marriage or no later than the first calendar month following the request for coverage from the employer group;
 - For new enrollment due to birth or adoption, the coverage effective date is:
 - For a newborn, on the date of birth.
 - For an adoptive child who has been living with the member and for whom the member has been receiving foster care payments, coverage is effective from the date of the petition to adopt.
 - For an adoptive child placed in a subscriber's home by a licensed adoption agency for purposes of adoption, coverage will be effective on the date of such placement in the home.
 - For an adoptive child placed with a subscriber for purposes of adoption by a licensed adoption agency in another state or in a foreign country, coverage is effective on the date the subscriber has legal and physical custody of the child. This means the subscriber has physical custody of the child and is free to return home with the child.

All health benefits under the Plan(s) are available to your employees as soon as they become effective as members.

Additional Provisions under Internal Revenue Code Section 125

According to Internal Revenue Service (IRS) regulations, a cafeteria plan must include a written plan document with rules concerning eligibility and qualifying events that allow an employee to make an election change.

The IRS regulations permit, but do not require, benefit election changes during the year based on a number of qualifying events such as:

- Changes in family status
- Separation from service
- Significant cost or coverage changes

If an Employer's HPHC plan coverage is offered under the Employer's Section 125 Cafeteria Plan, any requested enrollment change based on a qualifying event under the terms of that Section 125 Plan must satisfy HPHC's standard enrollment guidelines or be approved in writing by HPHC.

To request HPHC's approval, HPHC must be notified within thirty (30) days of the qualifying event and must be provided with a copy of the Employer's Section 125 Plan document.

HPHC will not approve any such request that HPHC, in its discretion, determines to be: (1) not permissible under the Employer's Section 125 Plan document or Section 125 of the Internal Revenue Code, or (2) in direct conflict with HPHC's standard enrollment guidelines, as interpreted by HPHC.

Enrolling New Members

How to Enroll Employees and Dependents

HPHC offers four methods of enrollment: The secure *Employer Account* (our secure web-based tool), Express Enrollment (batch file processing via the *Employer Account*), Electronic Data Interchange (used by employers to submit batch enrollment transactions electronically) and HPHC paper enrollment/change forms. Our standard method of enrollment is the *Employer Account*, which performs online validation to prevent the submission of incomplete or inaccurate enrollment transactions. provides faster processing time and improved service to our employers and their employees.

Employer Account

Enrollment requests for employees and their eligible dependent(s) can be submitted to HPHC via the *Employer Account*. This secure web-based enrollment tool offers the option for employers, employees, brokers or third-party administrators to enter enrollment information directly, eliminating the delays and streamlining the process associated with the manual entry of paper enrollment forms. Employers may choose to allow employees to add family members due to qualifying events, unenroll family members who are leaving the Plan, change products offered by the employer and change their personal information (e.g., primary care physician [PCP], name, address, phone number and email).

Express Enrollment

Enroll new members faster and more efficiently with Express Enrollment, our latest *Employer Account* self-service feature. Express Enrollment will let you enroll new employer groups on the *Employer Account* simply by uploading an Excel file in our required format. (Express Enrollment is for new policies only; for plan changes, demographic updates or adding a dependent, please use existing the *Employer Account* functionality.)

All enrollments, changes and terminations are sent to the employer for verification and approval, before being submitted electronically to HPHC.

For more information on *Employer Account*, go to harvardpilgrim.org or contact the Broker/Employer Services Team at **800-637-4751**.

Electronic Data Interchange

Some employers have the option of using the Electronic Data Interchange (EDI) enrollment process. This high-volume method for employers is used to submit enrollments or changes of their employee health benefits through a secure batch file transmission. The EDI process must be approved by HPHC before being used as a method of enrollment by an employer group. Contact your Broker/Employer Services Coordinator for more information regarding EDI.

Enrollment/Change Forms

For employers who are unable to submit enrollment requests via the *Employer Accounts* or EDI, HPHC will accept manually completed enrollment/change forms.

The enrollment/change form collects necessary Member information that is used for accurate enrollment. The HMO, Open Access HMO, POS and PPO and Medicare Enhance plans each have their own enrollment/change form. The enrollment/change form must be filled out completely and legibly. When an employee completes the form, it should be returned directly to the employer's benefits officer. **Incomplete forms will delay enrollment processing and the issuance of ID cards and may result in a denial of enrollment.**

Please note that HPHC processes enrollment/change forms in the order in which they are received. Employers should submit them within 60 days of the qualifying event to ensure accurate and timely enrollment of employees. If HPHC does not receive the form prior to the effective date, services may be denied.

Notification of enrollment requests must be received within 60 days of the effective date of coverage. If HPHC does not receive notification of enrollment within 60 days, the employee and/or the dependent(s) cannot be enrolled until the next open enrollment period or until a subsequent qualifying event.

PCP Selection Requirements

All members must choose a PCP upon enrollment in The Harvard Pilgrim HMO and POS plans in Massachusetts, Maine and New Hampshire. Members of The Harvard Pilgrim POS plan must select a PCP to make use of their in-network benefits. Members of the Rhode Island HMO and PPO plans must also designate a PCP. The PCP is responsible for providing or arranging most of the member's medical care. Therefore, if a PCP is not selected, non-emergency and most specialty care may not be covered or may be subject to additional member out-of-pocket expenses.

Note: In accordance with American Medical Association guidelines, HPHC prohibits a member from selecting a PCP who is an immediate family member.

Completing the Enrollment/Change Form to Enroll a Member

Please review the completed form to make sure all of the information is filled in. The form can be accessed [here](#).

- Send a copy of the application to HPHC's Enrollment and Billing Department.
- Retain a copy for your files.
- Give a copy to the employee for his/her records.

Completed enrollment/change forms must be mailed to:

Harvard Pilgrim Health Care
PO Box 9185
Quincy, MA 02269

Note: Whenever possible, HPHC should receive the enrollment form before the member's effective date of coverage. However, when a member needs urgent care in the next 24-48 hours, and HPHC has not yet received notification of the enrollment, you may call our Broker/Employer Services Team at **800-637-4751** to confirm coverage.

Changing a Member's Status, Including Termination

Reporting a Change in a Member's Status

HPHC requires notice of certain changes in a member's status. An enrollment/change request must be submitted for the following:

- Change from one coverage type to another. For example, when an employee changes from individual to family coverage to add an eligible dependent or from family to individual coverage to remove a dependent.
- Change from one HPHC plan to another HPHC plan (for example, a change from The Harvard Pilgrim HMO to The Harvard Pilgrim POS). These changes may be done at the following times: on the anniversary date, during a special open enrollment approved by HPHC, or when a member permanently moves into or out of the HPHC Enrollment Area
- Change in subscriber's or dependent's marital status
- Change in dependent status
- Addition of a dependent(s) due to birth, adoption or court order
- Change of the subscriber's or dependent's legal name
- Change of subscriber's or dependent's address that affects eligibility due to HPHC's Enrollment Area requirements
- Termination of dependent(s) who is no longer eligible or who will no longer be covered under the subscriber's policy

HPHC requests notice of member changes or a member termination of coverage prior to the effective date of the change or termination:

- If notification of an enrollment, re-enrollment or change request is received more than 60 days after the effective date, coverage will be denied and the requestor must wait for another qualifying event or the next open enrollment period for further consideration
- If notification of a member termination request is received more than 60 days after the desired termination date, the termination date will be set 60 days retroactive beginning on the date the notice was received by HPHC, and the employer will be required to pay the applicable monthly premium for coverage provided prior to the termination effective date.
- In New Hampshire, if notification of a member termination request is received more than 30 days after the desired termination date, the termination date will be set 30 days retroactive beginning on the date the notice was received by HPHC, and the employer will be required to pay the applicable monthly premium for coverage provided prior to the termination effective date.

Any member whose employer has an *Employer Account* can make the following changes online or by calling Member Services at **888-333-4742**:

- Spelling correction of a member's name
- Change of address
- Change of PCP (not applicable to members of The Harvard Pilgrim PPO plan). The PCP change is effective on the date of the call
- Change in other insurance information affecting coordination of benefits
- Adding a newborn child to an existing family plan

Some employer groups require employees to notify them first of these changes. Contact the Broker/Employer Services Team at **800-637-4751** if this applies to your company. HPHC will help to ensure the appropriate notation is placed in our system to prevent these changes from being made through our Member Services department. However, HPHC cannot guarantee 100% compliance with this request and cannot be held liable for claims incurred.

Methods to Use When Reporting a Change in Member Status

Employer Account

The *Employer Account* allows you and your employees to enter enrollment information directly and securely online, eliminating the delays and streamlining the process associated with the manual processing of the paper *Enrollment/Change Form*. Employees may be given secured access to their HPHC enrollment records to make status changes. Once submitted, the changes are sent to the employer for verification and approval, before being submitted electronically to HPHC.

EDI

If your group uses EDI for enrollment, changes in status must be sent according to the transmission format and schedule agreed to by the employer group and HPHC. Submitting enrollment transactions via EDI must first be approved by HPHC.

Enrollment/Change Form

The Enrollment/Change Form can be accessed [here](#). Please complete this fillable form, print and send it to:
Harvard Pilgrim Health Care
PO Box 9185
Quincy, MA 02269

Please make special note of the following sections:

Section 1 - Reason for Submission: Check off the appropriate box for the type of change(s) being reported. For example, if an employee had individual coverage and wishes to add a dependent, he or she must change to family coverage. You should check the box marked "Change Coverage Type," and indicate that the change is from individual to family. Be sure to include any other changes such as name or address and attach any supporting documentation.

Section 5 - In most cases, the effective date of coverage will be the date of the qualifying event. For a Qualified Medical Support Order (QMSO) and/or court order please list the applicable date.

Section 6 - Employee's Full Name, Address and Telephone Number(s): If the employee is changing his/her name, only the new name should be listed.

Section 8 - For all members: Full Name, Language Code, Date of Birth, Sex, Relationship Code, Social Security Number, and PCP and Town selection for each member listed. Each person listed must also indicate if he is an established patient of the PCP he has chosen. (PCP selection applies only to The Harvard Pilgrim HMO and POS plans.)

Terminating Subscriber Coverage

Reporting Subscriber Contract Terminations

HPHC requires notification from the employer group to terminate a subscriber's contract. Notice is required in the following cases: when an employee terminates employment, has a reduction in hours that results in a loss of eligibility for coverage; elects to voluntarily terminate membership, switches to another plan at open enrollment, or otherwise terminates his entire membership with HPHC.

Employers should notify HPHC prior to the effective date of the termination of employee coverage. If notice of a termination is received by HPHC more than 60 days (30 days in NH) after the desired termination date, the termination date will be set 60 days (30 days in NH) retroactive beginning on the date the notice was received by HPHC. Employers are responsible for the payment of any premium due for coverage provided prior to the termination effective date.

Coverage ends at midnight on the date a member's coverage is terminated. There is no coverage for any services received after midnight on the date a member's coverage terminates. All authorizations for services issued by HPHC or participating providers assume confirmation of membership and are invalid after termination of membership, including retroactive terminations.

Methods for Reporting Subscriber Contract Terminations

Employers may report terminations by any of the following methods:

Employer Account

Terminating employees and their dependents can occur through the *Employer Account*. Employers are encouraged to enter terminations immediately and receive confirmation of the termination through the *Employer Account*. This method is the most direct and reliable way to terminate members prior to the next premium invoice cycle.

Terminations can also be completed using the online billing feature available in the *Employer Account*. If processed prior to the final bill date, entering terminations in this manner will automatically adjust the balance due for that billing month.

EDI

Termination information may be transmitted during the regularly scheduled file transfers between the employer group and HPHC.

Enrollment/Change Form

This form may be used to terminate the subscriber's entire contract. Please provide the following information: (See sample **form**)

- Reason for submission and check off "Termination" and reason for termination
- Your group/customer account number
- The subscriber's ID number (HPHC contract or Social Security number)
- The employee's full name and address
- The termination date in the "Effective Date" box*
- Employer signature and date. The employee's signature is not required on a subscriber termination.

Do not mark up your monthly invoice or send in terminations with your premium payment. This will delay the processing of the terminations and the reflection of termination credits on your invoice. If you are reporting terminations for individual member(s) other than a subscriber, refer to the "Reporting a Change in a Member's Status" section of this guide

Consistent with HIPAA Privacy Rule provisions, if terminations and enrollments are reported via email, information must be contained within a password-protected file prior to transmission.

** Please note that enrollment/change forms submitted to HPHC with termination effective dates on the first of the month will be changed to the last day of the previous coverage month when processed. For example, if the Enrollment/Change Form is received with an effective date of May 1, HPHC will process the transaction effective April 30. Coverage will be effective until midnight on April 30.*

Continuation Coverage

Continuation coverage is governed by both federal and state law.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986)

The federal law known as COBRA establishes requirements for employers to provide continuing health care benefits for employees and their dependents upon certain "qualifying events."

Who is subject to COBRA?

Most employers with 20 or more employees are subject to COBRA and must offer employees and their eligible dependents the option to continue group health insurance coverage at the employee's expense for specific lengths of time. The federal government does not recognize domestic partners as eligible dependents and as such, they are not considered eligible COBRA beneficiaries, unless the employee also elects COBRA coverage. For employer groups that provide coverage for domestic partners, HPHC will approve requests from employer groups to offer COBRA continuation coverage to domestic partners. However, employers who exercise this option should consult their tax counsel to understand the tax implications of this choice.

What is a COBRA "qualifying event"?

Under COBRA, a qualifying event is one of the following specified events that cause a covered employee or his or her spouse and dependents to lose regular health plan coverage:

- Termination of employment (other than for gross misconduct) or the reduction of hours of a covered employee
- Divorce or legal separation from a covered employee
- Death of a covered employee
- A covered employee's entitlement to Medicare
- A child's loss of dependent status under the group health plan (e.g., no longer student verified)
- The start of bankruptcy proceedings with respect to an employer that provides health plan coverage to retirees

According to COBRA, a loss of coverage means that health care benefits cease to be covered under the same terms and conditions as in effect immediately before the qualifying event. For example, a loss of coverage includes an increase in employee premium or contribution related to a reduction of hours. For employer bankruptcies, the term loss of coverage means a substantial elimination of coverage that occurs within 12 months before or after the date on which the bankruptcy proceedings begin.

Who is a Qualified Beneficiary Under COBRA?

In general, a qualified beneficiary under COBRA is:

- Any individual who is covered under a group health plan, either as a covered employee or dependent, on the day before a qualifying event
- Any child born to or placed for adoption with a covered employee during a period of COBRA continuation of coverage
- With respect to the bankruptcy of an employer, any covered employee who retired on or before the date of any substantial elimination of group health coverage; and the spouse, surviving spouse, or dependent child of the covered employee provided such dependents were covered by the group health plan on the day before the bankruptcy qualifying event.

A covered employee can be a qualified beneficiary only in connection with a qualifying event that is either the termination of employment or reduction of hours.

When should COBRA coverage be elected?

To elect COBRA coverage, an eligible individual has 60 days from the later of the date of the qualifying event or the date COBRA election notice is provided.

May COBRA coverage be extended?

COBRA coverage generally lasts 18 months for subscribers and up to 36 months for eligible dependents. (See Table 3 on page 31). However, COBRA coverage may be extended in certain situations.

- **Disability extension:** Persons covered under COBRA due to a termination of employment or a reduction in hours may obtain an 11-month COBRA extension due to disability. To be eligible for this extension, the employee or family members must be deemed disabled within 60 days of the qualifying event. All covered family members are entitled to the 11-month extension.
- **Extension for multiple qualifying events:** If more than one qualifying event occurs during the initial 18-month coverage period or the 11-month extension period, coverage may be extended up to a maximum of 36 months from the date of the original qualifying event. An example of a multiple qualifying event is when an employee elects COBRA coverage due to a reduction in hours (first qualifying event) and, subsequently, the employee's covered dependent loses eligibility due to reaching the maximum age under the Plan (second qualifying event). In this case, the covered dependent is entitled to an 18-month extension for a total of up to 36 months of COBRA coverage.

Other circumstances also may entitle an employee and eligible dependents to extend COBRA coverage. Employers should consult with their legal counsel for an understanding of such situations.

Employer Election Notification Responsibilities

It's the employer's responsibility to notify employees, spouses and dependents of their rights under COBRA, and to notify HPHC when persons elect to continue coverage. Below are COBRA notification requirements:

- Employers are required to provide a notice of COBRA rights to covered employees and spouses upon enrollment in a group health plan
- In the event of a covered employee's reduction of hours or termination, the employer must notify the eligible individuals of their COBRA rights at the time of the qualifying event
- In the event of a dependent reaching maximum age, a divorce or a legal separation, the employee must notify the employer within 60 days of the event. The employer then has 14 days to notify the subscriber and dependent(s) of their COBRA rights
- In the event of the covered employee's death or Medicare entitlement or the employer's bankruptcy, the Employer has 14 days from the notice of such event to notify the eligible individuals of their COBRA rights
- Upon receipt of the notice of COBRA rights, eligible individuals have 60 days to elect COBRA. Each eligible member has an independent right to elect COBRA coverage

Note: Employers who use a TPA have an additional 30 days to notify their plan administrator.

HPHC requests the following:

- As soon as possible after the qualifying event occurs (but within 60 days), submit a termination request via the *Employer Account*, approved EDI transaction or an enrollment/change form to remove the employee, spouse, and/or dependent(s) from your group coverage. This step will relieve you of your responsibility for those premium payments during the member's election period
- When the eligible individual(s) elects the continuation coverage, submit an enrollment request via the *Employer Account* or approved EDI transaction. If an enrollment/change form is used, it must indicate the effective date of COBRA and the Reason for Submission as "COBRA Reinstatement"

Employer Responsibility to Respond to Member Eligibility Inquiries from Providers

From time to time, HPHC receives inquiries from medical providers about eligibility for coverage under the employer group's health plan. Under COBRA, employers have an obligation to respond to such inquiries.

HPHC's practice is to advise medical providers whether an individual is an active or inactive HPHC member. However, HPHC also may inform the provider that only the Employer is able to give complete and definitive information on member eligibility due to retroactive enrollments or dis-enrollments that may relate to COBRA election or other events. Employers are required to respond to any such provider inquiry with information about a member's coverage, including any applicable COBRA election period.

Premium Payment

As the Employer, you are responsible for collecting premium payments for those individuals covered under COBRA. Under COBRA law, you are allowed to charge up to 102% of the group premium amount. Subscribers, whose coverage is extended from 18 to 29 months due to Social Security disability, may be required to pay up to 150% of the group premium amount after the 18 months.

Exhaustion of COBRA Coverage

Persons who exhaust their continuation of group coverage under COBRA may be eligible for coverage in HPHC's nongroup plan. (Please refer to the Nongroup Coverage section of this guide for eligibility requirements.) Members interested in applying for the nongroup plan should call Member Services at **888-333-4742**.

Nongroup enrollment is limited to defined open enrollment periods. For information on nongroup enrollment rights, an individual may contact Member Services at **888-333-4742**. The law also permits enrollment outside of an open enrollment period under certain circumstances, such as, in many instances, the loss of other health insurance coverage. In most instances, an individual must apply for nongroup coverage within 63 days of their loss of coverage or wait until the next open enrollment period.

For specific information on COBRA requirements and your responsibility under COBRA, you should consult your company's legal counsel. The penalties for noncompliance with COBRA are severe and may lead to fines under the Internal Revenue Code, ERISA and the Public Health Service Act.

Additionally, you may obtain information on COBRA from the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) at 866-444-EBSA (3272) or visit the Department of Labor's website at dol.gov/dol/topic/health-plans/cobra.htm.

Mini-COBRA under Massachusetts (M.G.L. Chapter 176J Section 9)

"Mini-COBRA" is the Massachusetts law that establishes requirements for employers with 2 to 19 employees to provide continuation coverage for eligible employees and their eligible dependents.

The coverage obligations under Mini-COBRA are essentially the same as those required by the federal COBRA statute.

See table below for continuation coverage qualifying events, eligible individuals and the applicable coverage period.

HPHC requires all employers with 2 to 19 employees to provide eligible employees notice of their Mini-COBRA rights. This notice of rights must be given to employees and their spouses, if applicable: (1) at the time of hire, and (2) within 14 days of the date of the qualifying event. You must allow employees 60 days from the qualifying event or date of notice, whichever is later, to elect continuation coverage. Additionally, you must notify HPHC when the continuation period expires.

Qualifying Events for Federal COBRA Continuation Coverage and Massachusetts Mini-COBRA Continuation Coverage

Qualifying Event	Who is Eligible for Continuation Coverage	Standard Coverage Period
Reduction of hours (may include strike, layoff, regular and medical leave of absence and military duty), or termination of subscriber's employment (except termination for gross misconduct)	Subscriber and dependents	18 months*
Divorce or legal separation (the remarriage of a subscriber is not a qualifying event)	Dependents	36 months
Subscriber becomes entitled to Medicare	Dependents	36 months
A child reaches the maximum age for group coverage as a dependent or the child is no longer a full-time student	Dependent child	36 months
Death of the subscriber	Dependents	36 months
Bankruptcy proceeding	Retiree, and spouse of retiree and dependent child	Lifetime; until the retiree dies, then up to 36 months

* Coverage may be extended to a maximum of 29 months for the subscriber and dependents if any such member is determined to be disabled for Social Security disability purposes within 60 days of the qualifying event.

Rhode Island

Extended Medical Benefits (Rhode Island General Laws chapter 27-19.1-1)

Rhode Island Extended Medical Benefits (Rhode Island General Laws chapter 27-19.1-1) provides "mini-COBRA" coverage for medical benefits for those who lose eligibility to participate in a group medical insurance plan. Plan benefits may be continued for a period of up to eighteen (18) months from the termination date of the insured member when the insured member is terminated because of:

- Involuntary layoff or death,
- Workplace ceasing to exist, or
- Permanent reduction in size of the workforce.

Continuation may not exceed the shorter of the period which represents the period of continuous employment preceding termination with the employer under whose contract the member is insured or the time from the termination date of the insured member until the member, surviving spouse of a deceased member, and any other dependent(s) of the member who were covered under the plan ("Qualified Beneficiaries"), becomes employed by another group and eligible for benefits under another group plan.

Extended coverage must be elected within thirty (30) days after qualifying event. The extended coverage for the period shall be available to the Qualified Beneficiaries at:

- The same monthly premium rate or subscription fee for the group in which they were previously a member, or
- The monthly premium rate or subscription fee currently in effect for the same group subsequent to their qualification

The Qualified Beneficiary shall not be required to pay more than a monthly premium rate or subscription fee per month at one time.

Continuation Coverage for Maine and New Hampshire

Continuation of Coverage under Maine Law (24-A M.R.S.A. section 2809-A)

Maine law provides for the continuation of group health coverage under a variety of circumstances.

Continuation of coverage is available if an employee's group insurance coverage is terminated for one of the following reasons:

- The member or employee was temporarily laid off;
- The member or employee was permanently laid off and is eligible for premium assistance pursuant to federal law providing premium assistance for laid-off employees who continue coverage under their former employer's group health plan; or
- The member or employee lost employment because of an injury or disease that the employee claims to be compensable under former Title 39 or Title 39-A.

Members have 31 days from the date of coverage to elect continuation coverage and make the initial payment.

The extension periods available under this Maine continuation coverage are immediately terminated upon the occurrence of any of the following:

- Member becomes eligible for other group coverage
- Member fails to pay premiums
- The Workers' Compensation Board determines that the injury or disease that entitles the employee to continue coverage under this section is not compensable under Title 39-A.

Continuation Coverage under New Hampshire Law

New Hampshire law provides for the continuation of group health coverage under a variety of circumstances. These laws apply to groups of all sizes except that the laws described under the heading "Ineligibility for Group Coverage" do not apply to small employers with one employee.

1. Termination ending from strike, walkout or labor dispute

The Member may elect to continue coverage under HPHC when coverage is terminated as a result of a strike, lockout or other labor dispute. The member shall notify the employer group in writing of his or her election and pay the required premium within 30 days from the date coverage would otherwise terminate. The member is responsible for payment of the full premium, including the employer contribution. This coverage terminates on the earliest of the following dates:

- a) Six months from the date coverage would otherwise have ended;
- b) The date the agreement between HPHC and the employer is ended;
- c) The last date for which HPHC has received premium;
- d) The date the member becomes employed by another employer;
- e) The date a dependent no longer qualifies as a dependent.

At the end of a six-month period of such coverage, coverage may continue for an additional 12 months if the circumstances meet the requirements of the next paragraph.

2. State Continuation of Coverage (Ineligibility for Group Coverage)

When a member becomes ineligible for employer group coverage, the member may be entitled to continue coverage for an extension period of 18 to 36 months or until the member becomes eligible for full benefits through another employer group, whichever occurs first.

To be eligible, the member must have been enrolled though a subscriber who was not discharged for gross misconduct. The period of continued eligibility may vary depending on circumstances stated in the law, as summarized in the table on the following page.

A member must notify the employer of his election to continue coverage within 45 days of loss of eligibility. The member is responsible for making timely payments (within 30 days) to the employer group, which is responsible for making timely payment to HPHC. The premium may include an administration fee of up to two percent of the group premium.

The extension periods available under this New Hampshire continuation coverage may be terminated upon the occurrence of any of the following:

- Member becomes eligible for other group coverage
- Member becomes eligible for Medicare
- Member fails to pay premiums (assuming a grace period of 30 days)

3. Termination of a Group Policy or Contract

Upon the termination of the group policy or contract, members are entitled to continue coverage under the Plan for an extension period of up to 39 weeks or the date the member becomes eligible for health benefits under another plan, whichever occurs first.

HPHC will notify members of the option to continue coverage under this statute. Members must notify HPHC of the election of coverage and include the payment of the first monthly premium within 31 days of the date such notice was sent. The premium will include an administration fee of up to 2% of the group premium.

Qualifying Events for New Hampshire Continuation Coverage

Qualifying Event	Who is Eligible for Continuation Coverage	Standard Coverage Period
Voluntary or involuntary termination of subscriber’s employment (except termination for gross misconduct)	Subscriber and Dependents	18 months*
Divorce or legal separation: <ul style="list-style-type: none"> • Ex-spouse under 55 • Ex-spouse age 55 or older 	Dependents	36 months for ex-spouses under 55
		Unlimited for ex-spouses age 55 or older until: <ul style="list-style-type: none"> • Eligibility for other group coverage • Medicare eligibility
Subscriber becomes entitled to Medicare	Dependents	36 months

Qualifying Event	Who is Eligible for Continuation Coverage	Standard Coverage Period
A child reaches the maximum age for group coverage as a dependent or the child is no longer a full-time student	Dependent child	36 months
Death of the subscriber	Dependents	36 months
	Dependents age 55 and older	Unlimited until: <ul style="list-style-type: none"> • Eligibility for other group coverage • Medicare eligibility
Coverage reduction or termination within one year of Employer Group filing for Title 11 Bankruptcy	Subscriber and dependents	36 months

* Coverage may be extended to a maximum of 29 months for the subscriber and dependents if any such Member is determined to be disabled for Social Security disability purposes within 60 days of the qualifying event.

Continuation Coverage for Divorced or Separated Spouses

Massachusetts (M.G.L. Chapter 176G Section 5A and M.G.L. Chapter 175 Section 110I)

Massachusetts law requires all employer groups covered under an insured health plan in Massachusetts, including national employer groups, to provide continuation coverage through the employer group's health plan, at no additional premium, for divorced or separated spouses who otherwise would lose coverage due to loss of eligibility.

Coverage for divorced or separated spouses must continue through the employer group as long as the subscriber remains enrolled and until either the subscriber or the former spouse remarries (the only exception to this requirement must be established by a divorce decree). This coverage is available to the former spouse only while the subscriber continues to be a HPHC Member.

Upon remarriage of the subscriber, if the divorce decree requires the subscriber to continue to make coverage available to former spouse, HPHC and the employer group must comply with the divorce decree. In this case, the former spouse may obtain identical benefits and rates either through: (1) an individual policy under the employer group plan or (2) a special plan administered by and payable directly to HPHC.

New Hampshire

A divorced or legally separated spouse is entitled to continuation coverage for an extension period of 36 months or until he or she becomes eligible for full benefits through another employer group, whichever occurs first. A divorced or legally separated spouse age 55 or older is entitled to continue coverage for an extension period that lasts until he or she becomes eligible for other group health coverage or Medicare.

Continuation coverage must be requested in writing within 30 days of the date of the divorce decree by either the divorced or legally separated spouse, or the subscriber, whoever is responsible for payment of premium.

The individual responsible for payment must make timely payment to the employer group, which must make timely payment to HPHC. The employer may add a two percent administrative fee. Where the divorced or legally separated spouse is responsible for payment, the employer group may terminate coverage for failure to pay premium, following a grace period of 30 days. Where the subscriber is responsible for payment, the employer must give the divorced or legally separated spouse 30 days prior written notice before terminating coverage for the subscriber's non-payment of premium, during which time the divorced or legally separated spouse may opt to pay the premium directly and continue coverage. Upon termination of the extension period, the divorced or legally separated spouse may elect conversion coverage, if available.

For employer groups with 20 or more employees, this type of continuation coverage overlaps with federal COBRA continuation coverage. The employer group should advise the employee to select either this New Hampshire continuation coverage or federal COBRA coverage, whichever is more advantageous, depending on individual circumstances.

Continuation Coverage due to Plant Closing or Partial Plant Closing (M.G.L. Chapter 176G Section 4A and M.G.L. Chapter 175 Section 110D and 110G)

Massachusetts law requires employer groups to provide continuation coverage for existing members who would otherwise lose coverage due to a plant closing or partial plant closing. Continuation coverage for plant closings must extend, at the employer group's expense, for 90 days or until the member obtains similar coverage, whichever comes first. Employer groups are responsible for notifying employees of their continuation rights under this law.

Nongroup Coverage

When a member loses coverage through your employer group, he or she may be eligible to enroll in a nongroup plan issued by HPHC or one of its affiliated health plans. Such coverage is only available to residents of the states in which HPHC or one of its affiliates offer non group coverage at the time such coverage is sought. (At the time of this writing, HPHC and its affiliates offer nongroup plans to residents of Massachusetts and Maine.) Individual policies may also be available through state health insurance exchanges, high risk pools and reinsurance associations.

The applicant may enroll only in a non-group plan available in his or her state of residence. Benefits vary by state and are different than those offered under the member's group plan. Coverage purchased directly from HPHC may be different than the coverage under their previous employer-sponsored plan.

Maine residents: To explore all individual plan options, individuals can visit the Maine Health Insurance Marketplace at [CoverMe.gov](https://coverme.gov). If they wish to purchase a non-group plan from HPHC, we must receive their application within 90 days of their last date of employer coverage.

Massachusetts residents: To explore all individual plan options, individuals can visit the Massachusetts Health Connector at mahealthconnector.org or call the number below. The plans that HPHC sells on a direct basis are called Buy Direct. Individuals can obtain rates for these plans by using our online quoting and enrollment tool at harvardpilgrim.org. Those without Internet access can call us at **800-208-1221**.

If a dependent is a Massachusetts resident between 18 and 26 years of age, he or she may be eligible to enroll in Harvard Pilgrim's Pulse Plan, which is offered exclusively through the Massachusetts Health Connector. They can visit mahealthconnector.org or call **800-208-1221** for Pulse Plan questions.

New Hampshire residents: New Hampshire residents are eligible to purchase an individual policy from the New Hampshire high-risk pool. To receive more information about this plan, including rates and an application, individuals can call the New Hampshire Health Plan at **877-888-6447** or go to nhhealthplan.org. They may also be able to purchase individual coverage from another carrier. They may contact the New Hampshire Insurance Department at **800-852-3416** or go to nh.gov/insurance for information on companies that offer individual health policies in New Hampshire. Please note: If they wish to apply for individual coverage, they should submit their application to the new insurance carrier as soon as possible.

Please note that the rules concerning nongroup enrollment vary from state to state. For example, in some states, no coverage is available unless an application is made within 63 days of the last day of coverage under the terminating plan. In other states, a late applicant may only be able to obtain coverage that is subject to a waiting period for most benefits.

For information on nongroup rates and benefits, or to obtain a nongroup application, please call the Member Services Department at **888-333-4742**.

Rhode Island Residents: To explore all individual plan options, individuals can visit the HealthSource RI website at healthsourceri.com.

Maine – Persons 65 and Over

Federal regulations require that most employers of 20 or more employees offer their active employees and/or spouses ages 65 or over the option to continue coverage through their regular group plan.

Please contact your Sales account executive if you need more information.

Medicare Eligibles

Letters to HPHC Members Approaching Age 65

HPHC will mail letters to Members who are approaching their 65th birthday concerning their Medicare coverage options. For employers that do not offer group retiree coverage, HPHC will mail Members information concerning their option to enroll in an HPHC Medicare Supplement Plan. Where an employer provides group retiree coverage HPHC will mail Members a letter concerning their option to enroll in HPHC's Medicare Enhance Plan.

If you have questions about this process or the Medicare Supplement or Medicare Enhance products offered by HPHC, please contact your Sales account executive at (800) 848-9995.

Medicare Secondary Payer Provisions (42 U.S.C. Section 1395y(b))

Employer Groups offering group health coverage to Medicare beneficiaries are required to comply with Medicare Secondary Payer (MSP) rules established by CMS, the federal agency that administers the Medicare program.

Under these rules, Medicare is the secondary payer and the employer-sponsored health plan is the primary payer for the following categories of Medicare beneficiaries:

- The "working aged," meaning people who:
 - are eligible for Medicare on the basis of age
 - are covered by an employer group health plan of an employer with 20 or more employees have such group coverage by virtue of their own current employment or the current employment of their spouse
- People with disabilities, meaning people who:
 - are eligible for Medicare solely on the basis of disability (under age 65)
 - are covered by an employer group health plan of an employer with 100 or more employees
 - have such group coverage by virtue of their own current employment or the current employment of a family member
- People with permanent kidney failure or End Stage Renal Disease (ESRD) who:
 - became eligible for Medicare on the basis of ESRD when they were under age 65, and
 - are covered by an employer group health plan of an employer of any size by virtue of their own current or former employment or by the current or former employment of a family member.

For persons in this category, Medicare is the secondary payer and the group health plan is the primary payer for the first 30 months of Medicare entitlement.

Additionally, Medicare generally is the secondary payer for health services also covered by a workers' compensation law or plan, no-fault insurance (including automobile no-fault insurance), and any liability insurance policy or plan.

Employer Medicare Secondary Payer Responsibilities

Employers have numerous responsibilities under the MSP laws. To fully understand MSP obligations, HPHC encourages employers to consult with their legal counsel. The following is an overview of selected Employer responsibilities under the MSP laws:

- Follow the MSP rules to correctly determine their number of employees
- Identify Medicare beneficiaries (both active employees and retirees) to whom the MSP provisions apply
- Ensure primary payment is made when Medicare is the secondary payer
- Ensure that there is no discrimination with respect to group health coverage for Medicare beneficiaries for whom Medicare is the secondary payer, and no incentive for such beneficiaries to reject group health coverage
- Respond to “data match” inquiries from CMS

Important: the MSP provisions are highly technical. The summary listed above is intended as general information only. For specific information on MSP requirements and your responsibility under MSP provisions, consult your company’s legal counsel.

For information on MSP requirements, you may write to:

U.S. Department of Health and Human Services
The Centers for Medicare & Medicaid Services
6325 Security Boulevard
Baltimore, MD, 21207-5187

Premiums

Online Billing

HPHC provides a free online billing service to employer groups via the *Employer Account*. Online billing allows you to manage your invoice in a secure environment, making bill payment quicker, easier and more accurate.

With online billing, you will receive a preliminary bill on or about the 10th of each month. This provides you with a “preview” of what your next month’s bill will look like, allowing you to focus on any adjustments that need to be made.

HPHC’s online billing also lets you select a final bill date to align with your business processes. The final bill will reflect your premium due based on all membership changes made since your preliminary bill was presented. You will be allowed to select one of the following dates: 15th or 25th as your final bill presentment date.

Consolidated Billing

Consolidated billing is a billing method which allows Customer accounts to be combined for the purpose of invoice presentment. This method facilitates streamlined billing and payment processing based on customer needs.

New customer will default to the consolidated invoicing process. All divisions set up under a single customer number will be combined onto one invoice. Each summary account created will receive one consolidated invoice and will enable the customer to only submit one payment.

Premium breakdown by customer account will still be available. The consolidated invoice will create one balance which will be calculated and reconciled at the consolidated level.

Cash will be applied to the oldest open invoice first. The customer will be able to extract a single invoice for member information through online billing.

For more information about online billing, visit us online at harvardpilgrim.org or contact the Broker/Employer Services Team at **800-637-4751**.

Paper Invoicing

If an employer group is unable to receive invoices online via the *Employer Account*, HPHC will provide a paper invoice each month and mail it approximately 15 days before the payment due date.

Full premium payments are due on the first of the month for that coverage month (i.e., payment due by May 1 for the month of May).

Payment Terms

The following are HPHC’s requirements for premium payments:

- You must “pay as billed,” i.e., pay the full invoice amount
- You may not take credits until HPHC reflects them on your invoice. Doing so may result in the cancellation of your group coverage due to nonpayment
- Premium must be paid on either a “daily prorate” or “15-day wash” basis*
- Failure to remit premium on or before the beginning of the coverage period will result in either a delay in claims payment for your HPHC Members or in the loss of coverage**

In addition, please note the following requirement:

- COBRA premium payments and membership reports (with the exception of the first payment) must comply with HPHC's 60-day retroactive policy. HPHC requires formal notification of subscriber and Member COBRA terminations

If you have questions about termination credits, or payments not yet reflected on your invoice, please call the Broker/ Employer Services Team at **800-637-4751**.

** Small groups (1-50 eligible employees) are not eligible for the "15-day wash" method.*

*** HPHC follows state regulations with respect to payment of claims when an employer group becomes delinquent.*

Premium Calculation

Composite Rating Methodology

The current billing period premium is calculated by multiplying the current rate by the number of subscribers in each contract type. Debits and credits for prior month's retroactivity processed since the last invoice will also be included on this month's invoice.

Member Level List Billing Methodology

List billing currently applies to small groups (under 50 eligible) in Maine and New Hampshire.

Rates are calculated for each member of the policy based on the age of the member at the time of the policy effective date or renewal and other factors such as tobacco usage depending upon the state. The member level rates are then aggregated to the subscriber level (using all adults (over 21) and up to 3 oldest children (under 21), for presentment on the invoice.

Adding or removing dependents from the policy will cause a change in the rates being billed based on the demographics of the new members.

Invoice Presentation

Invoices will list each subscriber as a single line item with the combined premium total for all members on the contract.

HPHC calculates partial months of membership in two ways:

- The standard method is called the "daily prorate," and charges a prorated monthly rate for the actual days of membership. For example, if a subscriber is added with an effective date of the seventh of the month, you will be charged from the seventh of that month until the end of that month
 - The actual prorated premium is calculated by taking the monthly rate, dividing it by the number of days in that month, and then multiplying that figure by the actual number of days of membership. Retroactive credits are calculated in the same manner
- The other method is called the "15-day wash," and charges premium based on the effective date of membership*
 - Subscribers with effective dates on or before the 15th of the month will be billed for the entire month but are covered only from their actual effective dates.
 - Subscribers with effective dates after the 15th of the month will not be billed for the first month but will be billed from the first day of the following month. Subscribers are covered only from their actual effective dates.
 - Subscribers with termination dates before the 15th of the month will not be billed for the month in which termination occurred but are covered only through their actual termination dates.
 - Subscribers with termination dates on or after the 15th of the month will be billed for the entire month in which termination occurred but are covered only through their actual termination dates.

* The anniversary date for employer groups billed on the "15-day wash" method must be the first of the month.

Reading Your Invoice Through Online Billing

Harvard Pilgrim online billing via the *Employer Account* is the most efficient, accurate and timely method for you to receive your invoice and make payments to HPHC on a monthly basis. This real-time management of invoices and enrollment information is also flexible, allowing you to have a different invoice view/payment setup for each customer account.

Harvard Pilgrim online billing features:

Fully-Insured Groups:

- Preliminary invoice presentation
- Electronic payment processing
- Flexible billing date
- Invoice history
- Payment history if paying online

Self-Insured Groups:

- Preliminary invoice presentation
- Electronic payment processing
- Flexible billing date
- Invoice history
- Payment history if paying online
- Claim invoices

Reading Your Paper Invoice

If you choose to receive a paper invoice each month, your invoice will contain a cover page, a list of all your covered employees and their applicable premium rates, a detailed adjustment section and a summary of current billing.

Important sections to note on the Summary Page of the paper invoice

1. **Invoice Number** - Each invoice has a unique invoice number that should be referenced when you pay that invoice or if you have questions about that particular invoice.
2. **Invoice Date** - All transactions and payments processed on or before the invoice date are reflected on this invoice*.
3. **Bill Period** - The period of time for which you are currently being billed.
4. **Payment Due On/Before Date** - All premium payments are due on or before the first day of the coverage period.
5. **Adjustments** - Reflects the total of all retroactivity since your last invoice. These adjustments may reflect the addition of new employees, terminations and/or contract type changes.
6. **Balance Forward** - The amount remaining after the amount paid is subtracted from the previous balance, plus or minus any adjustments from the current month's invoice.
7. **Current Premiums** - Reflects premium charged for the current bill period, excluding adjustments.
8. **Please Pay This Amount** - This amount reflects the current premium plus or minus any previous balances and adjustments.

** Paper enrollment transactions received less than ten (10) days prior to the invoice date may not be reflected on your current month's invoice*

Please note that it is the responsibility of the employer group to audit all customer accounts billed by HPHC on a monthly basis. Doing so will ensure that accurate membership is reflected on invoices and avoid any potential membership or premium discrepancies.

Making Premium Payments

Payments are to be made based on the total amount due indicated on the invoice. Adjustments and any outstanding amounts due are calculated into the total amount due. Additional adjustments submitted after the bill date will be reflected on the next month's invoice.

When submitting payment that applies to more than one customer account, HPHC must receive the Remittance Coupon for each customer account or a remittance advice statement indicating exactly what payment amount should be applied to each customer account. Even if the group has only one division, the current process requires a Remittance Coupon.

Without this Remittance Coupon, there could be a substantial delay in the posting of your payment, or your payment may be misapplied to your account.

If you use a Third-Party Administrator to manage your payments (or other activities), please notify the Broker/Employer Services Team. Third Party Administrators are subject to the same requirements as employer groups for premium remittance and enrollment/termination processing.

Maine

In accordance with Maine law, there is a 30-day grace period on premium payments (except for the first month). Late payments may be subject to a finance charge. HPHC may terminate an Employer Group for nonpayment of premium in accordance with its termination rights and will pursue collection activity for unpaid premiums through the date of termination.

Massachusetts

In accordance with Massachusetts law, there is a 10-day grace period on premium payments. Late payments may be subject to a finance charge. HPHC may terminate an employer group for nonpayment of premium in accordance with its termination rights and will pursue collection activity for unpaid premiums through the date of termination.

New Hampshire

In accordance with New Hampshire law, there is a 31-day grace period on premium payments. Late payments may be subject to a finance charge. HPHC may terminate an employer group for nonpayment of premium in accordance with its termination rights and will pursue collection activity for unpaid premiums through the date of termination.

Using Harvard Pilgrim online billing via the *Employer Account*, employer groups have the option to pay invoices through an HPHC Electronic Funds Transfer (EFT), by wire or check. For maximum flexibility, payment methods can even be made differently for each group within your account.

Rhode Island

In accordance with Rhode Island law, there is a 31-day grace period on premium payments. Late payments may be subject to a finance charge. HPHC may terminate an employer group for nonpayment of premium in accordance with its termination rights and will pursue collection activity for unpaid premiums through the date of termination.

Premium Payment Methods

The following methods may be used to remit your premium payments:

- **Direct Debit (commercial customer accounts only):**

With your authorization, each month HPHC will automatically withdraw your payment amount from your bank account for the amount, and on the date, you specify. The bank account must either be a checking or savings account. This payment option can be established easily through the Direct Debit Setup/Edit screen within the online billing tool.

- **Electronic Funds Transfer (EFT)**

HPHC also accepts premium payments electronically by wire or Automatic Clearinghouse (ACH) transfer.

In addition to the premium due, HPHC must receive a remittance advice on the same day as the EFT. HPHC's banking information is as follows:

Wire:

Bank: Bank of America
ABA Routing Number: 026 009 593
Account Number: 561-02394

ACH:

Bank: Bank of America
ABA Routing Number: 011 000 138
Account Number: 561-02394

If you would like to remit your payment by EFT, please contact the Broker/Employer Services Team at **800-637-4751** to discuss the details of this arrangement.

- **Check**

HPHC utilizes an automated lock box service to ensure the most accurate and timely processing of your payment. Please forward your check, along with a printed coupon from the summary page of your online invoice or paper invoice, to the following address:

Harvard Pilgrim Health Care
PO Box 970050
Boston, MA 02297-0050

Form 5500 Schedule A

HPHC will provide health plan data used to complete Form 5500 Schedule A through its online self-service tool, the *Employer Account* or upon written request from the employer group or authorized Third Party Administrator. Information will be produced for each customer account unless otherwise requested. The following information will be provided:

- Insurance Carrier
- EIN
- NAIC Code
- Group Name
- Group Number
- Product Type
- Plan Year
- Total Billed Premium
- Total Paid Premium
- Premium Due and Unpaid at the End of the Plan Year
- Agency/Broker Name(s)
- Broker Commission Paid
- Broker Bonus Paid

A Plan administrator (such as an employer group or authorized third party administrator) can access Form 5500 Schedule A data via the *Employer Account*, our secure web-based administrative service tool. The data is compiled real time and presented in a reader-friendly view that can also be printed.

Written requests for Form 5500 Schedule A information should be directed to the Broker/Employer Services Team at **800-637-4751**. The request must include the following information:

- Group/Customer Account Names(s)
- Group/Customer Account Number(s)
- Plan Year(s) (e.g. January 1, 2024 through December 31, 2024)
- Facsimile e-mail or address for mailing of completed statements
- Contact name

HPHC certifies the data which it provides to Plan administrators for Form 5500- Schedule A filing purposes. HPHC compiles commissions paid and fees received that are attributable to the invoice to which it is posted during the reporting period and based on the date the report is generated. HPHC includes in such compilation, bonus payments attributable to the plan's most recent calendar year. Once HPHC determines that it has all of the information applicable to the appropriate period and, in the case of bonuses, the calendar year, HPHC will make sure that all such information is made available on the *Employer Account* and will certify to the accuracy and completeness of such posted data, subject to disclosures which you will be made aware of as you access the data.

Employer Group Contract Renewal/Termination

Renewal Information

Your contract with HPHC renews on the effective date specified in your Renewal Rate Letter (or another date agreed to by the employer group and HPHC), unless terminated as described below.

Employer's Termination Rights

The employer must give written notice to HPHC at least 30 days prior to the intended date of termination. If written notice is not received from the employer group at least 30 days prior to the requested termination date, HPHC will set the termination date at 30 days after the date HPHC receives written notice. In addition, the employer group will be responsible for the full premium amount up to the termination date established by HPHC. For example, if you choose to terminate coverage effective midnight June 30, HPHC must receive notification of the termination by May 31.

HPHC's Termination Rights

Coverage for the subscriber and any covered family dependents will end when the contract with HPHC is terminated. For example, if your contract terminates effective June 30, all benefits for your covered employees cease June 30. Therefore, if an employee is receiving services such as hospitalization, the services will no longer be covered by HPHC beyond June 30 at midnight. The plan is guaranteed renewable as required by state and federal laws, except under the following circumstances:

Maine

- a) **Termination for Nonpayment of Premium.** Harvard Pilgrim may terminate your contract for nonpayment of the full premium due at the end of the 30-day grace period for the payment of each month's premium. If Harvard Pilgrim terminates coverage for nonpayment of premium, all past due and current premium, plus a reinstatement fee, must be paid in order to have coverage reinstated with no gap.
- b) **Termination for Cause.** Harvard Pilgrim may terminate your contract by giving 45 days written notice to the employer for any of the following reasons:
 - i) Employer has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of a material fact to Harvard Pilgrim.
 - ii) Employer no longer has an employee who lives, resides or works in Harvard Pilgrim's enrollment area in the state of Maine.
- c) **Termination Due to Withdrawal of Product.** Harvard Pilgrim may terminate your contract by giving written notice to employer and its eligible participants enrolled in the Plan at least 90 days prior to the date Harvard Pilgrim ceases to offer the Plan in Maine. In the event of such termination, Harvard Pilgrim will offer Employer the option to purchase any other group health coverage Harvard Pilgrim offers in Maine for which employer would be eligible.
- d) **Termination Due to Withdrawal from Market.** Harvard Pilgrim may terminate your contract by giving written notice to employer and the Bureau of Insurance at least 180 days prior to the date Harvard Pilgrim ceases to offer coverage in either the large or small employer market in Maine.

- e) **Notice of Termination by Harvard Pilgrim.** At least 10 days prior to any termination by Harvard Pilgrim, Harvard Pilgrim will send notice of termination by first class U.S. mail to the employer and eligible participants. Such notice will include the termination date, the time-period for exercising any conversion rights, an explanation of any grace period and information on the availability of individual coverage. The notice will be sent to eligible participants at the last address provided to Harvard Pilgrim. A termination notice will not be sent to either the employer or eligible participant if the employer provides HPHC written notice that the employer has obtained replacement coverage.

In the event of termination by either party, all benefits under your contract will end at midnight on the termination date.

Massachusetts

- a) **Termination or non-renewal for nonpayment of premium.** HPHC may terminate your contract or exercise its right not to renew your contract at the anniversary date due to nonpayment of premium if payment is not made at the end of the 10-day grace period. If Harvard Pilgrim terminates coverage for nonpayment of premium, all past due and current premium, plus a reinstatement fee, must be paid in order to have coverage reinstated with no gap.
- b) **Termination for Cause.** Harvard Pilgrim may terminate your contract by giving 45 days written notice to the employer for any of the following reasons:
- i) Employer has committed fraud, misrepresented a person's eligibility as an eligible participant or misrepresented information necessary to determine employer's size, participation rate or premium rate.
 - ii) Employer is not actively engaged in business in Massachusetts.
- c) **Non-Renewal for Cause.** Harvard Pilgrim may refuse to renew your contract by giving employer written notice at least 60 days prior to the anniversary date for any of the reasons stated in Paragraph (b)., above, or for any of the following reasons:
- i) Refusal to comply with Harvard Pilgrim's reasonable request for information, or for the verification of information, necessary to determine employer's (or a member's) eligibility for coverage under the Plan.
- d) **Termination Due to Withdrawal of Product.** Harvard Pilgrim may terminate your contract by giving written notice to employer at least 90 days prior to the date Harvard Pilgrim ceases to offer the Plan in Massachusetts. In the event of such termination, Harvard Pilgrim will offer employer the option to purchase any other group health coverage Harvard Pilgrim offers in Massachusetts for which employer would be eligible.
- e) **Termination Due to Withdrawal from Market.** Harvard Pilgrim may terminate your contract by giving written notice to employer at least 180 days prior to the date Harvard Pilgrim ceases to offer coverage in either the large or small employer market in Massachusetts.

In the event of termination by either party, all benefits under your contract will end at midnight on the termination date.

New Hampshire

- a) **Termination for Non-payment of Premium.** HPIC may terminate your contract for non-payment of the full premium due at the end of the 31-day grace period for the payment of each month's premium. If Harvard Pilgrim terminates coverage for nonpayment of premium, all past due and current premium, plus a reinstatement fee, must be paid in order to have coverage reinstated with no gap.
- b) **Termination for Cause.** HPIC may terminate your contract by giving 45 days written notice to the employer for any of the following reasons:
- i) Employer has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of a material fact to HPIC.
 - ii) Employer has fewer than 51 eligible employees and no longer is actively engaged in the business that it was engaged in at the effective date of coverage.
 - iii) Employer medically underwrites employees or dependents or otherwise violates state insurance laws.

- c) **Termination Due to Withdrawal of Product.** HPIC may terminate your contract by giving written notice to Employer at least 90 days prior to the date HPIC ceases to offer the Plan in New Hampshire. In the event of such termination, HPIC will offer employer the option to purchase any other group health coverage HPIC offers in New Hampshire for which Employer would be eligible.
- d) **Termination Due to Withdrawal from Market.** HPIC may terminate your contract by giving written notice to Employer at least 180 days prior to the date HPIC ceases to offer coverage in either the large or small employer market in New Hampshire. In the event of termination by either party, all benefits under your contract will end at midnight on the termination date.

Rhode Island

- a) **Termination for Nonpayment of Premium.** Harvard Pilgrim may terminate this Agreement for nonpayment of the full premium due at the end of the 31-day grace period for the payment of each month's premium. If Harvard Pilgrim terminates coverage for nonpayment of premium, all past due and current premiums, plus a reinstatement fee, must be paid in order to have coverage reinstated with no gap.
- b) **Termination for Cause.** Harvard Pilgrim may terminate your contract by giving 45 days written notice to the employer for any of the following reasons:
 - i) Employer has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of a material fact to Harvard Pilgrim.
 - ii) Employer no longer has an employee who lives, resides or works in Harvard Pilgrim's Enrollment Area in the state of Rhode Island.
- c) **Non-Renewal for Cause.** Harvard Pilgrim may refuse to renew your contract by giving employer written notice at least 60 days prior to the Anniversary Date for any of the reasons stated under Termination for Cause above, or for any of the following reasons:
 - i) Failure to comply with the minimum participation requirements.
 - ii) Failure to comply with Plan provisions, including, but not limited to, requirements concerning employer contributions to group premiums.
 - iii) Refusal to comply with Harvard Pilgrim's reasonable request for information, or for the verification of information, necessary to determine Employer's (or a Member's) eligibility for coverage under the Plan.
- d) **Termination Due to Withdrawal of Product.** Harvard Pilgrim may terminate your contract by giving written notice to Employer and its Eligible Participants enrolled in the Plan at least 90 days prior to the date Harvard Pilgrim ceases to offer the Plan in Rhode Island. In the event of such termination, Harvard Pilgrim will offer Employer the option to purchase any other group health coverage Harvard Pilgrim offers in Rhode Island for which Employer would be eligible.
- e) **Termination Due to Withdrawal From Market.** Harvard Pilgrim may terminate your contract by giving written notice to Employer and the Office of the Health Insurance Commissioner at least 180 days prior to the date Harvard Pilgrim ceases to offer coverage in either the large or small employer market in Rhode Island.

Third Party Liability

HPHC's Insurance Liability Recovery (ILR) Department determines when another insurer or party may be liable for expenses for services provided by HPHC and coordinates benefits as allowed by law. Other coverage may include other health benefit plans, medical payment policies, governmental benefits and Medicare.

Benefits in the Event of Other Coverage

When a member is covered by two or more health benefit plans, one plan will be "primary" and the other plan will be "secondary." The benefits of the primary plan are determined before those of the secondary plan without considering the benefits of the secondary plan. The benefits of the secondary plan are determined after those of the primary plan and may be reduced because of the primary plan's benefits.

In the case of health benefit plans that contain provisions for the coordination of benefits (COB), the following rules shall decide which plan is primary and which plan is secondary:

- Dependent/non-dependent: The benefits of the plan that covers the person as an employee, member, or subscriber are determined before those of the plan that covers the person as a dependent
- A dependent child whose parents are not separated or divorced: The order of benefits is determined as follows:
 - The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in a year
 - If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time
 - However, if the other plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in this plan (the "birthday rule") will determine the order of benefits
- Dependent child/separated or divorced parents: Unless a court order, of which HPHC has knowledge, specifies one of the parents as responsible for the health care benefits of the child, or if the court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the birthday rule applies. If there is no court decree the order of benefits is determined as follows:
 - First the plan of the parent with custody of the child
 - Then, the plan of the spouse of the parent with custody of the child
 - Finally, the plan of the parent not having custody of the child
- Active/inactive employee: The benefits of the plan that covers the person as an active employee are determined before those of the plan that covers the person as a laid-off or retired employee.
- COBRA or state continuation coverage: If a person whose coverage is provided under the right of continuation pursuant to federal or state law is also covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary.
- Longer/shorter length of coverage: If none of the above rules determines the order of benefits, the benefits of the plan that covered the employee, member, or subscriber longer are determined before those of the plan that covered that person for the shorter time.
- If a member is covered by a health benefit plan that does not have provisions governing the coordination of benefits between plans, that plan will be the primary plan.
- The Final Fall-Back Rule: If none of the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the two plans.

Provider Payment when HPHC Coverage is Secondary

When a Member's HPHC coverage is secondary to a member's coverage under another Health Benefit Plan, HPHC may suspend payment to a provider of services until the provider has properly submitted a claim to the primary plan and the claim has been paid, in whole or in part, or denied by the primary plan. HPHC may recover any payments made for services in excess of HPHC's liability as the secondary plan, either before or after payment by the primary plan.

Medical Payment Policies

Maine

For members who are entitled to benefits under the medical payment benefit of a motorcycle, boat, homeowners, hotel, restaurant, or other insurance policy, HPHC has the right to coordinate with other insurance carriers under subrogation. The benefits provided by HPHC shall not duplicate any benefits to which the member is entitled under any medical payment policy or benefit. All sums payable for services provided by HPHC that are covered under any medical payment policy or benefit are payable to HPHC.

Massachusetts

For members who are entitled to benefits under the medical payment benefit of a motorcycle, boat, homeowners, hotel, restaurant, or other insurance policy, such coverage shall become primary to the coverage under the *Benefit Handbook* for services rendered in connection with a covered loss under that policy. The benefits under the *Benefit Handbook* shall not duplicate any benefits to which the member is entitled under any medical payment policy or benefit. All sums payable for services provided under the *Benefit Handbook* to members that are covered under any medical payment policy or benefit are payable to HPHC.

New Hampshire

For members who are entitled to coverage under the medical payment benefit of a motor vehicle, motorcycle, boat, homeowners, hotel, restaurant or other insurance policy, the benefits under the *Benefit Handbook* shall not duplicate any benefits for medical expenses to which a member is entitled under such policy. With the exception of a Motor Vehicle Liability Policy, as defined below, HPHC has the right to coordinate benefits with other insurance carriers with respect to any benefits for medical payments that may be available for services covered under the *Benefit Handbook*. HPHC shall have the right to receive reimbursement for services paid under the *Benefit Handbook* that are covered under a medical payment benefit or policy other than benefits paid under a Motor Vehicle Liability Policy.

For the purpose of this section, the term "Motor Vehicle Liability Policy" means a private motor vehicle liability policy, as defined in New Hampshire law under RSA 259:61, that covers a private passenger automobile that is registered or principally garaged in the State of New Hampshire. The term "Motor Vehicle Liability Policy" shall not include (1) a commercial policy covering more than four automobiles, or (2) any commercial policy covering a garage, automobile sales agency, repair shop, service station, trucking operation or public parking place operation hazards.

If you are injured in a motor vehicle accident in which medical payments coverage is available under a Motor Vehicle Policy, a member has a right to submit a claim under either the medical payments coverage or the *Benefit Handbook*, or both. However, members are not entitled to duplicate payments for the same expense under the medical payments coverage and the *Benefit Handbook*.

Rhode Island

For Members who are entitled to coverage under the medical payment benefit of a boat, homeowners, hotel, restaurant, or other insurance policy, or the first \$2,000 of Personal Injury Protection (PIP) coverage (or \$8,000 for self-funded plans governed by ERISA), such coverage shall become primary to the coverage under the *Benefit Handbook* for services rendered in connection with a covered loss under that policy. For Members who are entitled to

coverage under (1) a medical payment policy, or (2) Personal Injury Protection (PIP) coverage in excess of \$2,000 (or \$8,000 for self-funded plans governed by ERISA), such coverage shall become secondary to the coverage under the *Benefit Handbook* for services rendered in connection with a covered loss under that policy, where, and only to the extent, the law requires the coverage under this *Benefit Handbook* to be primary. The benefits under the *Benefit Handbook* shall not duplicate any benefits to which the Member is entitled under any medical payment policy or benefit. All sums payable for services provided under the *Benefit Handbook* to Members that are covered under any medical payment policy or benefit are payable to HPHC.

Workers' Compensation/Government Programs

Massachusetts, Maine, New Hampshire and Rhode Island

If HPHC has information indicating that services provided to a member are covered under Workers' Compensation, employer's liability or other program of similar purpose, or by a federal, state or other governmental agency, HPHC may suspend payment for such services until a determination is made whether payment will be made by such program.* If HPHC provides or pays for services for an illness or injury covered under Workers' Compensation, employer's liability, or other program of similar purpose, or by a federal, state or other government agency, HPHC will be entitled to recovery of its expenses from the provider of services or the party or parties legally obligated to pay for such services.

** In Maine, payment may be suspended unless a notice of controversy has been filed with the Workers' Compensation Board contesting the work-relatedness of the claimant's condition and no decision has been made by the Board.*

Subrogation

Subrogation is a means by which HPHC and other health insurance carriers recover expenses of services where a third party is legally responsible for a member's injury or illness. If another person or entity is, or maybe, liable to pay for services related to a member's illness or injury which have been paid for or provided by HPHC, HPHC will be subrogated and succeed to all rights of the member to recover against such person or entity 100% of the value of the services paid for or provided by HPHC.

Massachusetts

HPHC will have the right to seek such recovery from, among others, the person or entity that caused the injury or illness, his liability carrier or the member's own auto insurance carrier, in cases of uninsured or underinsured motorist coverage. HPHC will also be entitled to recover from a member 100% of the value of services provided or paid for by HPHC when a member has been, or could be, reimbursed for the cost of care by another party. HPHC's recovery will be made from any recovery the member receives from an insurance company or any third party.

HPHC's right to recover 100% of the value of services paid for or provided by HPHC is not subject to reduction for a pro rata share of any attorney's fees incurred by the member in seeking recovery from other persons or organizations. HPHC's right to 100% recovery shall apply even if a recovery the member receives for the illness or injury is designated or described as being for injuries other than health care expenses. The subrogation and recovery provisions in this section apply whether or not the member recovering money is a minor.

To enforce its subrogation rights under this guide, HPHC will have the right to take legal action, with or without the member's consent, against any party to secure recovery of the value of services provided or paid for by HPHC for which such party is, or may be, liable.

Nothing described herein shall be construed to limit HPHC's right to utilize any remedy provided by law to enforce its rights to subrogation.

Maine

If another person or entity is, or may be, liable to pay for services related to a member's illness or injury, which have been paid for or provided by HPHC, HPHC will be subrogated and succeed to all rights of the member to recover against such person or entity 100% of the value of the services paid for or provided by the Plan. HPHC will have the right to seek such recovery from, among others, the person or entity that caused the injury or illness, his/her liability carrier or the member's own auto insurance carrier, in cases of uninsured or underinsured motorist coverage. HPHC's right to recovery shall apply even if a recovery the member receives for the illness or injury is designated or described as being for injuries other than health care expenses. HPHC will also be entitled to recover from a member 100% of the value of services provided or paid for by HPHC when a member has been, or could be, reimbursed for the cost of care by another party. The subrogation and recovery provisions in this section apply whether or not the member recovering money is a minor.

All subrogation payments made under this section shall be made on a just and equitable basis, which means any factors that reduce the potential value of the services may likewise reduce HPHC's claim.

To enforce its subrogation rights, HPHC will have the right to take legal action, with or without the member's consent, against any party to secure recovery of the value of services provided or paid for by HPHC for which such party is, or may be, liable. By signing the enrollment form requesting coverage under the Plan, members have authorized HPHC's right of subrogation.

New Hampshire

If another person or entity is, or may be, liable to pay for services related to your illness or injury which have been paid for or provided by HPHC, HPHC 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 HPHC. HPHC will have the right to seek such recovery from, among others, the person or entity that caused the injury or illness, his/her liability carrier or your own auto insurance carrier, in cases of uninsured or underinsured motorist coverage. HPHC's right to recovery shall apply even if a recovery the member receives for the illness or injury is designated or described as being for injuries other than health care expenses. HPHC's recovery will be made from any recovery the member receives from any insurance company or any third party.

To enforce its subrogation rights, HPHC will have the right to take legal action, with or without the member's consent, against any party to secure recovery of the value of services provided or paid for by HPHC for which such party is, or may be, liable.

Nothing described herein shall be construed to limit HPHC's right to utilize any remedy provided by law to enforce its rights to subrogation.

Rhode Island

HPHC will have the right to seek such recovery from, among others, the person or entity that caused the injury or illness, his liability carrier or the member's own auto insurance carrier, in cases of uninsured or underinsured motorist coverage. HPHC will also be entitled to recover from a member 100% of the value of services provided or paid for by HPHC when a member has been, or could be, reimbursed for the cost of care by another party. HPHC's recovery will be made from any recovery the member receives from an insurance company or any third party.

HPHC's right to recover 100% of the value of services paid for or provided by HPHC is not subject to reduction for a pro rata share of any attorney's fees incurred by the member in seeking recovery from other persons or organizations. HPHC's right to 100% recovery shall apply even if a recovery the member receives for the illness or injury is designated or described as being for injuries other than health care expenses. The subrogation and recovery provisions in this section apply whether or not the member recovering money is a minor.

To enforce its subrogation rights under this guide, HPHC will have the right to take legal action, with or without the member's consent, against any party to secure recovery of the value of services provided or paid for by HPHC for which such party is, or may be, liable.

Nothing described herein shall be construed to limit HPHC's right to utilize any remedy provided by law to enforce its rights to subrogation.

Member Cooperation

The member agrees to cooperate with HPHC in exercising its rights of subrogation and coordination of benefits under the *Benefit Handbook*. Such cooperation will include, but not be limited to: (1) the provision of all information and documents requested by HPHC, (2) the execution of any instruments deemed necessary by HPHC to protect its rights, (3) the prompt assignment to HPHC of any monies received for services provided or paid for by HPHC, and (4) the prompt notification to HPHC of any instances that may give rise to HPHC's rights. The member further agrees to do nothing to prejudice or interfere with HPHC's rights to subrogation or coordination of benefits.

Failure of the member to perform the obligations stated in this subsection shall render the member liable to HPHC for any expenses HPHC may incur, including reasonable attorney's fees, in enforcing its rights.

HPHC's Rights

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

Members Eligible for Medicare

Massachusetts, Maine and New Hampshire and Rhode Island

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

For a member who is eligible for Medicare by reason of End Stage Renal Disease, HPHC will be the primary payer for Covered Benefits during the "coordination period" specified by federal regulations at 42 CFR Section 411.162. Thereafter, Medicare will be the primary payer. When Medicare is primary (or would be primary if the member were timely enrolled), HPHC will pay for services only to the extent payments would exceed what would be payable by Medicare.

Note: The *Benefit Handbook* provides more detailed information on coordination of payment in the event of other insurance. If you have additional questions, please call **888-888-4742** ext. 38999 or **617-509-8999** and ask for Coordination of Benefits, Motor Vehicle Accidents or Workers' Compensation.

Claims

Submitting a Claim

In most cases, members will not receive bills from participating providers. Members may need to submit claims for reimbursement when they receive urgent or emergency services from a non-participating provider.

POS and PPO members using out-of-network services may need to submit a bill for either payment or reimbursement if the provider does not or will not bill HPHC directly. Members may call HPHC's Member Services Department to request POS and PPO claim forms.

If an employee receives a bill for a covered service, he may ask the provider to bill HPHC on a standard health care claim form (i.e., HCFA 1500 or the UB-92 form). Claims should be sent to:

Claims for Mental Health Care:

Harvard Pilgrim Health Care Claims Department
P.O. Box 699183
Quincy, MA 02269

Pharmacy Claims:

OptumRx Claims Department
P.O. Box 29044
Hot Springs, AR 71903

All Other Claims:

Harvard Pilgrim Health Care Claims Department
P.O. Box 699183
Quincy, MA 02269

If a member pays a non-participating provider for a covered service, a request for reimbursement may be submitted to HPHC for payment consideration. The member will need to send copies of itemized receipts from the provider or pharmacy (if the employer group offers this benefit) which shows proof of payment.

The following information is needed to process a member's claim:

- The patient's full name
- The patient's date of birth
- The member's plan ID number (on the front of the member's plan ID card)
- The name and address of the person or facility providing the services for which a claim is made and their tax identification number
- The member's diagnosis or ICD 9 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 the member has paid the bill (if reimbursement is sought)
- For pharmacy items, a drug store receipt stating (a) the name of the drug or medical supply; (b) the prescription number; and (c) the amount paid.

Note: All claims must be submitted in U.S. currency. HPHC may require additional information for some claims. Members with questions about claims may call HPHC's Member Services Department at **888-333-4742**.

Member Confidentiality Policy

HPHC is committed to ensuring and safeguarding the confidentiality of its members' information, including personal and medical information. HPHC staff access member information only in connection with providing services and benefits and in accordance with HPHC's confidentiality policies and state and federal law. HPHC sometimes contracts with other organizations or entities to assist with the delivery of care or administration of benefits. Any such entity is informed of HPHC's confidentiality and privacy standards and is obligated to adhere to them. In addition, HPHC's contracted providers agree to protect the confidentiality of medical records, and cannot release a member's records to a third party without the member's authorization or unless allowed or required by law.

In order to provide coverage for treatment and administer services and benefits, there are times when HPHC will use and disclose protected health information (PHI) without a member's authorization. Examples include use in professional and utilization review activities, such as coordination of care, referrals and authorizations, disease management, and quality assurance; verifying eligibility; fraud detection; and certain oversight activities, such as accreditation and regulatory audits. There may be other instances that HPHC will be required or permitted to release protected health information. For example, those instances where a member authorization has been obtained, when the release of such information is in connection with certain activities allowed or required by law, or as otherwise allowed under the terms of the *Benefit Handbook*.

Except as provided above, HPHC will not disclose to third parties Member specific information (i.e., information from which the Member is personally identifiable) without specific authorization from the Member, unless permitted by law. HPHC does not sell personal information.

Note: This policy is not intended to discourage employer groups from contacting HPHC with employee claim questions. However, HPHC will determine whether a specific member authorization is required based on the classification of the employer group, i.e., self or fully insured, and whether the appropriate documentation is in place to support release of protected health information without the member's authorization.

For additional information on HPHC's protection of member PHI, please see the section on "HIPAA Administrative Simplification" below.

Select Federal and State Health Care Laws

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) applies to employer-sponsored health plans such as the plans offered by HPHC. HIPAA applies to all group plans, regardless of size, and makes it easier for persons who change jobs to remain continuously covered under employer-sponsored health plans.

HIPAA Administrative Simplification

Privacy Rule

HIPAA Privacy Rule requires HPHC to provide individuals with an accurate and thorough description of possible uses and disclosures of their protected health information (PHI). HPHC is committed to ensuring the utmost privacy and security protection of member/patient PHI. In accordance with the requirements defined by HIPAA, we will provide our members with a *Notice of Privacy Practices*, a document which describes permitted uses and disclosures of PHI, outlines an individual's rights relating to their PHI and provides a description of how to file a complaint if the member feels there has been a breach of privacy.

Transaction and Code Set Rule

As of October 16, 2003, HPHC was able to accept standard enrollment/disenrollment and premium payment electronic transactions as defined by HIPAA.

HIPAA Security Rule

HPHC is committed to maintaining the confidentiality and the security of electronic protected health information (PHI). Appropriate processes and procedures have been put in place to support the confidentiality, integrity and availability of PHI when interacting with our employer groups and/or their identified representatives.

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act (WHCRA) established specific benefits for women enrolled in group health plans. Consistent with the WHCRA requirements, the Plan includes the following benefits with respect to a mastectomy:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses for reconstruction
- Coverage for physical complication of all stages of mastectomy, including lymphedemas

The above care must be provided in consultation with the physician and patient. HPHC provides annual notice of these benefits to subscribers.

Glossary

Anniversary Date:

The date agreed to by HPHC and the employer group upon which the yearly employer group premium rate is adjusted and benefits become effective. The *Benefit Handbook*, the *Schedule of Benefits*, prescription drug rider, and any other riders, and the *Employer Agreement* will terminate unless renewed on the Anniversary Date.

Benefit Handbook (or Member Agreement):

The legal document that describes the terms and conditions of a member's coverage under his/her plan, including but not limited to, covered services, exclusions from coverage, and the conditions of coverage for members enrolled in the Plan.

Dependent:

A member of the subscriber's family who (1) meets the eligibility requirements for coverage through a subscriber and (2) is enrolled in the Plan. This eligibility is documented as part of the agreement between the employer group and HPHC and is also described in the *Benefit Handbook*.

Domestic Partner:

HPHC may offer coverage for domestic partners as a rider. Under the rider, a domestic partner is a person of either the same or opposite gender as the subscriber, who has a relationship with the subscriber similar to that of a married spouse. As part of the enrollment process, HPHC requires subscribers and their sole domestic partner to sign an affidavit attesting to, among other things, their intent to live together indefinitely and their intent to be jointly responsible for their common welfare and financial obligations.

Note: Please note that the term "domestic partner" may, on occasion also be referred to as "life partner."

Employer Group:

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

Enrollment Area: A list of cities and towns where HPHC providers are available to manage a member's care. Members of the HMO and Open Access HMO Plan, except for out-of-area dependent children, must maintain residence in the enrollment area and live there at least nine months of the year. HPHC may add cities and towns to the enrollment area from time to time.

Family Coverage:

Coverage for a subscriber and one or more eligible dependents.

Employer Account:

The *Employer Account* is HPHC's web-based administrative transaction service that provides the ability to facilitate transactions (e.g., enrollments, changes, additions and terminations) online, rather than through a paper-based process. The *Employer Account* gives employers and members the ability to enter their own information through a secure internet connection, which leads to greater data accuracy and a reduction in the need for duplicative paper processes. For more information, contact the Broker/Employer Services Team.

Harvard Pilgrim Health Care (HPHC):

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

Harvard Pilgrim Health Care of New England:

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. Harvard Pilgrim Health Care of New England provides or arranges for health care benefits to its members through a network of primary care physicians, specialists and other providers.

HPHC Insurance Company:

A Massachusetts corporation licensed as an insurer in the states of Rhode Island, Massachusetts, Maine and New Hampshire.

Member:

Any subscriber or dependent covered by the health plan.

Primary Care Physician (PCP):

A plan provider designated to help members maintain their health and to provide, coordinate or help members access a range of health care services. A PCP may be, but is not limited to, a physician in internal medicine, family practice, adolescent, pediatrics or geriatrics, or an advanced registered nurse practitioner who is under contract with HPHC to provide and authorize a member's care. A member selects a PCP at any affiliated practice. The PCP may designate other HPHC providers to provide or authorize a member's care.

Qualified Medical Support Order (QMSO):

A court order providing for coverage of a child under a group health plan that meets the requirements of ERISA. A child enrolled under a QMSO is subject to the same terms and limitations stated in the *Benefit Handbook*, *Prescription Drug Coverage Brochure* and any riders.

Subscriber:

The person who meets the eligibility requirements described in this document or as agreed to by the employer group and HPHC and in whose name premium payments are made.

Harvard Pilgrim Health Care and its affiliates, Harvard Pilgrim Health Care of New England and HPHC Insurance Company (collectively "HPHC") provide health benefits plans to Massachusetts, Maine, New Hampshire and Rhode Island-based employers.

This *Administrative Guide* contains information on policies and procedures relative to the enrollment and administration of Harvard Pilgrim's health plans. The *Administrative Guide* also includes general information, not intended as legal advice, on selected federal and state laws applicable to employer sponsored health plans. If any statement in the *Administrative Guide* conflicts with terms set forth in the *Benefit Handbook* or *Employer Agreement*, the *Benefit Handbook* or *Employer Agreement* controls. Harvard Pilgrim reserves the right to amend, modify or terminate the policies and procedures described in the *Administrative Guide* at any time.

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