Benefit Handbook

THE HARVARD PILGRIM ATRIUS HEALTH CHOICE POS PLAN *FOR SELF-INSURED MEMBERS MASSACHUSETTS*

This benefit plan is provided to you by your employer on a self-insured basis. Harvard Pilgrim Health Care has arranged for the availability of a network of health care providers and will be performing various administration services, including claims processing, on behalf of the Plan Sponsor. Although some materials may reference you as a member of one of Harvard Pilgrim's products, Harvard Pilgrim Health Care is not the issuer, insurer or provider of your coverage.

Important Notice: This plan utilizes providers in multiple provider networks, or benefit levels. In this plan, Members pay different levels of Copayments, Coinsurance or Deductibles depending on the level of the provider delivering a covered service or supply. Please consult the Atrius Health Choice POS Provider Directory or visit the provider search tool at **www.harvardpilgrim.org/atriushealth** to determine which level providers are covered under in the Atrius Health Choice POS Plan.

EFFECTIVE DATE: 01/01/2019
ASO_04

INTRODUCTION

Welcome to The Harvard Pilgrim Atrius Health Choice POS Plan *for Self-Insured Members* (the Plan). Thank you for choosing us to help meet your health care needs. Your benefits are provided by your Plan Sponsor. Harvard Pilgrim Health Care (Harvard Pilgrim or HPHC) administers the Plan's benefits on behalf of your Plan Sponsor. This Benefit Handbook is for Members covered under the Atrius Health Choice POS Plan.

Your health care under the Plan is administered by HPHC through its affiliated network of Primary Care Providers, specialists and other Plan Providers. This is a self-insured health benefits plan for the Plan Sponsor's eligible employees and their eligible dependents. The Plan Sponsor has assumed the financial responsibility for this Plan's health care benefits. This type of funding, known as self-funding, allows the Plan Sponsor to self-insure the health care costs associated with its employees with its own resources. HPHC will perform benefits and claims administration, and case management services on behalf of the Plan Sponsor as outlined in this Benefit Handbook and your Schedule of Benefits. HPHC is not, however, the insurer of your coverage.

When we use the words "we," "us," and "our" in this Handbook, we are referring to Harvard Pilgrim Health Care. When we use the words "you" or "your" we are referring to Members as defined in the Glossary.

The Plan has been designed to offer you the coordinated care and cost advantages of Health Maintenance Organization (HMO) health coverage as well as the choice of obtaining Covered Benefits outside the limited HMO provider network. However, your responsibilities and financial obligations differ depending upon whether you receive care In-Network or Out-of-Network.

In-Network Benefits
Your "In-Network" benefits provide coverage at a lower out of pocket cost. With very limited exceptions, you must receive care from "Plan Providers" to obtain In-Network benefits. Plan Providers are medical providers under contract to care for HPHC Members. Plan Providers including PCPs, medical specialists, and acute hospitals have been placed into two In-Network benefit levels based on their affiliation with the Plan Sponsor. These are (1) the Atrius Health Ecosystem (which includes Atrius Health Providers and its Preferred Providers), and (2) Non-Preferred Providers. When you receive Covered Benefits from providers within the Atrius Health Ecosystem, coverage is provided at lower In-Network Member Cost Sharing. When you are able to receive your care from an Atrius Health Provider or facility, you will be responsible for the lowest available In-Network Member Cost Sharing. When you receive Covered Benefits from Non-Preferred Providers, you will be responsible for the highest In-Network Member Cost Sharing. Keep in mind that different Member Cost Sharing may apply to the same Plan Provider based upon where you are treated by that Plan Provider. You can locate Plan Providers by using the Plan's Atrius Health Choice POS Provider Directory described in this Benefit Handbook. You may also call Member Services at **1-888-333-4742** for assistance in finding a Plan Provider.

In a Medical Emergency you should promptly go to the nearest emergency room or call 911 or other local emergency number. You always receive In-Network coverage for care at a hospital emergency room. This also includes emergency transportation by ambulance.

Out-of-Network Benefits
Your "Out-of-Network" benefits provide coverage at higher Member Cost Sharing. However, your Out-of-Network benefits allow you to receive Covered Benefits from almost any medical provider.

If you live in the Service Area, you must choose a PCP for yourself and each enrolled member of your family when you enroll in the Plan. When you enroll, the Plan provides the covered health care services described in this Handbook, the Schedule of Benefits, and any riders. Most care must be provided or arranged by your PCP, except as described in section *I.D.2. Your PCP Manages Your Health Care*.

If you choose to receive Covered Benefits from a Non-Plan Provider or facility, your benefits will be covered at the Out-of-Network level. Your benefits will also be covered at the Out-of-Network level if you receive services from a Plan Provider in the Service Area without a Referral from your PCP, when a Referral is required.

Some benefits have limits on the amount of coverage provided in a Calendar Year. If a Covered Benefit has a benefit limit, your In-Network and Out-of-Network services are combined and count against each other to reach your benefit limit.

As a Member, you can take advantage of a wide range of helpful online tools and resources at **www.harvardpilgrim.org/atriushealth**.

Your secure online account offers you a safe way to help manage your health care. You are able to check your Schedule of Benefits and Benefit Handbook, look up benefits, Copayments, claims history, Deductible status, and view Prior Approval and Referral activities. You can also learn how your Plan covers preventive care and conditions such as asthma, diabetes, COPD and high blood pressure. For details on how to register for a secure online account, log on to **www.harvardpilgrim.org/atriushealth**.

Our cost transparency tool allows you to compare cost and quality on many types of health care services including surgical procedures and office visits. The cost transparency tool provides estimated costs only. Your Member Cost Sharing may be different.

To access information, tools and resources online, visit **www.harvardpilgrim.org** and select the Member Login button (first time users must create an account and then log in). To access the cost transparency tool once you're logged in, click on the "Tools and Resources" link from your personalized Member dashboard and look for the Estimate My Cost link.

You may call the Member Services Department at **1–888–333–4742** if you have any questions. Member Services staff is also available to help you with questions about the following:

- Selecting a PCP
- Your Benefit Handbook
- Your In-Network and Out-of-Network benefits

- Your enrollment
- Your claims
- Provider Information
- Requesting a Provider Directory
- Requesting a Member Kit
- Requesting ID cards
- Registering a complaint

We can usually accommodate questions from non-English speaking Members, as we offer language interpretation services in more than 180 languages.

Deaf and hard-of-hearing Members who use a Teletypewriter (TTY) may communicate with the Member Services Department. For TTY services, please call **711**.

As we value your input, we would appreciate hearing from you with any comments or suggestions that will help us further improve the quality of service we bring you.

Harvard Pilgrim Health Care
Member Services Department
1600 Crown Colony Drive
Quincy, MA 02169
Phone: 1-888-333-4742
www.harvardpilgrim.org/atriushealth

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

Exclusions or Limitations for Preexisting Conditions. The Plan does not impose any restrictions, limitations or exclusions related to preexisting conditions on your Covered Benefits.

Language Assistance Services

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

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

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

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

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

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

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

ខ្មែរ (Cambodian) ប្រសិនជាលោកអ្នកនិយាយភាសាខ្មែរ, សេវាកម្មជំនួយផ្នែកភាសា ដោយឥតគិតថ្លៃ គឺមានសំរាប់បំរើលោកអ្នក។ សូមទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

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

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

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

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

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

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

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

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ສັ້ງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-333-4742 (TTY: 711).

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

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

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TABLE OF CONTENTS

Benefit Handbook

I. How the Plan Works

This section describes how to use your Benefit Handbook and how your coverage works under the The Harvard Pilgrim Atrius Health Choice POS Plan *for Self-Insured Members* (the Plan).

A. HOW TO USE THIS BENEFIT HANDBOOK

1. Why This Benefit Handbook Is Important

This Benefit Handbook, the Schedule of Benefits, and any applicable riders make up the agreement stating the terms of the Plan. If you have any questions about Dependent eligibility, we recommend that you see your Plan Sponsor for information.

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

- Covered Benefits
- Exclusions
- The requirements for In-Network and Out-of-Network coverage

You can view your Benefit Handbook, Schedule of Benefits, and any applicable riders online by using your secure online account at **www.harvardpilgrim.org/atriushealth**.

2. Words With Special Meaning

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

3. How To Find What You Need To Know

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

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

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

B. HOW TO USE YOUR PROVIDER DIRECTORY

To be eligible for In-Network coverage under the Plan, all services, except care in a Medical Emergency, must be received from Plan Providers. You can find Plan Providers by using the Atrius Health Choice POS Provider Directory.

Plan Providers including PCPs, medical specialists, and acute hospitals have been placed into two In-Network benefit levels, based on their affiliation with the Plan Sponsor. These are (1) the Atrius Health Ecosystem (which includes Atrius Health Providers and its Preferred Providers), and (2) Non-Preferred Providers. When you receive Covered Benefits from a Plan Provider within the Atrius Health Ecosystem, lower In-Network Member Cost Sharing applies. When you are able to receive your Covered Benefits from an Atrius Health Provider or facility, you will be responsible for the lowest available In-Network Member Cost Sharing. Covered Benefits received from Non-Preferred Providers will apply the highest In-Network Member Cost Sharing level.

The Atrius Health Choice POS Provider Directory lists the Plan Providers you must use to obtain In-Network coverage. It lists Plan Providers by benefit level, state and town, specialty, and languages spoken. You may view the Atrius Health Choice POS Provider Directory online at our website, **www.harvardpilgrim.org/atriushealth**.

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

The online Atrius Health Choice POS Provider Directory provides links to several physician profiling sites including one maintained by the Commonwealth of Massachusetts Board of Registration in Medicine at **www.massmedboard.org**. You can also get a paper copy of the Atrius Health Choice POS Provider Directory, free of charge, by calling the Member Services Department at **1–888–333–4742**.

Please Note: Plan Providers participate through contractual arrangements that can be terminated either by a provider or by HPHC. In addition, a provider may

leave the network because of retirement, relocation or other reasons. This means that we cannot guarantee that the Plan Provider you choose will continue to participate in the network for the duration of your membership. If your PCP leaves the network for any reason, we will attempt to notify you at least 30 days in advance, and will help you find a new Plan Provider. Under certain circumstances you may be eligible for transition services if your provider leaves the network (please see section *I.G. SERVICES PROVIDED BY A DISENROLLED OR NON-PLAN PROVIDER* for details).

C. MEMBER OBLIGATIONS

1. Choose a Primary Care Provider (PCP)

If you live in the Plan's Service Area you must select a Primary Care Provider (PCP) for yourself and each covered member of your family. You may choose a different PCP for each family member. If you do not choose a PCP when you first enroll, or if the PCP you select is not available, we will assign a PCP to you. The Plan Service Area includes the states of Massachusetts, New Hampshire, Maine, Rhode Island, Connecticut and Vermont.

Your Plan has two In-Network benefit levels, (1) the Atrius Health Ecosystem (which includes Atrius Health Providers and its Preferred Providers), and (2) Non-Preferred Providers. However, there are three levels of In-Network Member Cost Sharing determined by your choice of PCP.

When you choose a Primary Care Provider (PCP) in the Atrius Health Ecosystem, your Member Cost Sharing for In-Network services will generally be lower than if you choose a Non-Preferred PCP. If you choose an Atrius Health PCP you will generally have the lowest available Member Cost Sharing for In-Network services. For example, your PCP Copayment for consultations, evaluations, and sickness and injury care is lower if you have an Atrius Health PCP.

Please see your Schedule of Benefits for Member Cost Sharing details. PCPs are listed in the Atrius Health Choice POS Provider Directory. You can access our website at **www.harvardpilgrim.org/atriushealth** or call the Member Services Department at **1–888–333–4742** to confirm that the PCP you select is available.

Even if you do not live in the Service Area, we strongly recommend that you choose a PCP for yourself and each covered person in your family.

A PCP may be a physician, a physician assistant or a nurse practitioner specializing in one or more of the following specialties: internal medicine, adult medicine, adolescent medicine, geriatric medicine, pediatrics or family practice. PCPs are listed in the Atrius Health Choice POS Provider Directory. You can access our website at **www.harvardpilgrim.org/atriushealth** or call the Member Services Department at **1–888–333–4742** to confirm that the PCP you select is available.

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

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

Important Notice: Many Atrius Health employees receive their clinical care at an Atrius Health site, and Atrius Health supports and encourages employees to do so. Atrius Health also supports respecting the Patient-Clinician relationship and ensuring, to the extent possible, that potential conflicts of interest or privacy concerns for the Employee-Patient and/or the treating Clinicians are not inadvertently created. Therefore, Atrius Health has guidelines in place that provide guidance on what is considered appropriate interactions between an employee who is also an Atrius Health patient and their Atrius Health provider.

For further information about this policy, please refer to the Atrius Health Employee as a Patient Policy, which can be found in Atrius Health's SharePlace.

2. Obtain Referrals to In-Network Specialists

In order to be eligible for In-Network coverage by the Plan, most care you receive in the Service Area must be provided or arranged by your PCP. For more information, please see section *I.D. HOW TO OBTAIN CARE*.

If you need to see a specialist in the Service Area, you must contact your PCP for a Referral prior to the appointment. In most cases, a Referral will be given to

a Plan Provider who is affiliated with the same hospital as your PCP or who has a working relationship with your PCP. Referrals to Plan Providers must be given in writing.

You do not need a Referral from your PCP when you receive care outside of the Service Area (The Service Area includes the states of Massachusetts, New Hampshire, Maine, Rhode Island, Connecticut and Vermont). However, except in a Medical Emergency, you must obtain care from a Plan Provider to obtain In-Network coverage under this Handbook.

3. Show Your Identification Card

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

4. Share Costs

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

- Copayments
- Coinsurance
- Deductibles

Member Cost Sharing amounts for Covered Benefits provided by Primary Care Providers, specialists or hospitals are dependent upon the network placement of the provider. Your Plan may also have an Out-of-Pocket Maximum that limits the amount of Member Cost Sharing you may be required to pay. Your specific Member Cost Sharing responsibilities are listed in your Schedule of Benefits. See the *Glossary* for more information on Copayments, Coinsurance, Deductibles and Out-of-Pocket Maximums.

5. Obtain Prior Approval

You are required to obtain Prior Approval before receiving certain Covered Benefits. Please see section *I.F. PRIOR APPROVAL* for more information on these requirements.

6. Be Aware that your Plan Does Not Pay for All Health Services

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

D. HOW TO OBTAIN CARE

IMPORTANT POINTS TO REMEMBER

1) You and each enrolled Member of your family who lives in the Service Area must select a PCP.
2) The Service Area is the states of Massachusetts, New Hampshire, Maine, Rhode Island, Connecticut and Vermont.
3) You have two types of Covered Benefits, known as "In-Network" and "Out-of-Network."
4) Plan Providers fall into two designated networks, the Atrius Health Ecosystem (which includes Atrius Health Providers and its Preferred Providers), and Non-Preferred Providers. Member Cost Sharing is lowest with Atrius Health Providers, and highest with Non-Preferred Providers.
5) In order to receive In-Network Covered Benefits in the Service Area, your care must be provided or arranged by your PCP through Plan Providers, except as noted below.
6) To receive In-Network Covered Benefits outside of the Service Area, you must use Plan Providers, including Plan Providers enrolled in the Plan's national provider network who are outside the Service Area. See page 6 of this handbook for more details.
7) Out-of-Network Covered Benefits are available when received from Non-Plan Providers or Plan Providers without a proper Referral when one is required.
8) Some services require Prior Approval by the Plan.
9) In the event of a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. You do not need a Referral for services in a Medical Emergency.

In-Network and Out-of-Network

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

To receive In-Network coverage you must use Plan Providers. Plan Providers fall into two In-Network benefit levels; (1) the Atrius Health, Ecosystem (which includes Atrius Health Providers and its Preferred Providers), and (2) Non-Preferred Providers. These Plan Providers are described in section *I.D.4. Using Plan Providers*. Plan Providers have agreed to participate in the Plan and accept the Plan payment minus Member Cost Sharing as payment in full. Since we pay Plan Providers directly, if you show your Member ID card you should not have to file a claim when you use your In-Network coverage.

You receive Out-of-Network coverage when Covered Benefits are provided by Non-Plan Providers or Plan Providers without a PCP referral when one is required. Although your Member Cost Sharing is generally higher for Out-of-Network benefits, you may obtain Covered Benefits from the provider of your choice.

Please Note: If you receive Covered Benefits from a Plan Provider but some or all of those Covered Benefits are provided by a Non-Plan Provider, you will be responsible for the Member Cost Sharing associated with Covered Benefits provided by Plan Providers, unless you had a reasonable opportunity to choose to obtain the Covered Benefits from a Plan Provider.

✔ FOR EXAMPLE: you may receive treatment in a Plan Provider's office but choose to receive associated blood work from a non-plan laboratory. In this example, the Plan Provider would be paid at the In-Network coverage level and the laboratory would be paid at the Out-of-Network coverage level because the laboratory is a Non-Plan Provider and you chose to receive those services from a Non-Plan Provider. However, if a Plan Provider directs you to a Non-Plan Provider and you did not choose that Non-Plan Provider to provide such services, you would be entitled to In-Network coverage for those services from the Non-Plan Provider.

To find out if a provider is a Plan Provider, see the Atrius Health Choice POS Provider Directory. The Atrius Health Choice POS Provider Directory is available online at **www.harvardpilgrim.org/atriushealth** or by calling our Member Services Department at the telephone number listed on your ID card.

Your coverage is described further below.

Some services require Prior Approval by the Plan. Please see the section titled *I.F. PRIOR APPROVAL* for information on the Prior Approval Program.

Please see your Schedule of Benefits for the specific Member Cost Sharing that applies to the In-Network and Out-of-Network benefits.

1. How Your In-Network Benefits Work

To obtain In-Network coverage **in the Service Area**, you must choose a PCP who is a Plan Provider and receive Covered Benefits in one of the following ways:

- The service must be provided by your PCP;
- The service must be provided by a Plan Provider upon Referral from your PCP;
- The service must be one of the special services that do not require a Referral listed in section *I.D.8. Services That Do Not Require a Referral*, and be received from a Plan Provider;
- In the case of mental health and substance use disorder treatment, the service must be provided: (1) by a Plan Provider, and (2) upon referral from the Behavioral Health Access Center.
- The service must be provided in a medical emergency. In a Medical Emergency, including an emergency mental health condition, the Plan provides In-Network coverage for ambulance and hospital emergency room services. You do not need to use a Plan Provider and you do not need a referral from your PCP.

To obtain In-Network coverage **outside the Service Area**, you must receive Covered Benefits through the Plan's national provider network. To find a Plan Provider, see the Atrius Health Choice POS Provider Directory. The provider directory is available online at **www.harvardpilgrim.org/atriushealth** or by calling our Member Services Department at **1–888–333–4742**

When obtaining In-Network benefits, some services require Prior Approval by the Plan. Please see section *I.F. PRIOR APPROVAL* for information on the Prior Approval Program.

2. Your PCP Manages Your Health Care

When you need care **in the Service Area**, call your PCP. The Service Area includes the states of Massachusetts, New Hampshire, Maine, Rhode Island, Connecticut and Vermont.

In order to be eligible for In-Network coverage in the Service Area, most services must be provided or arranged by your PCP. The only exceptions are:

- Care in a Medical Emergency.
- Mental health and substance use disorder treatment. For mental health and substance use disorder treatment, you should call the Behavioral Health Access Center at **1-888-777-4742**. The telephone number for the Behavioral Health

Access Center is also listed on your ID card. Please see section *III. Covered Benefits*, *Mental Health and Substance Use Disorder Treatment* for information on this benefit.

- Special services that do not require a Referral that are listed in section *I.D.8. Services That Do Not Require a Referral*.

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

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

3. Referrals for Hospital and Specialty Care

When you need hospital or specialty care **inside the Service Area** you must first call your PCP. Your PCP will coordinate your care. Your PCP generally uses one hospital for inpatient care. This is where you will need to go for coverage, unless it is Medically Necessary for you to get care at a different hospital.

When you need specialty care, your PCP will refer you to a Plan Provider who is affiliated with the hospital your PCP uses. This helps your PCP coordinate and maintain the quality of your care. Please ask your PCP about the Referral networks that he or she uses.

If the services you need are not available through your PCP's Referral network, your PCP may refer you to any Plan Provider. If you or your PCP has difficulty finding a Plan Provider who can provide the services you need, we will assist you. For help finding a medical provider, please call **1-888-333-4742**. For help finding a mental health or substance use disorder treatment provider, please call **1-888-777-4742**. If no Plan Provider has the expertise needed to meet your medical needs, we will assist you in finding an appropriate Non-Plan Provider.

Plan Providers with recognized expertise in specialty pediatrics are covered with a Referral from your PCP. Pediatric mental health care may be obtained by calling the Behavioral Health Access Center at **1–888–777–4742**.

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

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

There are certain specialized services for which you will be directed to a Center of Excellence for care. Please see section *I.D.5. Centers of Excellence* for more information.

Certain specialty services may be obtained without involving your PCP. For more information please see section *I.D.8. Services That Do Not Require a Referral*.

When you need hospital or specialty care **outside the Service Area** you may obtain Covered Benefits from the provider of your choice. You do not need a Referral for services received outside of the Service Area. However, you must receive Covered Benefits through a Plan Provider to receive In-Network coverage.

4. Using Plan Providers

Plan Providers are under contract to provide Covered Benefits to Members of the Plan. They are listed in the Atrius Health Choice POS Provider Directory with their benefit level. There are two levels of Plan Providers under your Plan. These are (1) the Atrius Health Ecosystem (which includes Atrius Health Providers and its Preferred Providers), and (2) Non-Preferred Providers. Covered Benefits received from Atrius Health Providers will have the lowest In-Network Member Cost Sharing. Covered Benefits received from Non-Preferred Providers will have the highest In-Network Member Cost Sharing. Keep in mind that different out of pocket costs may apply to the same provider based upon where you are treated by that provider.

Covered Benefits must be received from a Plan Provider to be eligible for In-Network coverage. However, there are specific exceptions to this requirement. Covered Benefits from a Non-Plan Provider will only be covered at the In-Network benefit level if one of the following exceptions applies:

1) The service was received in a Medical Emergency from an emergency room or for ambulance transport. (Please see section *I.D.6. Medical Emergency Services* for information on your coverage in a Medical Emergency.)

2) No Plan Provider has the professional expertise needed to provide the required service. In this case, services by a Non-Plan Provider must be authorized in advance by us, unless one of the exceptions above applies.

3) Your physician is disenrolled as a Plan Provider or you are a new Member of the Plan, and one of the exceptions stated in section *I.G. SERVICES PROVIDED BY A DISENROLLED OR NON-PLAN PROVIDER* applies. Please refer to that section for the details of these exceptions.

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

5. Centers of Excellence

Plan Providers with special training, experience, facilities or protocols for certain specialized services are designated as "Centers of Excellence."

Centers of Excellence are selected by us based on the findings of recognized specialty organizations or government agencies such as Medicare. Centers of Excellence are located in Massachusetts, Maine, Connecticut, Rhode Island and New Hampshire. The following specialized service should be obtained through a designated Center of Excellence:

- Weight loss surgery (bariatric surgery)

A list of Centers of Excellence may be found in the Provider Directory. The Provider Directory is available online at **www.harvardpilgrim.org/atriushealth** or by calling our Member Services Department at **1–888–333–4742**.

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

To receive In-Network benefits for the services listed above in Massachusetts, Maine, Connecticut, Rhode Island or New Hampshire, you must obtain care at a Plan Provider that has been designated as a Center of Excellence.

Important Notice: If you choose to receive care in Massachusetts, Maine, Connecticut, Rhode Island or New Hampshire for the above service at a facility other than a contracted Center of Excellence, coverage will be at the Out-of-Network benefit level.

To receive In-Network benefits for the service listed above outside of Massachusetts, Maine, Connecticut, Rhode Island or New Hampshire, you must obtain care at a hospital that is listed as a Plan Provider. Please check your provider directory for a list of participating hospitals.

If you choose to receive care for the above service at a facility other than a Plan Provider, coverage will be at the Out-of-Network benefit level.

6. Medical Emergency Services

In a Medical Emergency, including an emergency related to a substance use disorder or mental health condition, you should go to the nearest emergency facility or call 911 or other local emergency number. Your emergency room Member Cost Sharing is listed in your Schedule of Benefits. Please remember that if you are hospitalized, you must call the Plan at **1-888-333-4742** within 48 hours or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to the Plan by an attending emergency physician no further notice is required. If notification is not received when the Member's condition permits, the Member is responsible for the Penalty Payment

Follow up care outside the Plan's network will be covered at the Out-of-Network benefit level.

7. Coverage for Services When You Are Outside the Service Area

In-Network Coverage

In-Network Coverage is available outside of the Service Area by using Plan Providers enrolled in the Plan's national provider network. You can locate Plan Providers outside of the Service Area by using the Atrius Health Choice POS Plan Provider Directory described earlier in this Handbook.

If you need mental health or substance use disorder treatment outside of the Service Area, simply

contact the Plan's Behavioral Health Access Center at **1-888-777-4742**.

As is the case within the Service Area, you do not need to use a Plan Provider to obtain care in a Medical Emergency, including an emergency related to a substance use disorder or mental health condition. You also do not need to obtain a referral from your PCP. In a medical emergency the Plan provides In-Network coverage for ambulance and hospital emergency room services.

Out-of-Network Coverage
When you are outside the Service Area you may also obtain Out-of-Network coverage from Non-Plan Providers.

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

8. Services That Do Not Require a Referral

When you are inside the Service Area you will usually need a Referral from your PCP to get In-Network coverage from any other Plan Provider. However, you do not need a Referral for the services listed below. You may obtain In-Network coverage for these services from any Plan Provider without a Referral from your PCP. Plan Providers are listed in the Atrius Health Choice POS Provider Directory.

i. Family Planning Services:

- Contraceptive monitoring
- Family planning consultation, including pregnancy testing
- Tubal ligation
- Voluntary termination of pregnancy

ii. Outpatient Maternity Services

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

iii. Gynecological Services

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

iv. Dental Services:

- Emergency Dental Care
- Extraction of teeth impacted in bone

v. Other Services:

- Spinal manipulative therapy
- Routine eye examination
- Urgent Care services

9. How Your Out-of-Network Benefits Work

You use your Out-of-Network coverage whenever you obtain Covered Benefits from Non-Plan Providers. This allows you to obtain services from any licensed health care professional. You do not need a Referral from your PCP. A wide range of health care services, including physician and hospital services are covered at the Out-of-Network benefit level.

Services will also be covered as Out-of-Network services if you receive care from a Plan Provider without a PCP Referral when one is required.

The Plan pays only a percentage of the cost of Covered Benefits you receive from Non-Plan Providers. You are responsible for paying the balance. Your Member Cost Sharing is generally higher for Out-of-Network benefits. However, you have more flexibility in obtaining care and may go to the licensed health care professional of your choice.

When obtaining Out-of-Network benefits, some services require Prior Approval by the Plan. Please see section *I.F. PRIOR APPROVAL* for information on the Prior Approval Program.

Payments to Plan Providers are usually based on a contracted rate between us and the Plan Provider. Since we have no contract with Non-Plan Providers, there is no limit on what such providers can charge. You are responsible for any amount charged by a

Non-Plan Provider in excess of the Allowed Amount for the service.

E. MEMBER COST SHARING

You are required to share the cost of Covered Benefits provided under the Plan. Your Member Cost Sharing may include Copayments, Coinsurance and Deductibles when using Plan Providers or Non-Plan Providers.

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

1. Out-of-Network Charges in Excess of the Allowed Amount

On occasion, a Non-Plan Provider may charge amounts in excess of the Allowed Amount. In those instances, you will be financially responsible for the difference between what the provider charges and the amount of the Allowed Amount payable by the Plan. This means that you will be responsible for paying the full amount above the Allowed Amount. Amounts charged by a Non-Plan Provider in excess of the Allowed Amount do not count toward the Out-of-Pocket Maximum. You may contact the Member Services Department at **1–888–333–4742** or at **711** for TTY service if you have questions about the maximum Allowed Amount that may be permitted by HPHC for a service.

2. Penalty

A Member is responsible to pay a Penalty for certain Out-of-Network services when Prior Approval has not been received before obtaining the services. The Penalty charge is in addition to any Member Cost Sharing amounts. Penalty charges do not count towards any Out-of-Pocket Maximum. Please see section *I.F. PRIOR APPROVAL* for a detailed explanation of the Prior Approval Program.

3. Combined Payment Levels

Under some circumstances you may receive services from both a Plan Provider and a Non-Plan Provider when obtaining care. When this occurs, your entitlement to In-Network or Out-of-Network coverage always depends upon the participation status of the individual service Provider. For example, you may receive treatment in a Plan Provider's office and receive associated blood work from an non-plan laboratory. Since the payment level is dependent upon the participation status of the provider, the Plan Provider would be paid at the In-Network coverage level and the laboratory would be paid at the Out-of-Network coverage level.

The benefit payment level that is applied to a hospital admission depends on the participation status of both the admitting physician and the hospital. If a Plan Provider admits you to a participating hospital, both the hospital and physician are paid at the In-Network coverage level. If an Out-of-Network physician admits you to a participating hospital, the hospital's charges are paid at the In-Network coverage level but the physician's charges are paid at the Out-of-Network coverage level. Likewise if a Plan Provider admits you to a non-plan hospital, the hospital's charges are paid at the Out-of-Network coverage level but the physician's charges are paid at the In-Network coverage level. All Out-of-Network payments by the Plan are limited to the Allowed Amount.

Your Member Cost Sharing will depend on who you choose as your PCP. Please see the Section *1. Choose a Primary Care Provider (PCP)* earlier in this document for Member Cost Sharing details when choosing your PCP.

F. PRIOR APPROVAL

This section explains when Prior Approval is required and the procedures to follow to meet those requirements.

Please note that your doctor or hospital can seek Prior Approval on your behalf. Also, you do not need to obtain Prior Approval if services are needed in a Medical Emergency.

1. When Prior Approval is Required

Prior Approval must be obtained for any of the services listed below. If you will receive these services from a Non-Plan Provider, you must seek Prior Approval. If you will receive these services from a Plan Provider, he or she will obtain Prior Approval for you.

a. **For Substance Use Disorder Treatment from a Provider not certified or licensed by the Massachusetts Department of Public Health**
Except for Acute Treatment Services and Clinical Stabilization Services, Prior Approval must be obtained before receiving substance use disorder treatment from a Provider not certified or licensed by the Massachusetts Department of Public Health (i.e. Providers located outside the Commonwealth of Massachusetts). To

obtain Prior Approval for substance use disorder treatment you should call the Behavioral Health Access Center at **1-888-777-4742**.

Please Note: Prior Approval is not required to obtain Acute Treatment Services or Clinical Stabilization Services from either a Plan Provider or Non-Plan Provider. For more information on utilizing Non-Plan Providers, please refer to your Out-of-Network benefits. The terms "Acute Treatment Services" and "Clinical Stabilization Services" are defined in the Glossary at Section II of this Benefit Handbook. Services beyond the 14 day period may be subject to concurrent review as described in Section *X.J. UTILIZATION REVIEW PROCEDURES* of this Handbook.

b. **For Mental Health Treatment from a Non-Plan Provider**

Prior Approval must be obtained before receiving certain mental health treatment from a Non-Plan Provider. To obtain Prior Approval for mental health treatment, you should call the Behavioral Health Access Center at **1-888-777-4742**.

The following is a list of the mental health services that require Prior Approval when obtained from a Non-Plan Provider.

Please refer to HPHC's website at www.harvardpilgrim.org/atriushealth, or call Member Services for updates and revisions to this list:

- **Inpatient services**
- **Intensive Outpatient Program Treatment** - Treatment programs at an outpatient clinic or other facility generally lasting three or more hours a day for two or more days a week.
- **Partial Hospitalization and Day Treatment Programs**
- **Extended Outpatient Treatment Visits** – Outpatient visits of more than 60 minutes duration with or without medication management or any treatment routinely involving more than one outpatient visit in a day.
- **Outpatient Electro-Convulsive Treatment (ECT)**
- **Psychological Testing**
- **Applied Behavior Analysis (ABA) for the treatment of Autism**

Please Note: You may also contact the Behavioral Health Access Center at **1-888-777-4742** for assistance in obtaining covered mental health and substance use disorder treatment, even if Prior Approval is not required for the service you require.

c. **For Medical Services from a Non-Plan Provider or Plan Provider Outside the Service Area.**

You must obtain Prior Approval in advance of receiving any of the medical services or Medical Drugs listed below from a Non-Plan Provider or Plan Provider outside the Service Area. To obtain Prior Approval for medical services or Medical Drugs you should call:

- **1-800-708-4414** for medical services
- **1-844-387-1435** for Medical Drugs

Please refer to HPHC's website at www.harvardpilgrim.org/atriushealth, or call Member Services for updates and revisions to the following list:

- **Bronchial thermoplasty treatments —** outpatient treatments only.
- **Cochlear implants**
- **Cosmetic, reconstructive and restorative procedures** – All Covered Benefits, including, but not limited to, blepharoplasty, breast reduction mammoplasty, including breast implant removal and gynocomastia surgery, panniculectomy, ptosis repair, rhinoplasty, and scar revision. (Please note that the Plan provides very limited coverage for Cosmetic Services. Please see "Reconstructive Surgery" in section *III. Covered Benefits* for details.)
- **Cryotherapy**
- **Dental services** – All Covered Benefits, including, but not limited to, surgical treatment of tempromandibular joint dysfunction (TMD) and extraction of teeth impacted in bone. (Please note that the Plan provides very limited coverage for Dental Care. Please see "Dental Services" in section *III. Covered Benefits* and your Schedule of Benefits for details.)
- **Diabetes equipment** — Continuous glucose monitoring systems and insulin pumps.
- **Formulas and enteral nutrition** – Outpatient services only.
- **Genetic testing –** Including, but not limited to, breast cancer (BRCA) testing.

- **Home health care** – Includes home infusion and home hospice care.
- **Hospital inpatient admissions** – All inpatient admissions.
- **Hyperbaric oxygen therapy**
- **Infertility Services** – All Covered Benefits for the treatment of infertility.
- **Interventional pain management for back pain** – Including, but not limited to, epidural injections; facet joint injections and facet neurolysis.
- **Medical Drugs –** Including, but not limited to, antibiotics for lyme disease; hyaluronate injections; immune globulin (IVIg); and immunobiologics (e.g., Remicade and Rituxin).
- **Non—emergency ground transportation —** Please note Prior Approval is not required for transportation provided by a wheelchair van.
- **Non—emergency air transportation —** Please note, Prior Approval is not required for emergency air ambulance. Emergency air ambulance transportation is immediate transportation by air ambulance that is arranged by police, fire or other emergency rescue officials during a Medical Emergency.
- **Outpatient surgery** – All outpatient surgeries.
- **Prenatal ultrasound (detailed fetal anatomic) & fetal echocardiography**
- **Prosthetic devices** – Upper and lower prosthetic arms and legs only.
- **Pulmonary rehabilitation** – Outpatient services only.
- **Radiation oncology** – IMRT and proton beam.
- **Radiology – advanced radiology**- Computerized axial tomography (CAT and CT and CTA scans); magnetic resonance imaging (MRI and MRA scans); nuclear medicine; and positron emission tomography (PET scans)
- **Skilled Nursing Facility (SNF) and rehabilitation hospital care** – Includes all admissions to Skilled Nursing Facilities (SNFs) and inpatient rehabilitation facilities.

Please refer to HPHC's website, www.harvardpilgrim.org/atriushealth for updates and revisions to the above list.

2. How to Obtain Prior Approval

To seek Prior Approval for medical services, Medical Drugs or mental health and substance use disorder treatment received from a Non-Plan Provider or a Plan Provider outside the Service Area, you should call:

- **1-800-708-4414** for medical services
- **1-844-387-1435** for Medical Drugs
- **1-888-777-4742** for mental health and substance use disorder treatment

The following information must be given when seeking Prior Approval for medical services or Medical Drugs:

- The Member's name
- The Member's ID number
- The treating physician's name, address and telephone number
- The diagnosis for which care is ordered
- The treatment ordered and the date it is expected to be performed

For inpatient admission to a Non-Plan Provider or a Plan Provider outside the Service Area, the following additional information must be given:

- The name and address of the facility where care will be received
- The admitting physician's name, address and telephone number
- The admitting diagnoses and date of admission
- The name of any procedure to be performed and the date it is expected to be performed

3. The Effect of Prior Approval on Coverage

If you obtain Prior Approval when required, the Plan will pay up to the full benefit limit stated in this Benefit Handbook and your Schedule of Benefits.

If you do not obtain Prior Approval when required, you will receive coverage only for services later determined to be Medically Necessary and will be responsible for any applicable Member Cost Sharing. For services received fron a Non-Plan Provider, you will also be responsible for paying the penalty amount stated in the Schedule of Benefits.

If HPHC determines at any point that a service is not Medically Necessary, no coverage will be provided for the services at issue, and you will be responsible for the entire cost of those services.

Prior Approval does not entitle you to any benefits not otherwise payable under this Benefit Handbook or the Schedule of Benefits.

Please see section *X.J. UTILIZATION REVIEW PROCEDURES* for information on the time limits

for Prior Approval decisions and reconsideration procedures for providers if coverage is denied. Please see section *VI. Appeals and Complaints* for a description of your appeal rights if coverage for a service is denied by HPHC.

4. What the Prior Approval Program Does

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

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

If the Prior Approval Program conducts a medical review of a service, you and your attending physician will be notified of the Plan's decision to approve or not to approve the care proposed. When level of care, place of service or setting is part of the review, services that can be safely provided to you in a lower level of care, place of service or setting will not be Medically Necessary if they are provided in a higher level of care, place of service or setting. All decisions to deny a medical service will be reviewed by a physician (or, in the case of Medical Drugs or mental health and substance use disorder treatment, a qualified clinician) in accordance with written clinical criteria. Medical review criteria will be based on a number of sources including medical policy and clinical guidelines. The relevant criteria will be made available to providers and Members upon request.

If the Prior Approval Program denies a coverage request, it will send you a written notice that explains the decision, your provider's right to obtain reconsideration of the decision, and your appeal rights.

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

1. Disenrollment of Primary Care Provider (PCP)

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

2. Pregnancy

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

3. Terminal Illness

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

4. New Membership

If you are a new Member, the Plan will provide In-Network coverage for services delivered by a physician who is a Non-Plan Provider, under the terms of this Handbook and your Schedule of Benefits, for up to 30 days from your effective date of coverage if;

- Your Plan Sponsor only offers employees a choice of plans in which the physician is a Non-Plan Provider, and
- The physician is providing you with an ongoing course of treatment or is your PCP.

With respect to a Member in her second or third trimester of pregnancy, this provision shall apply to services rendered through the first postpartum visit. With respect to a Member with a Terminal Illness, this provision shall apply to services rendered until death.

5. Conditions for Coverage of Services by a Disenrolled or Non-Plan Provider

Services received from a disenrolled or Non-Plan Provider as described in the paragraphs above, are only covered when the physician agrees to:

- Accept reimbursement from us at the rates applicable prior to notice of disenrollment as

payment in full and not to impose Member Cost Sharing with respect to the Member in an amount that would exceed the Member Cost Sharing that could have been imposed if the provider had not been disenrolled;

- Adhere to the quality assurance standards of the Plan and to provide us with necessary medical information related to the care provided; and
- Adhere to our policies and procedures, including procedures regarding Referrals, obtaining Prior Approval and providing Covered Benefits pursuant to a treatment plan, if any, approved by us.

H. CLINICAL REVIEW CRITERIA

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

I. PROVIDER FEES FOR SPECIAL SERVICES (CONCIERGE SERVICES)

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

In considering arrangements with physicians for special services, you should understand exactly what services are to be provided and whether those services are worth the fee you must pay. For example, the Plan does not require participating providers to be available by telephone 24-hours a day. However, the Plan does require PCPs to provide both an answering service that can be contacted 24-hours a day and prompt appointments when Medically Necessary.

J. BUNDLED PAYMENT ARRANGEMENTS

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

II. Glossary

This section lists words with special meaning within the Handbook.

Activities of Daily Living The basic functions of daily life include bathing, dressing, and mobility, including, but not limited to, transferring from bed to chair and back, walking, sleeping, eating, taking medications and using the toilet.

Acute Treatment Services 24-hour medically supervised addiction treatment for adults or adolescents provided in a medically managed or medically monitored inpatient facility, as defined by the Massachusetts Department of Public Health. Acute Treatment Services provide evaluation and withdrawal management and may include biopsychological assessment, individual and group counseling, psychoeducational groups and discharge planning.

Allowed Amount The Allowed Amount is the maximum amount the Plan will pay for Covered Benefits minus any applicable Member Cost Sharing.

The Allowed Amount for In-Network benefits is the contracted rate the Plan has agreed to pay Plan Providers.

If services provided by a Non-Plan Provider are Covered Benefits under this Benefit Handbook, the Allowed Amount for such services depends upon where you receive the service, as explained below:

a. If you receive Out-of-Network services in the states of Massachusetts, New Hampshire, Maine, Rhode Island, Connecticut and Vermont, the Allowed Amount is defined as follows: The Allowed Amount is the lower of the provider's charge or a rate determined as described below: The Allowed Amount is an amount that is consistent, in the judgment of the Plan, with the normal range of charges by health care providers for the same, or similar, products or services provided to a Member. If the Plan has appropriate data for the area, the Plan will determine the normal range of charges in the geographic area where the product or services were provided to the Member. If the Plan does not have data to reasonably determine the normal range of charges where the products or services were provided, the Plan will utilize the normal range of charges in Boston, Massachusetts. Where services are provided by non-physicians but the data on provider charges available to the Plan is based on charges for services by physicians, the Plan will, in its discretion, make reasonable reductions in its determination of the allowable charge for such non-physician providers.

b. If you receive Out-of-Network services outside of the states of Massachusetts, New Hampshire, Maine, Rhode Island, Connecticut and Vermont, the Allowed Amount is defined as follows: The Allowed Amount is the lower of the provider's charge or a rate determined as described below: The Allowed Amount is determined based on 150% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market. When a rate is not published by CMS for the service, we use other industry standard methodologies to determine the Allowed Amount for the service as follows: For services other than Pharmaceutical Products, we use a methodology called a relative value scale, which is based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by Optuminsight, Inc. If the Optuminsight, Inc. relative value scale becomes no longer available, a comparable scale will be used. For Pharmaceutical Products, we use industry standard methodologies that are similar to the pricing methodology used by CMS and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource. When a rate is not published by CMS for the service and no industry standard methodology applies to the service, or the provider does not submit sufficient information on the claim to pay it under CMS published rates or an industry standard methodology, the Allowed Amount will be 50% of the provider's billed charge, except that the Allowed Amount for certain mental health and substance use disorder treatment services will be 80% of the billed charge.

Pricing of the Allowed Amount will be conducted by UnitedHealthcare, Inc. United Healthcare, updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.

Anniversary Date The date agreed to by HPHC and your Plan Sponsor upon which the yearly benefit changes normally become effective. This

Benefit Handbook, Schedule of Benefits, and any applicable riders will terminate unless renewed on the Anniversary Date.

✔ FOR EXAMPLE: If your Anniversary Date is January 1st, this is the date when the Plan goes into effect and begins to pay for Covered Benefits.

Atrius Health Ecosystem In-Network coverage level including designated Atrius Health Providers and facilities, and its Preferred Providers and facilities. Preferred Providers have higher Member Cost Sharing than Atrius Health Providers.

Atrius Health Provider Designated Plan Providers in the Atrius Health Choice POS Plan within the Atrius Health Ecosystem. Atrius Health Providers include Primary Care Providers (PCPs), specialists and other providers. Atrius Health Providers are covered with the lowest Member Cost Sharing when Members are able to utilize them.

Atrius Health Choice POS Provider Directory (or Provider Directory) A directory that identifies providers. We may revise the Provider Directory from time to time without notice to Members. The most current listing of Plan Providers is available on **www.harvardpilgrim.org/atriushealth**.

Behavioral Health Access Center The organization, designated by HPHC, that is responsible for arranging for the provision of services for Members in need of mental health and substance use disorder treatment. You may contact the Behavioral Health Access Center by calling **1–888–777–4742**. The Behavioral Health Access Center will assist you in finding an appropriate Plan Provider and arranging the services you require.

Benefit Handbook (or Handbook) This document that describes the terms and conditions of the Plan, including but not limited to, Covered Benefits and exclusions from coverage.

Benefit Limit The day, visit or dollar limit maximum that applies to certain Covered Benefits. Once the Benefit Limit has been reached, no more benefits will be paid for such services or supplies. If you exceed the Benefit Limit, you are responsible for all charges incurred. The Benefit Limits applicable to your Plan are listed in your Schedule of Benefits.

✔ FOR EXAMPLE: If your Plan offers 30 visits per Calendar Year for physical therapy services, once you reach your 30 visit limit for that Calendar Year, no additional benefits for that service will be covered by the Plan.

Calendar Year The one year period beginning on January 1 for which benefits are purchased and administered. Benefits for which limited yearly coverage is provided renew at the beginning of the Calendar Year. Benefits for which limited coverage is provided every two years renew at the beginning of every second Calendar Year. Benefits under your Plan are administered on a Calendar Year basis.

Centers of Excellence Plan Providers with special training, experience, facilities or protocols for certain services, selected by us based on the findings of recognized specialty organizations or government agencies such as Medicare. Certain specialized services are only covered as In-Network services in Massachusetts, Maine, Connecticut, Rhode Island or New Hampshire when received from designated Centers of Excellence.

Clinical Stabilization Services 24-hour clinically managed post detoxification treatment for adults or adolescents, as defined by the Massachusetts Department of Public Health. Clinical Stabilization Services usually follow Acute Treatment Services for substance use disorders. Clinical Stabilization Services may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others and after care planning, for individuals beginning to engage in recovery from addiction.

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

✔ FOR EXAMPLE: If the Coinsurance for a service is 20%, you pay 20% of the Allowed Amount while the Plan pays the remaining 80%.

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

✔ FOR EXAMPLE: If your Plan has a $20 Copayment for outpatient visits, you'll pay $20 at the time of the visit or when you are billed by the provider.

Cosmetic Services Cosmetic Services are surgery, procedures or treatments that are performed primarily to reshape or improve the individual's appearance.

Covered Benefit The products and services that a Member is eligible to receive, or obtain payment for, under the Plan.

Custodial Care Services provided to a person for the primary purpose of meeting non-medical personal needs (e.g., bathing, dressing, preparing meals, including special diets, taking medication, assisting with mobility).

Deductible A specific dollar amount that is payable by the Member for Covered Benefits received each Calendar Year before any benefits subject to the Deductible are payable by the Plan. Deductible amounts are incurred on the date of service. Your Deductible amounts, and the services to which they apply are stated in the Schedule of Benefits.

If a family Deductible applies, it can be met in one of two ways: a. If a Member of a covered family meets an individual Deductible, then that Member has no additional Deductible Member Cost Sharing

responsibilities for Covered Benefits for the remainder of the Calendar Year. b. If any number of Members in a covered family collectively meets a family Deductible, then all Members in that covered family have no additional Deductible Member Cost Sharing responsibilities for Covered Benefits for the remainder of the Calendar Year.

✔ FOR EXAMPLE: If your Plan has a $500 Deductible and you have a claim with the Allowed Amount of $1,500, you will be responsible for the first $500 to satisfy your Deductible requirement before the Plan begins to pay benefits.

Deductible Rollover A Deductible Rollover allows a Member to apply any Deductible amount incurred for Covered Benefits during the last three months of a Calendar Year toward the Deductible for the next Calendar Year. To be eligible for a Deductible Rollover, a Member must have had continuous coverage with us through the same Plan Sponsor at the time the prior Calendar Year charges were incurred. If your Plan has a Deductible Rollover it will be listed in your Schedule of Benefits.

Please Note: Deductible Rollover amounts will not apply to the Out-of-Pocket Maximum amount for the next Calendar Year.

Dental Care Any service provided by a licensed dentist involving the diagnosis or treatment of any disease, pain, injury, deformity or other condition of the human teeth, alveolar process, gums, jaw or associated structures of the mouth. However, surgery performed by an oral maxillofacial surgeon to correct positioning of the bones of the jaw (orthognathic surgery) is not considered Dental Care within the meaning of this definition.

Dependent A Member of the Subscriber's family who (1) meets the eligibility requirements for coverage through a Subscriber as agreed upon by the Plan Sponsor and HPHC and (2) is enrolled in the Plan. Eligibility requirements are documented as part of the contract between the Plan Sponsor and HPHC. Please see your Plan Sponsor's Benefits Office for details on the agreement between HPHC and your Plan Sponsor.

Experimental, Unproven, or Investigational Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests, will be deemed Experimental, Unproven, or Investigational by us under this Benefit Handbook for use in the diagnosis or treatment of a particular medical condition if any the following is true:

a) The product or service is not recognized in accordance with generally accepted medical standards as being safe and effective for the use in the evaluation or treatment of the condition in question. In determining whether a service has been recognized as safe or effective in accordance with generally accepted evidence-based medical standards, primary reliance will be placed upon data from published reports in authoritative medical or scientific publications that are subject to established peer review by qualified medical or scientific experts prior to publication. In the absence of any such reports, it will generally be determined a service, procedure, device or drug is not safe and effective for the use in question. b) In the case of a drug, the drug has not been approved by the United States Food and Drug Administration (FDA). (This does not include off-label uses of FDA approved drugs).

Family Coverage Coverage for a Member and Dependents (spouse plus one or more children).

Habilitation Services Health care services that help a person keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapies and speech-language services.

Harvard Pilgrim Health Care, Inc. (HPHC or Harvard Pilgrim) Harvard Pilgrim Health Care, Inc. is an insurance company that provides, arranges or administers health care benefits for Members through a network of Plan Providers. Under self insured plans such as this one, HPHC adjudicates and pays claims, and manages benefits on behalf of the Plan Sponsor.

Health Benefit Plan All group HMO and other group prepaid health plans, medical or hospital service corporation plans, commercial health insurance and self-insured health plans, which are separate from this Plan.

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

In-Network The level of benefits or coverage a Member receives when Covered Benefits are obtained through a Plan Provider.

Licensed Mental Health Professional For services provided in Massachusetts a Licensed Mental Health Professional is any one of the following: a licensed physician who specializes in the practice of psychiatry; a licensed psychologist; a licensed independent clinical social worker; a licensed nurse mental health clinical specialist; a level I licensed alcohol and drug counselor; a licensed marriage and family therapist; or a licensed mental health counselor. For services provided outside of Massachusetts, a Licensed Mental Health Professional is an independently licensed clinician with at least a masters degree in a clinical mental health discipline from an accredited educational institution and at least two years of clinical experience. The term "clinical mental health discipline" includes the following: psychiatry; psychology, clinical social work; marriage and family therapy; clinical counseling; developmental psychology; pastoral counseling; psychiatric nursing; developmental or educational psychology; counselor education; or any other discipline deemed acceptable by the Plan.

Medical Drugs A prescription drug that is administered to you either (1) in a doctor's office or other outpatient medical facility, or (2) at home while you are receiving home health care services or receiving

drugs administered by home infusion services. Medical Drugs cannot be self-administered. The words "cannot be self-administered" mean that the active participation of skilled medical personnel is always required to take the drug. When a Member is receiving drugs in the home, the words "cannot be self-administered" will also include circumstances in which a family member or friend is trained to administer the drug and ongoing supervision by skilled medical personnel is required.

Medical Emergency A medical condition, whether physical or mental (including a condition resulting from a substance use disorder), manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the Member or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part. With respect to a pregnant woman who is having contractions, Medical Emergency also means that there is inadequate time to effect a safe transfer to another hospital before delivery or that transfer may pose a threat to the health or safety of the woman or the unborn child.

Examples of Medical Emergencies are: heart attack or suspected heart attack, stroke, shock, major blood loss, choking, severe head trauma, loss of consciousness, seizures and convulsions.

Please remember that if you are hospitalized, you must call HPHC within 48 hours or as soon as you can. If the notice of hospitalization if given to HPHC by an attending emergency physician, no further notice is required.

Medically Necessary or Medical Necessity Those health care services that are consistent with generally accepted principles of professional medical practice as determined by whether: (a) the service is the most appropriate supply or level of service for the Member's condition, considering the potential benefit and harm to the individual; (b) the service is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; and, (c) for services and interventions that are not widely used, the use of the service for the Member's condition is based on scientific evidence.

Member Any Subscriber or Dependent covered under the Plan.

Member Cost Sharing The responsibility of Members to assume a share of the cost of the benefits provided under the Plan. Member Cost Sharing may include Copayments, Coinsurance and Deductibles. Please refer to your Schedule of Benefits for the specific Member Cost Sharing that applies to your Plan.

Network Providers of health care services, including but not limited to, physicians, hospitals and other health care facilities, that are under contract with us to provide services to Members.

Non-Plan Provider A provider not under contract with HPHC or its affiliates to provide care to Members of your Plan.

Non-Preferred Provider In-Network Plan Providers and facilities who participate in the Atrius Health Choice POS Plan, but fall outside the Atrius Health Ecosystem. Covered Benefits with Non-Preferred Plan Providers have the highest In-Network Member Cost Sharing.

Out-of-Network The level of benefits or coverage a Member receives when Covered Benefits are obtained through a Non-Plan Provider or through a Plan Provider in the Service Area without a Referral when a Referral is required.

Out-of-Pocket Maximum An Out-of-Pocket Maximum is a limit on the amount of Copayments, Coinsurance and Deductibles that you must pay for Covered Benefits in a Calendar Year. Penalty amounts and charges above the Allowed Amount never apply to the Out-of-Pocket Maximum. The Out-of-Pocket Maximum is specified in your Schedule of Benefits.

If a family Out-of-Pocket Maximum applies, it can be met in one of two ways: a. If a Member of a covered family meets an individual Out-of-Pocket Maximum, then that Member has no additional Member Cost Sharing responsibilities for Covered Benefits for the remainder of the Calendar Year. b. If any number of Members in a covered family collectively meets a family Out-of-Pocket Maximum, then all Members in that covered family have no additional Member Cost Sharing responsibilities for Covered Benefits for the remainder of the Calendar Year.

✔ FOR EXAMPLE: If your Plan has an individual Out-of-Pocket Maximum of $4,000, this is the most Member Cost Sharing you would pay in a Calendar Year for services to which the Out-of-Pocket Maximum applies. For example, as long as the services you received are not excluded from the Out-of-Pocket Maximum, you could combine $1,500 in Deductible expenses, $500 in Copayments, and $2,000 in Coinsurance payments to reach the $4,000 Out-of-Pocket Maximum.

Penalty The amount that a Member is responsible to pay for certain Out-of-Network services when Prior Approval has not been received before receiving the services. The Penalty charge is in addition to any Member Cost Sharing amounts. Please see section *I.F. PRIOR APPROVAL* for a detailed explanation of the Prior Approval Program. A Penalty amount does not apply to an Out-of-Pocket Maximum, if any.

Physical Functional Impairment A condition in which the normal or proper action of a body part is damaged, and affects the ability to participate in Activities of Daily Living. Physical Functional Impairments include, but are not limited to, problems with ambulation, communication, respiration, swallowing, vision, or skin integrity.

A physical condition may impact an individual's emotional well-being or mental health. However such impact is not considered in determining whether or not a Physical Functional Impairment exists. Only the physical consequences of a condition are considered.

Plan This package of health care benefits known as The Harvard Pilgrim Atrius Health Choice POS that is administered by HPHC on behalf of your Plan Sponsor. HPHC or your Plan Sponsor may take action on behalf of the Plan. For In-Network coverage under this Plan, Covered Benefits must be obtained from an HPHC Plan Provider.

Plan Provider Providers of health care services that are under contract to provide care to Members. Plan Providers include, but are not limited to physicians, podiatrists, psychologists, psychiatrists, nurse practitioners, advanced practice registered nurses, physician's assistants, psychiatric social workers, certified psychiatric nurses, psychotherapists, licensed independent clinical social workers, licensed nurse mental health clinical specialist, nurse midwives, nurse anesthetists, and licensed mental health counselors, level I licensed alcohol and drug counselors, and early intervention specialists who are credentialed and certified by the Massachusetts Department of Public Health.

Plan Providers inside the Service Area (the states of Massachusetts, New Hampshire, Maine, Rhode Island, Connecticut and Vermont) are made up of providers in two levels of In-Network Coverage, (1) the Atrius Health Ecosystem (which includes Atrius Health Providers and its Preferred Providers), and (2) Non-Preferred Providers.

Plan Providers outside the Service Area (the states of Massachusetts, New Hampshire, Maine, Rhode Island, Connecticut and Vermont) are made up of Non-Preferred Providers enrolled in the Plan's national provider network.

All Plan Providers are listed in the Atrius Health Choice POS Provider Directory.

Plan Sponsor The entity that has contracted with HPHC to provide health care services and supplies for its employees and their dependents under the Plan. The Plan Sponsor pays for the health care coverage provided under the Plan.

Preferred Provider Designated Plan Providers, including PCPs, specialists and facilities who participate in the Atrius Health Choice POS Plan within the Atrius Health Ecosystem. Preferred Providers have higher Member Cost Sharing than Atrius Health Providers, but they have lower Member Cost Sharing than Non-Preferred Providers.

Primary Care Provider (PCP) A Plan Provider designated to help you maintain your health and to provide and authorize your medical care under the Plan. A PCP may be a physician, a physician assistant or a nurse practitioner specializing in one or more of the following specialties: internal medicine, adult medicine, adolescent medicine, geriatric medicine, pediatrics or family practice. A PCP may designate other Plan Providers to provide or authorize a Member's care.
Certain PCPs are designated as Atrius Health PCPs. This Plan generally designates lower Member Cost Sharing when a Member chooses an Atrius Health PCP. Atrius Health PCPs are listed in the online Provider Directory at **www.harvardpilgrim.org/atriushealth**. Please also see the Section *1. Choose a Primary Care Provider (PCP)* earlier in this document for Member Cost Sharing details when choosing your PCP.

Prior Approval or Prior Approval Program (also known as Prior Authorization) A program to (1) verify that certain Covered Benefits are and continue to be, Medically Necessary and provided in an appropriate and cost-effective manner or (2) arrange for the payment of benefits.

Please see section*I.F. PRIOR APPROVAL* for a detailed explanation of the Prior Approval Program.

Referral An instruction from your PCP that gives you the ability to see another Plan Provider for services that may be out of your PCP's scope of practice. Referrals to Plan Providers must be given in writing. You do not need a Referral from your PCP when you receive services from a Plan Provider outside of the Plan Service Area.

✔ FOR EXAMPLE: If you need to visit a specialist, such as a dermatologist or cardiologist, you must contact your PCP first. Your PCP will refer you to a specialist who is a Plan Provider. Your PCP will generally refer you to a specialist with whom he or she is affiliated or has a working relationship.

Rehabilitation Services Rehabilitation Services are treatments for disease or injury that help restore or move an individual toward functional capabilities he/she had prior to disease or injury. For treatment of congenital anomalies with significant functional impairment, Rehabilitation Services improve functional capabilities to or toward normal function for age appropriate skills. Only the following are covered: cardiac rehabilitation therapy; occupational therapy; physical therapy; pulmonary rehabilitation therapy; speech therapy; or an organized program of these services when rendered by a health care professional licensed to perform these therapies.

Schedule of Benefits A summary of the benefits selected by your Plan Sponsor and covered under your Plan are listed in the Schedule of Benefits. In addition, the Schedule of Benefits contains any limitations and Copayments, Coinsurance or Deductible you must pay.

Service Area The Service Area includes the states of Massachusetts, New Hampshire, Maine, Rhode Island, Connecticut and Vermont.

Skilled Nursing Facility An inpatient extended care facility, or part of one,

that is operating pursuant to law and provides skilled nursing services.

Subscriber The person who meets the Subscriber eligibility requirements described in this Benefit Handbook and is enrolled in the Plan.

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

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

Urgent Care Medically Necessary services for a condition that requires prompt medical attention but is not a Medical Emergency.

III. Covered Benefits

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

Basic Requirements for Coverage

All Services

To be covered by the Plan, a product or service must meet each of the following requirements. It must be:

- Medically Necessary.
- Listed as a Covered Benefit in this section.
- Not excluded in section *IV. Exclusions*.
- Received while an active Member of the Plan.

In-Network Coverage

To be covered as an In-Network benefit, a product or service must also be (1) provided by a Plan Provider and (2) meet one of the following requirements:

- Provided by or upon Referral from your PCP. This requirement does not apply to care needed in a Medical Emergency and care received outside of the Plan Service Area. Please see section *I.D.2. Your PCP Manages Your Health Care* for other exceptions that may apply.
- Provided by a Plan Provider. This requirement does not apply to ambulance or emergency room care needed in a Medical Emergency. Please see section *I.D.4. Using Plan Providers* for other exceptions that may apply.

Out-of-Network Coverage

You may obtain Out-of-Network coverage for Covered Benefits from any licensed health care provider. Out-of-Network services do not need to be provided or arranged by your PCP or the Behavioral Health Access Center.

Some services require Prior Approval by the Plan. For information on the Plan's Prior Approval Program, please see section *I.F. PRIOR APPROVAL*.

Benefit	Description
1 . Ambulance Transport	
	Emergency Ambulance Transport If you have a Medical Emergency (including an emergency related to a mental health or substance use disorder condition), your Plan covers ambulance transport to the nearest hospital that can provide you with Medically Necessary care. **Non-Emergency Ambulance Transport** You're also covered for non-emergency ambulance transport between hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary. For In-Network coverage, services must be arranged by a Plan Provider. **Prior Approval Required:** You must obtain Prior Approval for non-emergency transportation. Please note Prior Approval is not required for transportation provided by a wheelchair van. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.

Benefit	Description
2 . Autism Spectrum Disorders Treatment	
	Coverage is provided for the diagnosis and treatment of Autism Spectrum Disorders, as defined below. Covered Benefits include the following: • Diagnosis of Autism Spectrum Disorders. This includes Medically Necessary assessments, evaluations, including neuropsychological evaluations, genetic testing or other tests to diagnose whether an individual has one of the Autism Spectrum Disorders. • Professional services by physicians, Licensed Mental Health Professionals, speech therapists, occupational therapists, and physical therapists. • Rehabilitation and Habilitation Services, including, but not limited to, applied behavior analysis supervised by a board certified behavior analyst as defined by law. Autism Spectrum Disorders include any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. These include Autistic Disorder; Asperger's Disorder; and Pervasive Developmental Disorders Not Otherwise Specified. Applied behavior analysis is defined as the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior. It includes the use of direct observation, measurement and functional analysis of the relationship between environment and behavior. There is no coverage for services related to autism spectrum disorders provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor.
3 . Cardiac Rehabilitation Therapy	
	The Plan covers cardiac rehabilitation. Coverage includes only Medically Necessary services for Members with established coronary artery disease or unusual and serious risk factors for such disease.
4 . Chemotherapy and Radiation Therapy	
	The Plan covers outpatient chemotherapy administration and radiation therapy at a hospital or other outpatient medical facility. Covered Benefits include the facility charge, the charge for related supplies and equipment, and physician services for anesthesiologists, pathologists and radiologists. **Prior Approval Required:** You must obtain Prior Approval for radiation oncology. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
5 . Clinical Trials for the Treatment of Cancer or Other Life-Threatening Diseases	
	The Plan covers services for Members enrolled in a qualified clinical trial of a treatment for any form of cancer or other life-threatening disease under the terms and condition provided for under Massachusetts and federal law. All of the requirements for coverage under the Plan apply to coverage under this benefit. The following services are covered under this benefit: (1) all services that are Medically Necessary for treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the Plan; and (2) the reasonable cost of an investigational drug or device that has been approved for use in the clinical trial to the extent it is not paid for by its manufacturer, distributor or provider.

Benefit	Description
6 . Dental Services	
	Important Notice: The Plan does not provide dental insurance. It covers only the limited Dental Care described below. No other Dental Care is covered. **Cleft Palate:** For coverage of orthodontic and dental care related to the treatment of cleft lip or cleft palate for children under the age of 18, please see section *III. Covered Benefits*, *Reconstructive Surgery,* for information on this benefit. **Emergency Dental Care:** The Plan covers emergency Dental Care needed due to an injury to sound, natural teeth. All services, except for suture removal, must be received within three days of injury. Only the following services are covered: • Extraction of the teeth damaged in the injury when needed to avoid infection • Reimplantation and stabilization of dislodged teeth • Repositioning and stabilization of partly dislodged teeth • Suturing and suture removal • Medication received from the provider **Extraction of Teeth Impacted in Bone:** The Plan covers extraction of teeth impacted in bone. Only the following services are covered: • Extraction of teeth impacted in bone • Pre-operative and post-operative care, immediately following the procedure • Anesthesia • X-rays **Prior Approval Required:** You must obtain Prior Approval for the extraction of teeth impacted in bone. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
7 . Diabetes Services and Supplies	
	Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care: The Plan covers outpatient self-management education and training for the treatment of diabetes, including medical nutrition therapy services, used to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes. Services must be provided on an individual basis. Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care. The following items are also covered: **Diabetes Equipment:** • Blood glucose monitors • Dosage gauges • Injectors

Benefit	Description
Diabetes Services and Supplies (Continued)	
	• Insulin pumps (including supplies) and infusion devices • Lancet devices • Therapeutic molded shoes and inserts • Visual magnifying aids • Voice synthesizers **Prior Approval Required:** You must obtain Prior Approval for insulin pumps and continuous glucose monitoring systems. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
8 . Dialysis	
	The Plan covers dialysis on an inpatient, outpatient or at home basis. When federal law permits Medicare to be the primary payer, you must apply for Medicare and also pay any Medicare premium. When Medicare is primary (or would be primary if the Member were timely enrolled), the Plan will only cover those costs that exceed what would be payable by Medicare. Coverage for dialysis in the home includes non-durable medical supplies, and drugs and equipment necessary for dialysis. For In-Network coverage, your PCP must refer you to a Plan Provider for dialysis care. **Prior Approval Required:** You must obtain Prior Approval for any planned inpatient admission or for any services provided in the home. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414.** Please see section *I.F. PRIOR APPROVAL* for more information.
9 . Drug Coverage	
	You have limited coverage for prescription drugs under this Benefit Handbook. Your coverage is as follows: This Benefit Handbook covers drugs administered to you by a medical professional in either of the following circumstances: • Drugs Received During Inpatient Care. The drug is administered to you while you are an inpatient at a hospital, Skilled Nursing Facility or other medical facility at which Covered Benefits are provided to you on an inpatient basis; or • Drugs that Cannot be Self-Administered. The drug cannot be self-administered and is given to you either (a) in a doctor's office or other outpatient medical facility, or (b) at home while you are receiving home health care services covered by the Plan. Drugs that cannot be self-administered include intravenously administered or injected cancer medications. The words "cannot be self-administered" mean that the active participation of skilled medical personnel is always required to take the drug. When a Member is receiving home health care services, the words "cannot be self-administered" will include circumstances in which a family member or friend is trained to administer the drug and ongoing supervision by skilled medical personnel is required. An example of a drug that cannot be self-administered is a drug that must be administered intravenously. Examples of drugs that can be self-administered

Benefit	Description
Drug Coverage (Continued)	
	are drugs that can be taken in pill form and drugs that are typically self-injected by the patient. This Benefit Handbook also provides coverage for: (a) certain diabetes supplies; and (b) certain orally administered medications for the treatment of cancer. Please see the benefit for "Diabetes Services and Supplies" for the details of those benefits. **Please Note:** Your Plan covers orally administered medications for the treatment of cancer with no Member Cost Sharing. Please contact the Member Services Department to confirm the Member Cost Sharing that applies to this benefit. No coverage is provided under this Benefit Handbook for: (1) drugs that have not been approved by the United States Food and Drug Administration; (2) drugs the Plan excludes or limits, including, but not limited to, drugs for cosmetic purposes or weight loss; and (3) any drug that is obtained at an outpatient pharmacy except covered diabetes supplies as explained above. **Prior Approval Required:** You must obtain Prior Approval for select Medical Drugs. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-844-387-1435**. Please see section *I.F. PRIOR APPROVAL* for more information.
10 . Durable Medical Equipment (DME)	
	The Plan covers DME when Medically Necessary and ordered by a provider. The Plan may rent or buy the equipment you need. The cost of the repair and maintenance of covered equipment is also covered. In order to be covered, all equipment must be: • Able to withstand repeated use; • Not generally useful in the absence of disease or injury; • Normally used in the treatment of an illness or injury or for the rehabilitation of an abnormal body part ; and • Suitable for home use. Coverage is only available for: • The least costly equipment adequate to allow you to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports; and • One item of each type of equipment. No back-up items or items that serve a duplicate purpose are covered. For example, the Plan covers a manual or an electric wheelchair, not both. Covered equipment and supplies include: • Canes • Certain types of braces • Crutches • Hospital beds • Oxygen and oxygen equipment • Respiratory equipment • Walkers • Wheelchairs Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan.

Benefit	Description
11 . Early Intervention Services	
	The Plan covers early intervention services provided for Members until three years of age. Covered Benefits include: • Nursing care • Physical, speech, and occupational therapy • Psychological counseling • Screening and assessment of the need for services
12 . Emergency Room Care	
	If you have a Medical Emergency, you are covered for care in a hospital emergency room. Please remember the following: • If you need follow-up care after you are treated in an emergency room, you should call your PCP. To be eligible for In-Network coverage, you must obtain Covered Benefits from a Plan Provider. • If you are hospitalized, you must call HPHC at **1-888-333-4742** within 48 hours or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to HPHC by an attending emergency physician no further notice is required
13 . Family Planning Services	
	The Plan covers family planning services, including the following: • Contraceptive monitoring • Family planning consultation • Pregnancy testing • Genetic counseling • FDA approved birth control drugs, implants or devices. • Professional services relating to the injection of birth control drugs and the insertion or removal of birth control implants or devices.
14 . Hearing Aids	
	The Plan covers hearing aids up to the limit listed in your Schedule of Benefits. A hearing aid is defined as any instrument or device, excluding a surgical implant, designed, intended or offered for the purpose of improving a person's hearing. The Plan will pay the full cost of each medically necessary hearing aid up to the limit listed in your Schedule of Benefits, minus any applicable Member Cost Sharing. If you purchase a hearing aid that is more expensive than the limit listed in your Schedule of Benefits, you will be responsible for the additional cost. No back-up hearing aids that serve a duplicate purpose are covered. Covered Services and supplies related to your hearing aid are not subject to the dollar limit listed in your Schedule of Benefits. Covered Benefits include the following: • One hearing aid per hearing impaired ear; • Except for batteries, any necessary parts, attachments or accessories, including ear moldings; and • Services provided by a licensed audiologist, hearing instrument specialist or licensed physician that are necessary to assess, select, fit, adjust or service the hearing aid. **Prior Approval Required:** You must obtain Prior Approval for cochlear implants. If you use a Plan Provider located within the Service Area, he/she will

Benefit	Description
Hearing Aids (Continued)	
	seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
15 . Home Health Care	
	If you are homebound for medical reasons, you are covered for home health care services listed below. To be eligible for home health care, your provider must determine that skilled nursing care or physical therapy is an essential part of active treatment. There must also be a defined medical goal that your provider expects you will meet in a reasonable period of time. When you qualify for home health care services as stated above, the Plan covers the following services when Medically Necessary: • Durable medical equipment and supplies (must be a component of the home health care being provided) • Medical and surgical supplies • Medical social services • Nutritional counseling • Physical therapy • Occupational therapy • Services of a home health aide • Skilled nursing care • Speech therapy **Prior Approval Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414.** Please see section *I.F. PRIOR APPROVAL* for more information.
16 . Hospice Services	
	The Plan covers hospice services for terminally ill Members who need the skills of qualified technical or professional health personnel for palliative care. Care may be provided at home or on an inpatient basis. Inpatient respite care is covered for the purpose of relieving the primary caregiver and may be provided up to 5 days every 3 months not to exceed 14 days per Calendar Year. Inpatient care is also covered in an acute hospital or extended care facility when it is Medically Necessary to control pain and manage acute and severe clinical problems that cannot be managed in a home setting. Covered Benefits include: • Care to relieve pain • Counseling • Drugs that cannot be self-administered • Durable medical equipment appliances • Home health aide services • Medical supplies • Nursing care • Physician services • Occupational therapy • Physical therapy • Speech therapy

Benefit	Description
Hospice Services (Continued)	
	• Respiratory therapy • Respite care • Social services **Prior Approval Required:** You must obtain Prior Approval for home hospice care. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414.** Please see section *I.F. PRIOR APPROVAL* for more information.
17 . Hospital – Inpatient Services	
	The Plan covers acute hospital care including, but not limited to, the following inpatient services: • Semi-private room and board • Doctor visits, including consultation with specialists • Medications • Laboratory, radiology and other diagnostic services • Intensive care • Surgery, including related services • Anesthesia, including the services of a nurse-anesthetist • Radiation therapy • Physical therapy • Occupational therapy • Speech therapy In order to be eligible for In-Network coverage, the following service must be received at a Center of Excellence: • Weight loss surgery (bariatric surgery) Please see section *I.D.5. Centers of Excellence* for more information. **Prior Approval Required:** You must obtain Prior Approval for any planned inpatient admission. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* more information.
18 . House Calls	
	The Plan covers house calls.
19 . Human Organ Transplant Services	
	The Plan covers human organ transplants, including bone marrow transplants for a Member with metastasized breast cancer in accordance with the criteria of the Massachusetts Department of Public Health. The Plan covers the following services when the recipient is a Member of the Plan: • Care for the recipient • Donor search costs through established organ donor registries • Donor costs that are not covered by the donor's health plan If a Member is a donor for a recipient who is not a Member, then the Plan will cover the donor costs for the Member, when they are not covered by the recipient's health plan.

Benefit	Description
20 . Infertility Services and Treatment	
	Infertility is defined as the inability of a woman aged 35 or younger to conceive or produce conception during a period of one year. In the case of a woman over age 35, the time period is reduced to 6 months. If a woman conceives but is unable to carry the pregnancy to live birth, the time she attempted to conceive prior to that pregnancy is included in the one year or 6 month period, as applicable. The Plan covers the following diagnostic services for infertility: • Consultation • Evaluation • Laboratory tests The Plan covers the following infertility treatment: • Therapeutic artificial insemination (AI), including related sperm procurement and banking • Donor egg procedures, including related egg and inseminated egg procurement, processing and banking • Assisted hatching • Gamete intrafallopian transfer (GIFT) • Intra-cytoplasmic sperm injection (ICSI) • Intra-uterine insemination (IUI) • In-vitro fertilization (IVF) and embryo transfer • Zygote intrafallopian transfer (ZIFT) • Preimplantation genetic diagnosis (PGD) • Miscrosurgical epididiymal sperm aspiration (MESA) • Testicular sperm extraction (TESE) • Sperm collection, freezing and up to one year of storage is also covered for male Members in active infertility treatment. • Cryopreservation of eggs **Prior Approval Required:** You must obtain Prior Approval for all services for the treatment of infertility. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414.** Please see section*I.F. PRIOR APPROVAL* for more information. **Important Notice:** We use clinical guidelines to evaluate whether the use of infertility treatment is Medically Necessary. If you are planning to receive infertility treatment we recommend that you review the current guidelines. To obtain a copy, please call **1-888-888-4742**

Benefit	Description
21 . Laboratory, Radiology, and Other Diagnostic Services	
	The Plan covers laboratory and radiology services, (including High End Radiology), and other diagnostic services on an outpatient basis. The term "High End Radiology" means CT scans, PET Scans, MRI and MRA, and nuclear medicine services. Coverage includes: • The facility charge and the charge for supplies and equipment • The charges of anesthesiologists, pathologists and radiologists In addition, the Plan covers the following: • Human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish bone marrow transplant donor suitability (including testing for A, B, or DR antigens, or any combination, consistent with rules, regulations and criteria established by the Department of Public Health). • Diagnostic screenings and tests including: hereditary and metabolic screening at birth; tuberculin tests; lead screenings; hematocrit, hemoglobin or other appropriate blood tests, human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish bone marrow transplant donor suitability, and urinalysis. • Screening and diagnostic mammograms. **Prior Approval Required:** You must obtain Prior Approval for computerized axial tomography (CAT and CT and CTA scans); Magnetic resonance imaging (MRI and MRA scans); Nuclear cardiac studies; and Positron emission tomography (PET scans). If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414.** Please see section *I.F. PRIOR APPROVAL* for more information.
22 . Low Protein Foods	
	The Plan covers food products modified to be low-protein ordered for the treatment of inherited diseases of amino acids and organic acid up to the limit stated in your Schedule of Benefits.
23 . Maternity Care	
	The Plan covers the following maternity services: • Routine outpatient prenatal care, including evaluation and progress screening, physical exams, recording of weight and blood pressure monitoring • Prenatal genetic testing (office visits require a Referral) • Delivery, including a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean section. Any decision to shorten the inpatient stay for the mother and her newborn child will be made by the attending physician and the mother. If early discharge is decided, the mother will be entitled to a minimum of one home visit. • Newborn care. Coverage is limited to routine nursery charges for a healthy newborn unless the child is enrolled in the Plan. Please see section *VII.E. ADDING A DEPENDENT* for more enrollment information. • Routine outpatient postpartum care for the mother, up to six weeks after delivery **Prior Approval Required:** You must obtain Prior Approval for any planned inpatient admission or when a newborn is admitted to a neonatal intensive care unit. If you use a Plan Provider located within the Service Area, he/she will

Benefit	Description
Maternity Care (Continued)	
	seek Prior Approval for you. The Prior Approval process is initiated by calling **1–800–708–4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
24 . Medical Formulas	
	The Plan covers the following up to the limit stated in your Schedule of Benefits: • Non-prescription enteral formulas for home use for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction and inherited diseases of amino acids and organic acids. • Prescription formulas for the treatment of phenylketonuria, tyrosinemia, homocystrinuria, maple syrup urine disease, propionic acidemia or methylmalonic acidemia in infants and children or to protect the unborn fetuses of pregnant women with phenylketonuria. **Prior Approval Required:** You must obtain Prior Approval for outpatient formulas and enteral nutrition. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
25 . Mental Health and Substance Use Disorder Treatment	
	The Plan covers both inpatient and outpatient mental health and substance use disorder treatment to the extent Medically Necessary as outlined below. For In-Network coverage of mental health and substance use disorder treatment, you should call the Behavioral Health Access Center at **1-888-777-4742**. All In-Network mental health and substance use disorder treatment must be arranged through the Behavioral Health Access Center and provided by a contracted Plan Provider. (The exceptions to this rule are listed in section *I.D.4. Using Plan Providers*. To locate a Plan Provider, you may call the Behavioral Health Access Center at **1-888-777-4742**. The Behavioral Health Access Center phone line is staffed by licensed mental health clinicians. A clinician will assist you in finding an appropriate Plan Provider and arranging the services you require. You must obtain Prior Approval for Out-of-Network coverage of certain mental health treatment and substance use disorder treatment, (except Acute Treatment Services and Clinical Stabilization Services) from a Provider not certified or licensed by the Massachusetts Department of Public Health. To obtain Prior Approval you should call the Behavioral Health Access Center at **1-888-777-4742.** **Please Note:** Prior Approval is not required to obtain Acute Treatment Services or Clinical Stabilization Services from either a Plan Provider or a Non-Plan Provider. For more information on utilizing Non-Plan Providers, please refer to your Out-of-Network benefits. The terms "Acute Treatment Services" and "Clinical Stabilization Services" are defined in the Glossary at Section II of this Benefit Handbook. Services beyond the 14 day period may be subject to concurrent review as described in Section *X.J. UTILIZATION REVIEW PROCEDURES* of this Handbook. The following is a list of the mental health and substance use disorder treatment services that require Prior Approval when obtained from a Non-Plan Provider:

Benefit	Description
Mental Health and Substance Use Disorder Treatment (Continued)	
	• **Inpatient Services** • **Intensive Outpatient Program Treatment** – Treatment programs at an outpatient clinic or other facility generally lasting three or more hours a day on two or more days a week. • **Partial Hospitalization and Day Treatment Programs** • **Extended Outpatient Treatment Visits** – Outpatient visits of more than 60 minutes duration with or without medication management. Also included is any treatment routinely involving more than one outpatient visit in a day. • **Outpatient Electro-Convulsive Treatment (ECT)** • **Psychological Testing** • **Applied Behavioral Analysis (ABA) for the treatment of Autism** Even when Prior Approval is not required, mental health care may be arranged through the Behavioral Health Access Center by calling **1-888-777-4742**. (The only exception applies to care required in a Medical Emergency.) The Behavioral Health Access Center phone line is staffed by licensed mental health clinicians. A clinician will assist you in finding an appropriate Provider and arranging the services you require. In a Medical Emergency you should go to the nearest emergency facility or call 911 or your local emergency number. The Plan requires consent to the disclosure of information regarding services for mental disorders to the same extent it requires consent for disclosure of information for other medical conditions. Any determination of Medical Necessity for mental health care will be made in consultation with a Licensed Mental Health Professional. **Minimum Requirements for Covered Providers** To be eligible for coverage under this benefit, all services must be provided either (1) at the office of a Licensed Mental Health Professional, or (2) at a facility licensed or approved by the health department or mental health department of the state in which the service is provided. (In Massachusetts those departments are the Department of Public Health and the Department of Mental Health, respectively.) To qualify, a facility must be both licensed as, and function primarily as, a health or mental health care facility. A facility that is also licensed as an educational or recreational institution will not meet this requirement unless the predominate purpose of the facility is the provision of mental health care services. To qualify for coverage, all services rendered outside of a state licensed or approved facility must be provided by an independently Licensed Mental Health Professional. For services provided in Massachusetts, a Licensed Mental Health Professional must be one of the following types of providers: a licensed physician who specializes in the practice of psychiatry; a licensed psychologist; a licensed independent clinical social worker; a licensed nurse mental health clinical specialist; a licensed marriage and family therapist; a licensed mental health counselor or a level I licensed alcohol and drug counselor. For services provided outside of Massachusetts, a Licensed Mental Health Professional is an independently licensed clinician with at least a Masters degree in a clinical mental health discipline from an accredited educational institution and at least two years of clinical experience. The term "clinical mental health discipline" includes the following: psychiatry; psychology; clinical social work; marriage and family therapy; clinical counseling; developmental psychology; pastoral

Benefit	Description
Mental Health and Substance Use Disorder Treatment (Continued)	
	counseling; psychiatric nursing; developmental or educational psychology; counselor education; or any other discipline deemed acceptable by the Plan. **Benefits** The Plan will provide coverage for the care of all conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. (The only exception is conditions for which only a "Z Code" designation applies, which means that the condition is not attributable to a mental disorder.) Please refer to your Schedule of Benefits, it will tell you the Member Cost Sharing and any benefit limits that apply to the coverage of these services. Covered mental health and substance use disorder treatment services include the following: a) **Mental Health and Substance Use Disorder Treatment** Subject to the Member Cost Sharing and any benefit limits stated in your Schedule of Benefits, the Plan provides coverage for the following Medically Necessary mental health care services: 1) **Inpatient Services** • Hospitalization, including detoxification 2) **Intermediate Care Services** • Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization • Intensive outpatient programs, partial hospitalization and day treatment programs 3) **Outpatient Services** • Care by a Licensed Mental Health Professional • Detoxification • Medication management • Methadone maintenance • Psychological testing and neuropsychological assessment.
26 . Observation Services	
	The Plan covers observation services including short term treatment, assessment and reassessment for up to 48 hours. Observation services determine if a Member needs to be admitted for additional treatment or if the Member is able to be discharged from the hospital.
27 . Ostomy Supplies	
	The Plan covers ostomy supplies up to the Benefit Limit listed in the Schedule of Benefits. Only the following supplies are covered: • Irrigation sleeves, bags and catheters • Pouches, face plates and belts • Skin barriers

Benefit	Description
28 . Physician and Other Professional Office Visits	

	Physician services, including services of all covered medical professionals, can be obtained on an outpatient basis in a physician's office or a hospital. These services may include:
	• Routine physical examinations, including routine gynecological examination and annual cytological screenings
	• Follow-up care provided by an obstetrician or gynecologist for obstetrical or gynecological conditions identified during maternity care or an annual gynecological visit
	• Immunizations, including childhood immunizations as recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention and the American Academy of Pediatrics
	• Well baby and well child care, including physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and developmental screening, and assessment at the following intervals:
	  • At least six visits per Calendar Year are covered for a child from birth to age one.
	  • At least three visits per Calendar Year are covered for a child from age one to age two.
	  • At least one visit per Calendar Year is covered for a child from age two to age six
	• School, camp, sports and premarital examinations
	• Health education and nutritional counseling
	• Sickness and injury care
	• Vision and Hearing screenings
	• Medication management
	• Consultations concerning contraception and hormone replacement therapy
	• Chemotherapy
	• Radiation therapy
	Please Note: The Plan covers certain preventive services and tests with no Member Cost Sharing. Please see your Schedule of Benefits for the coverage that applies to your Plan.

29 . Prosthetic Devices	
	The Plan covers prosthetic devices as described below. The cost of the repair and maintenance of a covered device is also covered. In order to be covered, all devices must be able to withstand repeated use. Coverage is only available for: • The least costly prosthetic device adequate to allow you to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports.); and • One item of each type of prosthetic device. No back-up items or items that serve a duplicate purpose are covered. Covered prostheses include: • Breast prostheses, including replacements and mastectomy bras • Prosthetic arms and legs (including myoelectric and bionic arms and legs) • Prosthetic eyes

Benefit	Description
Prosthetic Devices (Continued)	
	BMember Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan. **Prior Approval Required:** You must obtain Prior Approval for upper and lower prosthetic arms and legs. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
30 . Reconstructive Surgery	
	The Plan covers reconstructive and restorative surgical procedures as follows: • Reconstructive surgery is covered when the surgery can reasonably be expected to improve or correct a Physical Functional Impairment resulting from an accidental injury, illness, congenital anomaly, birth injury or prior surgical procedure. If reconstructive surgery is performed to improve or correct a Physical Functional Impairment, as stated above, Cosmetic Services that are incidental to that surgery are also covered. After a Physical Functional Impairment is corrected, no further Cosmetic Services are covered by the Plan. • Restorative surgery is covered to repair or restore appearance damaged by an accidental injury. (For example, this benefit would cover repair of a facial deformity following an automobile accident.) Benefits are also provided for post mastectomy care, including coverage for: • Prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient; • Reconstruction of the breast on which the mastectomy was performed; and • Surgery and reconstruction of the other breast to produce a symmetrical appearance. Coverage is also provided for the treatment of cleft lip and cleft palate for children under the age of 18, including coverage for: • Medical, dental, oral, and facial surgery, including surgery performed by oral and plastic surgeons, and surgical management and follow-up care related to such surgery; • Orthodontic treatment; • Preventative and restorative dentistry to ensure good health and adequate dental structures to support orthodontic treatment or prosthetic management therapy; • Speech therapy; • Audiology services; and • Nutrition services. Benefits include coverage for procedures that must be done in stages, as long as you are an active Member. Membership must be effective on all dates on which services are provided. There is no coverage for Cosmetic Services or surgery except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care as described above.

Benefit	Description
Reconstructive Surgery (Continued)	
	Important Note: We use clinical guidelines to evaluate whether different types of reconstructive and restorative procedures are Medically Necessary. If you are planning to receive such treatment, you may review the current guidelines. To obtain a copy, please call **1-888-888-4742 ext. 38732.** **Prior Approval Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
31 . Rehabilitation Hospital Care	
	The Plan covers care in a facility licensed to provide rehabilitative care on an inpatient basis. Coverage is provided when you need daily Rehabilitation Services that must be provided in an inpatient setting. Rehabilitation Services include cardiac rehabilitation therapy, physical therapy, pulmonary rehabilitation therapy, occupational therapy and speech therapy. The Benefit Limit is listed in the Schedule of Benefits. **Prior Approval Required:** You must obtain Prior Approval for rehabilitation hospital care. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling **1–800–708–4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
32 . Rehabilitation and Habilitation Services – Outpatient	
	The Plan covers the following outpatient Rehabilitation and Habilitation Services: • Occupational therapy • Physical therapy • Pulmonary rehabilitation therapy Outpatient Rehabilitation and Habilitation Services are covered up to the Benefit Limit listed in the Schedule of Benefits. Services are covered only: • If, in the opinion of your provider, there is likely to be significant improvement in your condition within the period of time benefits are covered; and • When needed to improve your ability to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports. Rehabilitation and Habilitation Services are also covered under your inpatient hospital and home health benefits. **Prior Approval Required:** You must obtain Prior Approval for coverage of pulmonary rehabilitation therapy. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. **Please Note:** Outpatient physical and occupational therapies for children under the age of 3 are covered to the extent Medically Necessary. The benefit limit stated in the Schedule of Benefits does not apply.

Benefit	Description
33 . Scopic Procedures – Outpatient Diagnostic	
	The Plan covers diagnostic scopic procedures and related services received on an outpatient basis. Diagnostic scopic procedures are those for visualization, biopsy and/or polyp removal. Scopic procedures are: • Colonoscopy • Endoscopy • Sigmoidoscopy
34 . Skilled Nursing Facility Care	
	The Plan covers care in a health care facility licensed to provide skilled nursing care on an inpatient basis. Coverage is provided only when you need daily skilled nursing care that must be provided in an inpatient setting. The Benefit Limit is listed in the Schedule of Benefits. **Prior Approval Required:** You must obtain Prior Approval for Skilled Nursing Facility care. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1–800–708–4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
35 . Speech-Language and Hearing Services	
	The Plan covers diagnosis and treatment of speech, hearing and language disorders to the extent Medically Necessary by speech-language pathologists and audiologists.
36 . Spinal Manipulative Therapy (including care by a chiropractor)	
	The Plan covers musculoskeletal adjustment or manipulation up to the Benefit Limit listed in the Schedule of Benefits.
37 . Surgery - Outpatient	
	The Plan covers outpatient surgery, including related services. Outpatient surgery is defined as any surgery or procedure in a day surgery department, ambulatory surgery department or outpatient surgery center. There are certain specialized services for which you will be directed to a Center of Excellence for care. See section *I.D.5. Centers of Excellence* for more information. **Prior Approval Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414.** Please see section *I.F. PRIOR APPROVAL* for more information.
38 . Telemedicine Services	
	The Plan covers Medically Necessary telemedicine services for the purpose of diagnosis, consultation or treatment. Telemedicine services include the use of real-time interactive audio, video or other electronic media telecommunications, telemonitoring, and telemedicine services involving stored images forwarded for future consultations, i.e. "store and forward" telecommunication as a substitute for in-person consultation with Plan Providers.

Benefit	Description
39 . Temporomandibular Joint Dysfunction Services	
	The Plan covers medical treatment of Temporomandibular Joint Dysfunction (TMD). Only the following services are covered: • Initial consultation with a physician • Physical therapy, (subject to the visit limit for outpatient physical therapy listed in the Schedule of Benefits) • Surgery • X-rays **Important Notice:** No Dental Care is covered for the treatment of Temporomandibular Joint Dysfunction (TMD). **Prior Approval Required:** You must obtain Prior Approval for surgery and physical therapy coverage under this benefit. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
40 . Transgender Health Services	

	The Plan covers transgender health services as described below. Services are covered when your provider has determined that you are an appropriate candidate for transgender health services in accordance with HPHC clinical guidelines. Coverage includes surgery, related physician and behavioral health visits.
	Benefits for transgender health services are in addition to the other benefits provided under the Plan. HPHC does not consider transgender health services to be reconstructive surgery to correct a Physical Functional Impairment or Cosmetic Services. Coverage for reconstructive surgery or Cosmetic Services is limited to the services described under the Reconstructive Surgery benefit in this Handbook.
	Transgender health services are limited to the specific surgical procedures listed below. No other services are covered in connection with transgender health services except the following:
	Transfeminine:
	• Augmentation mammoplasty
	• Clitoroplasty
	• Colovaginoplasty
	• Facial feminization procedures:
	  • blepharoplasty (lower and upper eyelid)
	  • blepharoptosis
	  • brow ptosis
	  • forehead contouring
	  • genioplasty
	  • mandible/jaw contouring
	  • osteoplasty
	  • otoplasty
	  • rhinoplasty
	  • rhytidectomy

Benefit	Description
Transgender Health Services (Continued)	
	• suction assisted lipectomy • tracheoplasty • Labiaplasty • Orchiectomy • Penectomy • Vaginoplasty **Transmasculine:** • Bilateral mastectomy • Colpectomy • Hysterectomy • Metoidioplasty • Phalloplasty • Rhinoplasty • Salpingo-oophorectomy • Scrotoplasty with placement of testicular prostheses • Urethroplasty Once initial transgender health services have been completed, the Plan does not cover any further cosmetic changes. In addition, no coverage is provided for reversal of transgender health services whether or not originally covered by the Plan. Certain services covered under the benefit are provided by only a limited number of providers in the country and may not currently be in the Plan's network. However, the Plan will work with you and your physician to identify one or more providers who are appropriate to provide services under this benefit. For coverage of behavioral health services related to transgender health services, please see "Mental Health and Substance Use Disorder Treatment" in section *III. Covered Benefits* for details. **Important Notice:** We use clinical guidelines to evaluate whether transgender health services are Medically Necessary. If you are planning to receive transgender health services, we recommend that you review the current guidelines. To obtain a copy, please call **1-888-888-4742**. **Prior Approval Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see the section *I.F. PRIOR APPROVAL* for more information.

Benefit	Description
41 . Urgent Care Services	
	The Plan covers Urgent Care services you receive at (1) a convenience care clinic or (2) an Atrius Health urgent care location; or (3) an urgent care center. Convenience care clinics provide treatment for minor illnesses and injuries. They are usually staffed by non-physician providers, such as nurse practitioners, and are located in stores, supermarkets or pharmacies. To see a list of convenience care clinics covered by the Plan, please refer to your Atrius Health Choice POS Provider Directory and search under "convenience care." Urgent care centers provide treatment for illnesses and injuries that require urgent attention but are not life threatening. Urgent care centers are independent clinics or certain hospital-owned clinics that provide urgent care services. Urgent care centers are staffed by doctors, nurse practitioners, and physician assistants. To see a list of urgent care centers covered by the Plan, please refer to your Atrius Health Choice POS Provider Directory and search under "urgent care". Some hospitals provide urgent care services as part of the hospital's outpatient services. Because the services provided are considered outpatient hospital services, only the hospitals are listed in the Atrius Health Choice POS Provider Directory. These services may require higher Member Cost Sharing than urgent care services received at independent urgent care centers. Please refer to your Schedule of Benefits for your specific Member Cost Sharing requirements for urgent care services. Coverage for Urgent Care is provided for services that are required to prevent deterioration to your health resulting from an unforeseen sickness or injury. Services you may obtain at an Urgent Care center include, but are not limited to, the following: • Care for minor cuts, burns, rashes or abrasions, including suturing • Treatment for minor illnesses and infections, including ear aches • Treatment for minor sprains or strains You do not need to obtain a referral from your PCP to be covered for Urgent Care services at an urgent care or convenience care clinic. Whenever possible, you should contact your PCP prior to obtaining care at an Urgent Care center. Your PCP may be able to provide the services you require at a lower out-of-pocket cost. In addition, your PCP is responsible for coordinating your health care services and should know about the services you receive. Please refer to your Schedule of Benefits for your specific Member Cost Sharing requirements. **Important Notice:** Urgent care is not emergency care. You should call 911 or go directly to a hospital emergency room if you suspect you are having a Medical Emergency. These include heart attack or suspected heart attack, shock, major blood loss, or loss of consciousness. Please see section *I.D.6. Medical Emergency Services* for more information.

Benefit	Description
42 . Vision Services	
	Routine Eye: The Plan covers routine eye examinations. **Vision Hardware for Special Conditions:** The Plan provides coverage for contact lenses or eyeglasses needed for the following conditions: • Keratonconus. One pair of contact lenses is covered per Calendar Year. The replacement of lenses, due to a change in the Member's condition, is limited to 3 per affected eye per Calendar Year. • Post cataract surgery with an intraocular lens implant (pseudophakes). Coverage is limited to $140 per surgery toward the purchase of eyeglass frames and lenses. The replacement of lenses due to a change in the Member's prescription of .50 diopters or more within 90 days of the surgery is also covered up to a limit of $140. • Post cataract surgery without lens implant (aphakes). One pair of eyeglass lenses or contact lenses is covered per Calendar Year. Coverage up to $50 per Calendar Year is also provided for the purchase of eyeglass frames. The replacement of lenses due to a change in the Member's condition is also covered. Replacement of lenses due to wear, damage, or loss, is limited to 3 per affected eye per Calendar Year. • Post retinal detachment surgery. For a Member who wore eyeglasses or contact lenses prior to retinal detachment surgery, the Plan covers the full cost of one lens per affected eye up to one Calendar Year after the date of surgery. For Members who have not previously worn eyeglasses or contact lenses, the Plan covers either (1) a pair of eyeglass lenses and up to $50 toward the purchase of the frames, or (2) a pair of contact lenses.
43 . Voluntary Sterilization	
	The Plan covers voluntary sterilization, including tubal ligation and vasectomy.
44 . Voluntary Termination of Pregnancy	
	The Plan covers voluntary termination of pregnancy.
45 . Wigs and Scalp Hair Prostheses	
	The Plan covers wigs and scalp hair prostheses when needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis or permanent hair loss due to injury up to the Benefit Limit listed in the Schedule of Benefits.

IV. Exclusions

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

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

Exclusion	Description
1 . Alternative Treatments	
	1. Acupuncture services. 2. Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments. 3. Aromatherapy, treatment with crystals and alternative medicine. 4. Any of the following types of programs: Health resorts, spas, recreational programs, camps, outdoor skills programs, educational programs for children in residential care, self-help programs, life skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs and wellness clinics; and wilderness programs (therapeutic outdoor programs). 5. Massage therapy. 6. Myotherapy.
2 . Dental Services	
	1. Dental Care, except when specifically listed as a Covered Benefit. 2. All services of a dentist for Temporomandibular Joint Dysfunction (TMD). 3. Preventive dental care for children. 4. Dentures
3 . Durable Medical Equipment and Prosthetic Devices	
	1. Any devices or special equipment needed for sports or occupational purposes. 2. Any home adaptations, including, but not limited to home improvements and home adaptation equipment. 3. Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. 4. Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.
4 . Experimental, Unproven or Investigational Services	
	1. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.
5 . Foot Care	
	1. Foot orthotics, except for the treatment of severe diabetic foot disease. 2. Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members with diabetes.
6 . Maternity Services	
	1. Planned home births.

Exclusion	Description
7 . Mental Health and Substance Use Disorder Treatment	
	1. Biofeedback. 2. Educational services or testing, except services covered under the benefit for Early Intervention Services. No benefits are provided: (1) for educational services intended to enhance educational achievement; (2) to resolve problems of school performance; (3) to treat learning disabilities; (4) for driver alcohol education; or (5) for community reinforcement approach and assertive continuing care. 3. Sensory integrative praxis tests. 4. Services for any condition with only a "Z Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder. 5. Mental health and substance use disorder treatment that is (1) provided to Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health. 6. Services or supplies for the diagnosis or treatment of mental health and substance use disorders that, in the reasonable judgment of the Behavioral Health Access Center, are any of the following: • Not consistent with prevailing national standards of clinical practice for the treatment of such conditions. • Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome. • Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. 7. Services related to autism spectrum disorders provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor.
8 . Physical Appearance	
	1. Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care. 2. Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. 3. Liposuction or removal of fat deposits considered undesirable. 4. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). 5. Skin abrasion procedures performed as a treatment for acne. 6. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. 7. Treatment for spider veins.

Exclusion	Description
9 . Procedures and Treatments	
	1. Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial X-ray. 2. Commercial diet plans, weight loss programs and any services in connection with such plans or programs. 3. If a service in Massachusetts, Maine, Connecticut, Rhode Island or New Hampshire is listed as requiring that it be provided at a Center of Excellence, no In-Network coverage will be provided if that service is received in Massachusetts, Maine, Connecticut, Rhode Island or New Hampshire from a Provider that has not been designated as a Center of Excellence. Please see section *I.D.5. Centers of Excellence* for more information. 4. Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). 5. Physical examinations and testing for insurance, licensing or employment. 6. Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. 7. Testing for central auditory processing. 8. Group diabetes training, educational programs or camps.
10 . Providers	
	1. Charges for services provided after the date on which your membership ends. 2. Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit under this Handbook. 3. Charges for missed appointments. 4. Concierge service fees. Please see section*I.I. PROVIDER FEES FOR SPECIAL SERVICES (CONCIERGE SERVICES)* for more information. 5. Inpatient charges after your hospital discharge. 6. Provider's charge to file a claim or to transcribe or copy your medical records. 7. Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.

Exclusion	Description
11 . Reproduction	
	1. Birth control drugs, implants and devices that must be purchased at an outpatient pharmacy 2. Any form of Surrogacy or services for a gestational carrier. 3. Infertility drugs that must be purchased at an outpatient pharmacy. 4. Infertility treatment for Members who are not medically infertile. 5. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). 6. Sperm collection, freezing and storage except as described in the section *III. Covered Benefits*, *Infertility Services and Treatment*. 7. Sperm identification when not Medically Necessary (e.g., gender identification). 8. The following fees: wait list fees, non-medical costs, shipping and handling charges etc.
12 . Services Provided Under Another Plan	
	1. Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. 2. Costs for services for which payment is required to be made by a Workers' Compensation plan or an employer under state or federal law.
13 . Telemedicine Services	
	1. Telemedicine services (i.e. e-mail, fax, texting, or audio-only telephone) except as described in section III. Covered Benefits, Telemedicine Services. 2. Provider fees for technical costs for the provision of telemedicine services.
14 . Transgender Health Services	
	1. Abdominoplasty. 2. Chemical peels. 3. Collagen injections. 4. Dermabrasion. 5. Electrolysis, hair removal, or hair transplantation. 6. Implantations (e.g. calf, pectoral, gluteal). 7. Lip reduction/enhancement. 8. Liposuction. 9. Panniculectomy. 10. Reimbursement for travel expenses. 11. Removal of redundant skin. 12. Reversal of transgender health services and all related drugs and procedures. 13. Silicone injections (e.g. breast enlargement). 14. Voice modification therapy/surgery.

Exclusion	Description
15 . Types of Care	
	1. Custodial Care. 2. Recovery programs including rest or domiciliary care, sober houses, transitional support services, and therapeutic communities. 3. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. 4. Pain management programs or clinics. 5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. 6. Private duty nursing. 7. Sports medicine clinics. 8. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
16 . Vision and Hearing	
	1. Eyeglasses, contact lenses and fittings, except as listed in this Benefit Handbook. 2. Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD. 3. Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occuring myopia, hyperopia and astigmatism.
17 . All Other Exclusions	
	1. Any service or supply furnished in connection with a non-Covered Benefit. 2. Any service or supply (with the exception of contact lenses) purchased from the internet. 3. Beauty or barber service. 4. Any drug or other product obtained at an outpatient pharmacy, including, but not limited to, hypodermic needles and syringes. 5. Diabetes equipment replacements when solely due to manufacturer warranty expiration. 6. Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription. 7. Guest services. 8. Medical services that are provided to Members who are confined or committed to jail, house of correction, prison, or custodial facility of the Department of Youth Services. 9. Services for non-Members. 10. Services for which no charge would be made in the absence of insurance. 11. Services for which no coverage is provided in this Benefit Handbook or Schedule of Benefits. 12. Services that are not Medically Necessary. 13. Taxes or governmental assessments on services or supplies. 14. Transportation other than by ambulance.

Exclusion	Description
All Other Exclusions (Continued)	
	15. The following products and services: • Air conditioners, air purifiers and filters, dehumidifiers and humidifiers. • Car seats. • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners. • Electric scooters. • Exercise equipment. • Home modifications including but not limited to elevators, handrails and ramps. • Hot tubs, jacuzzis, saunas or whirlpools. • Mattresses. • Medical alert systems. • Motorized beds. • Pillows. • Power-operated vehicles. • Stair lifts and stair glides. • Strollers. • Safety equipment. • Vehicle modifications including but not limited to van lifts. • Telephone • Television

V. Reimbursement and Claims Procedures

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

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

A. BILLING BY PROVIDERS

You may receive bills from a Non-Plan Provider or a Plan Provider when you do not have a Referral. If you get a bill for a Covered Benefit you may ask the provider to:

1) Bill us on a standard health care claim form (such as the CMS 1500 or the UB-04 form); and

2) Send it to the address listed on the back of your Plan ID card.

B. REIMBURSEMENT FOR BILLS YOU PAY

If you pay a Non-Plan Provider for a Covered Benefit, the Plan will reimburse you less your applicable Member Cost Sharing. Please send any request for reimbursement for claims you have paid to the appropriate address below:

Claims for Mental Health and Substance Use Disorder Treatment:

Behavioral Health Access Center
P.O. Box 30602
Salt Lake City, UT 84130–0783

All Other Claims:

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

Please Note: Prior Approval is required to receive full coverage for certain services. Please see section *I.F. PRIOR APPROVAL*for more information on these requirements. For services that require Prior Approval from HPHC, please have your provider call **1–800–708–4414**.

To obtain reimbursement for a bill you have paid you must provide us with a legible claim form from the provider or facility that provided your care which includes all of the following information:

- The Member's full name and address
- The Member's date of birth
- The Member's Plan ID number (on the front of the Member's Plan ID card)
- The 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 10 code
- The date the service was rendered
- The CPT code (or a brief description of the illness or injury) for which payment is sought
- The amount of the provider's charge
- Proof that you have paid the bill

Important Notice: We may need more information for some claims. If you have any questions about claims, please call our Member Services Department.

1. International Claims

If you are requesting reimbursement for services received while outside of the United States you must submit an International Claim Form. The form can be obtained online at **www.harvardpilgrim.org/atriushealth** or by calling the Member Services Department. In addition to the International Claim Form you will need to submit an itemized bill and proof of payment. We may also require you to provide additional documentation, including, but not limited to: (1) records from financial institutions clearly demonstrating that you have paid for the services that are the subject of the claim; and (2) the source of funds used for payment.

C. TIME LIMITS ON FILING CLAIMS

To be eligible for payment, we must receive claims within one year of the date care was received.

D. TIME LIMITS FOR THE REVIEW OF CLAIMS

HPHC will generally review claims within the time limits stated below. Under some circumstances these time limits may be extended by the Plan upon notice to Members. Unless HPHC notifies a Member that an extension is required, the review time for the types of claims outlined below will be as follows:

- **Pre-service claims.** A pre-Service claim is one in which coverage is requested for a health care service that the Member has not yet received. Pre-service claims will generally be processed within 15 days after receipt of the claim by HPHC.
- **Post-service claims.** A post-service claim requests coverage of a health care service that the

Member has already received. Post-service claims will generally be processed within 30 days after the receipt of the claim by HPHC.

- **Urgent Care claims.**. Urgent Care claims will generally be processed within 72 hours of receipt of the claim by HPHC. An Urgent Care claim is one in which the use of the standard time period for processing pre-service claims:

  1. Could seriously jeopardize a Member's life or health or ability to regain maximum function; or
  2. Would result in severe pain that cannot be adequately managed without the care or treatment requested.

  If a physician with knowledge of the Member's medical condition determines that one of the above criteria has been met, the claim will be treated as an Urgent Care claim by HPHC.

E. PAYMENT LIMITS

The Plan limits the amount payable for services that are not rendered by Plan Providers. The most the Plan will pay for such services is the Allowed Amount. You may have to pay the balance if the claim is for more than the Allowed Amount.

VI. Appeals and Complaints

This section explains the procedures for processing appeals and complaints and the options available if an appeal is denied.

A. BEFORE YOU FILE AN APPEAL

Claim denials may result from a misunderstanding with a provider or a claim processing error. Since these problems can be easy to resolve, we recommend that Members contact an HPHC Member Services Associate prior to filing an appeal. (A Member Services Associate can be reached toll free at (888) 333-4742 or call 711 for TTY service.) The Member Services Associate will investigate the claim and either resolve the problem or explain why the claim is being denied. If you are dissatisfied with the response of the Member Services Associate, you may file an appeal using the procedures outlined below.

B. MEMBER APPEAL PROCEDURES

Any Member who is dissatisfied with a decision on the coverage of services may appeal to HPHC. Appeals may be filed by a Member or a Member's authorized representative, including a provider acting on a Member's behalf. HPHC has established the following steps to ensure that Members receive a timely and fair review of internal appeals.

A Member may also appeal a rescission of coverage. A rescission of coverage is defined in section *VI.C.1. External Review*.

If you need assistance filing your appeal, there may be consumer assistance programs in your state available to you. Also, HPHC staff is available to assist you with the filing of an appeal. If you wish such assistance or would like the telephone number for one of these programs, please call (888) 333-4742.

1. Initiating Your Appeal

To initiate your appeal, you or your representative can mail or FAX a letter to us about the coverage you are requesting and why you feel the denial should be overturned. (If your appeal qualifies as an expedited appeal, you may contact us by telephone. (See Section *VI.B.3. The Expedited Appeal Process*. for the expedited review procedure.)

You must file your appeal within 180 days after you receive notice that a claim has been denied. Please be as specific as possible in your appeal request. We need all the important details in order to make a fair decision, including pertinent medical records and itemized bills.

If you have a representative submit an appeal on your behalf, the appeal should include a statement, signed by you, authorizing the representative to act on your behalf. In the case of an expedited appeal relating to Urgent Care, such authorization may be provided within 48 hours after submission of the appeal. Where Urgent Care is involved, a medical provider with knowledge of your condition, such as your treating physician, may act as your representative without submitting an authorization form you have signed.

For all appeals, except those involving mental health and substance use disorder treatment, please send your request to the following address:

Appeals and Grievances Department
1600 Crown Colony Drive
Quincy, MA 02169
Telephone: 1-888-333-4742
Fax: 1–617–509–3085
www.harvardpilgrim.org/atriushealth

If your appeal involves mental health and substance use disorder treatment, please send it to the following address:

HPHC Behavioral Health Access Center
c/o United Behavioral Health
Appeals Department
P.O. Box 30512
Salt Lake City, UT 84130-0512
Telephone: 1–888–777-4742
Fax: 1–855–312-1470

No appeal shall be deemed received until actual receipt by HPHC at the appropriate address or telephone number listed above.

When we receive your appeal, we will assign an Appeals and Grievances Analyst to coordinate your appeal throughout the entire appeal process. We will send you an acknowledgement letter identifying your Appeals and Grievances Analyst. That letter will include detailed information on the appeal process. Your Appeals and Grievances Analyst is available to answer any questions you may have about your appeal. Please feel free to contact your Appeals and Grievances Analyst if you have any questions or concerns at any time during the appeal process.

There are two types of appeal processes, the standard process, which applies to most denied claims and the

expedited appeal process which is only available for claims involving claims for Urgent Care services.

2. The Standard Appeal Process

The Appeals and Grievances Analyst will investigate your appeal and determine if additional information is required. Such information may include medical records, statements from your doctors, and bills and receipts for services you have received. You may also provide HPHC with any written comments, documents, records or other information related to your claim.

HPHC divides standard appeals into two types, "Pre-Service Appeals" and "Post-Service Appeals," as follows:

- A "Pre-Service Appeal" requests coverage of a denied health care service that the Member has not yet received.
- A "Post-Service Appeal" requests coverage of a denied health care service that the Member has already received.

HPHC will review Pre-Service Appeals and send a written decision within 30 days of the date the appeal was received by HPHC. HPHC will review Post-Service Appeals and send a written decision within 60 days of the date the appeal was received by HPHC. These time limits may be extended by mutual agreement between you and HPHC.

After we receive all the information needed to make a decision, your Appeals and Grievances Analyst will inform you, in writing, whether your appeal is approved or denied. HPHC's decision of your appeal will include: (1) a summary of the facts and issues in the appeal; (2) a summary of the documentation relied upon; (3) the specific reasons for the decision, including the clinical rationale, if any; (4) the identification of any medical or vocational expert consulted in reviewing your appeal; and (5) any other information required by law. This decision is HPHC's final decision under the appeal process. If HPHC's decision is not fully in your favor, the decision will also include a description of other options for further review of your appeal. These are also described in Section C, below.

If your appeal involves a decision on a medical issue, the Appeals and Grievances Analyst will obtain the opinion of a qualified physician or other appropriate medical specialist. The health care professional conducting the review must not have either participated in any prior decision concerning the appeal or be the subordinate of the original reviewer. Upon request, your Appeals and Grievances Analyst will provide you with a copy, free of charge, of any written clinical criteria used to decide your appeal and; where required by law, the identity of the physician (or other medical specialist) consulted concerning the decision.

You have the right to receive, free of charge, all documents, records or other information relevant to the initial denial and your appeal.

3. The Expedited Appeal Process

HPHC will provide you with an expedited review if your appeal involves medical services which, in the opinion of a physician with knowledge of your medical condition:

- Could, if delayed, seriously jeopardize your life or health or ability to regain maximum function, or
- Would, if delayed, result in severe pain that cannot be adequately managed without the care or treatment requested.

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

You, your representative or a provider acting on your behalf may request an expedited appeal by telephone or fax. (Please see "Initiating Your Appeal," above, for the telephone and fax numbers.)

HPHC will investigate and respond to your request within 72 hours. We will notify you of the decision on your appeal by telephone and send you a written decision within two business days thereafter.

If you request an expedited appeal of a decision to discharge you from a hospital, the Plan will continue to pay for your hospitalization until we notify you of our decision. Such notice may be provided by telephone or any other means.

Except as otherwise required by law, the expedited appeal process is limited to the circumstances listed above. Your help in promptly providing all necessary information is important for us to provide you with this quick review. If we do not have sufficient information necessary to decide your appeal, HPHC will notify you within 24 hours of receipt of your appeal.

Important Notice: If you are filing an expedited appeal with HPHC, you may also file a request for expedited external review at the same time. You do not have to wait until HPHC completes your expedited appeal to file for expedited external review. Please see the section *VI.C.1. External Review*, for information on how to file for external review.

C. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED

If your appeal is denied by HPHC there are a few ways in which you may be able obtain further review of the appeal. These are described below.

1. External Review

If you disagree with the denial of your appeal you may be entitled seek external review though an Independent Review Organization (IRO).

An IRO provides you with the opportunity for a review of your appeal by an independent organization that is separate from HPHC. The decision of the IRO is binding on both you and the Plan (except to the extent that other remedies are available under state or federal law).

You, your representative, or a provider acting on your behalf, may request external review by sending a completed "Request for Voluntary Independent External Review" form by mail or fax to your Appeals and Grievances Analyst at the following address or fax number:

Appeals and Grievances Department
Customer Service Department
1600 Crown Colony Drive
Quincy, MA 02169
Telephone: 1-888-333-4742
Fax: 1–617–509–3085
www.harvardpilgrim.org/atriushealth

You or your representative may request expedited external review by telephone. Please call your Appeals and Grievances Analyst, if one has been assigned to your appeal. You may also request expedited external review by calling a Member Services Associate at **1-888-333-4742** .

In addition to the requirements for external review, stated below, to be eligible for expedited external review, the appeal must meet the criteria for an expedited appeal stated above in section *VI.B.3. The Expedited Appeal Process*).

In submitting a request for external review, you understand that if HPHC determines that the appeal is eligible for external review, HPHC will send a copy of the complete appeal file directly to the IRO.

In order to be eligible for external review, your appeal must meet each of the following requirements:

a. You must request external review within four (4) calendar months of the date you receive notice that your appeal has been denied. If we send a notice of the denial of an appeal by First Class Mail, we will assume receipt of that notice five (5) days after the date of mailing.

b. You must pay the $25 external review filing fee (up to $75 per year if you file more than one request). The fee will be returned to you if your appeal is approved by the IRO. The fee may be waived upon a showing of undue financial hardship.

c. Your appeal must involve a denial of coverage based on either: (1) a medical judgment; or (2) a rescission of coverage. The meaning of these terms is as follows:

   Medical Judgment. A "medical judgment" includes, but is not limited to, the following types of decisions: (i) whether the service is Medically Necessary; (ii) whether the health care facility, level of care, or service is appropriate for treatment of the member's condition; (iii) whether the service is likely to be effective, or more effective than an alternative service, in treating a member's condition; or (iv) whether the service is Experimental, Unproven or Investigational. A medical judgement does not include a decision that is based on an interpretation of the law, or the benefits or wording of your Plan, without consideration of your clinical condition or what is best for you medically.

   Unless a medical judgment is involved, external review is not available for certain types of appeals. These include the following:

   - Denials of coverage based on benefit limitations stated in your Plan documents
   - Denials of coverage for services excluded under your Plan (except Experimental, Unproven or Investigational services)
   - Denials of coverage based on the Member Cost Sharing requirements stated in your Plan.

   Rescission of Coverage. A "rescission of coverage" means a retroactive termination of a Member's coverage. However, a termination

of coverage is not a rescission if it is based on a failure to pay required premiums or contributions for coverage in a timely manner.

The final decision on whether an appeal is eligible for external review will be made by the Independent Review Organization (IRO), not by HPHC.

2. Legal Action

You may also seek legal action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) if your Plan is governed by ERISA. Please note that any legal action under section 502(c) of ERISA must be brought within the time period stated in section *X.B. LIMITATION ON LEGAL ACTIONS*. Please note that governmental plans are not subject to ERISA.

D. THE FORMAL COMPLAINT PROCESS

If you have any complaints about your care under the Plan or about HPHC's service, we want to know about it. We are here to help. For all complaints, except mental health and substance use disorder treatment complaints, please call or write to us at:

Customer Service Department
Harvard Pilgrim Health Care
1600 Crown Colony Drive
Quincy, MA 02169
Telephone: 1-888-333-4742
Fax: 1–617–509–3085
www.harvardpilgrim.org/atriushealth

For a complaint involving mental health and substance use disorder treatment, please call or write to us at:

HPHC Behavioral Health Access Center
c/o United Behavioral Health
Complaints Department
100 East Penn Square, Suite 400
Philadelphia, PA 19107
Telephone: 1–888–777-4742
Fax: 1–888–881-7453

We will respond to you as quickly as we can. Most complaints can be investigated and responded to within thirty (30) days.

VII. Eligibility

Important Notice: Your membership in the Plan is effective on the date of enrollment by your Plan Sponsor. Because your employer may notify Harvard Pilgrim of enrollment changes retroactively, we may not have current information concerning membership status. Only your Plan Sponsor can confirm membership status.

This section describes requirements concerning eligibility under the Plan. It is important to understand that eligibility of Dependents and effective dates of coverage are determined by the Plan Sponsor. Please see your Plan Sponsor for descriptions of eligibility for Dependents and effective dates of coverage.

A. MEMBER ELIGIBILITY

1. Subscriber Eligibility

To be a Subscriber under this Plan, you must:

- Be an employee of the Plan Sponsor, in accordance with employee eligibility guidelines agreed to by the Plan Sponsor and HPHC; and
- Be enrolled through a Plan Sponsor that is up-to-date in the payment of the applicable payments for coverage.

2. Dependent Eligibility

Please see your Plan Sponsor for a description of Dependent eligibility as agreed upon by your Plan Sponsor and HPHC.

B. EFFECTIVE DATE - NEW AND EXISTING DEPENDENTS

Please see your Plan Sponsor for information on enrollment and effective dates of coverage. Please also see section *VII.H. SPECIAL ENROLLMENT RIGHTS*

C. EFFECTIVE DATE - ADOPTIVE DEPENDENTS

An adoptive child who has been living with you, and for whom you have been receiving foster care payments, may be covered from the date the petition to adopt is filed. An adoptive child who has not been living with you may be covered from the date of placement in your home for purposes of adoption by a licensed adoption agency. Please see section *VII.H. SPECIAL ENROLLMENT RIGHTS* for additional rights upon adoption of a child.

D. CHANGE IN STATUS

It is your responsibility to inform your Plan Sponsor and us of all changes that affect Member eligibility. These changes include: address changes; marriage of a Dependent; and death of a Member.

E. ADDING A DEPENDENT

It is important to understand that eligibility of Dependents and effective dates of coverage are determined by the Plan Sponsor. Dependents of eligible employees who meet the Plan Sponsor's eligibility guidelines will be enrolled in the Plan using HPHC enrollment forms or in a manner otherwise agreed to in writing by HPHC and the Plan Sponsor.

HPHC must receive proper notice from the Plan Sponsor of any Member enrollment in, or termination from, the Plan.

Please see your Plan Sponsor for information on Dependent eligibility and effective dates of coverage.

F. NEWBORN COVERAGE

A newborn infant of a Member is eligible for coverage under the Plan from the moment of birth. Please see section *VII.E. ADDING A DEPENDENT* for information on enrollment procedures. Please see section *VII.H. SPECIAL ENROLLMENT RIGHTS* for additional rights upon the birth of a child.

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

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

For In-Network coverage, you must be hospitalized in an In-Network hospital. If you are hospitalized at an Out-of-Network hospital, you must notify HPHC by calling **1-800-708-4414** for medical services. For all mental health and substance use disorder treatment

please call **1-888-777-4742**. Please see section *I.F. PRIOR APPROVAL* for more information.

H. SPECIAL ENROLLMENT RIGHTS

If an employee declines enrollment for the employee and his or her Dependents (including his or her spouse) because of other health insurance coverage, the employee may be able to enroll himself or herself, along with his or her Dependents in this Plan if the employee or his or her Dependents lose eligibility for that other coverage (or if the employer stops contributing toward the employee's or Dependents' other coverage). However, you must request enrollment from the Plan Sponsor within 30 days after the other coverage ends (or after the employer stops contributing toward the employee's or Dependents' other coverage).

In addition, if an employee has a new Dependent as a result of marriage, birth, adoption or placement for adoption, the employee may be able to enroll himself or herself and his or her Dependents. However, you must request enrollment from the Plan Sponsor within 30 days after the marriage, birth, adoption or placement for adoption.

Special enrollment rights may also apply to persons who lose coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for state premium assistance under Medicaid or CHIP. An employee or Dependent who loses coverage under Medicaid or CHIP as a result of the loss of Medicaid or CHIP eligibility may be able to enroll in this Plan, if enrollment is requested from the Plan Sponsor within 60 days after Medicaid or CHIP coverage ends. An employee or Dependent who becomes eligible for group health plan premium assistance under Medicaid or CHIP may be able to enroll in this Plan if enrollment is requested from the Plan Sponsor within 60 days after the employee or Dependent is determined to be eligible for such premium assistance.

VIII. Termination and Transfer to Other Coverage

Important Notice: HPHC may not have current information concerning membership status. Plan Sponsors may notify HPHC of enrollment changes retroactively. As a result, the information HPHC has may not be current. Only your Plan Sponsor can confirm membership status.

A. TERMINATION BY THE SUBSCRIBER

You may end your membership under this Plan with your Plan Sponsor's approval. HPHC must receive a completed Enrollment/Change form from the Plan Sponsor to end your membership.

B. TERMINATION FOR LOSS OF ELIGIBILITY

A Member's coverage will end under this Plan if the Plan Sponsor's contract with HPHC is terminated. A Member's coverage may also end under this Plan for failing to meet any of the specified eligibility requirements. You will be notified if coverage ends for loss of eligibility. HPHC or the Plan Sponsor will inform you in writing.

You may be eligible for continued enrollment under federal law, if your membership is terminated. See *D. CONTINUATION OF COVERAGE REQUIRED BY LAW* for more information.

Please Note: We may not have current information concerning membership status. Plan Sponsors may notify us of enrollment changes retroactively. As a result, the information we have may not be current. Only your Plan sponsor can confirm membership status.

C. MEMBERSHIP TERMINATION FOR CAUSE

The Plan may end a Member's coverage for any of the following causes:

- Misrepresentation of a material fact on an application for membership;
- Committing or attempting to commit fraud to obtain benefits for which the Member is not eligible under this Handbook;
- Obtaining or attempting to obtain benefits under this Handbook for a person who is not a Member; or
- The commission of acts of physical or verbal abuse by a Member, which pose a threat to providers, or other Members and which are unrelated to the Member's physical or mental condition.

Termination of membership for providing false information shall be effective immediately upon notice to a Member. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Termination of membership for the other causes will be effective fifteen (15) days after notice.

D. CONTINUATION OF COVERAGE REQUIRED BY LAW

Under Federal law, if you lose Plan Sponsor eligibility and the Plan Sponsor has twenty (20) or more employees, you may be eligible for continuation of group coverage under the Federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA). You should contact the Plan Sponsor for more information if health coverage ends due to: 1) separation from employment; 2) reduction of work hours; or 3) loss of dependency status.

IX. When You Have Other Coverage

This section explains how benefits under this Benefit Handbook will be coordinated with other insurance benefits available to pay for health services that a Member has received. Benefits are coordinated among insurance carriers to prevent duplicate recovery for the same service.

Nothing in this section should be interpreted to provide coverage for any service or supply that is not expressly covered under this Handbook.

A. BENEFITS IN THE EVENT OF OTHER INSURANCE

Benefits under the Plan will be coordinated to the extent permitted by law with other plans covering health benefits, including: motor vehicle insurance, medical payment policies, home owners insurance, governmental benefits (including Medicare), and all Health Benefit Plans. The term "Health Benefit Plan" means all group HMO and other prepaid health plans, medical or hospital service corporation plans, commercial health insurance and self-insured health plans. There is no coordination of benefits with Medicaid plans or with hospital indemnity benefits amounting to less than $100 per day.

Coordination of benefits will be based upon the Allowed Amount for any service that is covered at least in part by any of the plans involved. If benefits are provided in the form of services, or if a provider of services is paid under a capitation arrangement, the reasonable value of these services will be used as the basis for coordination. No duplication in coverage of services will occur among plans.

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

In the case of health benefit plans that contain provisions for the coordination of benefits, the following rules shall decide which health benefit plans are primary or secondary:

1. Employee/Dependent

The benefits of the plan that covers the person as an employee or Subscriber are determined before those of the plan that covers the person as a Dependent.

2. Dependent Children

i. Dependent Child Whose Parents Are Not Separated or Divorced

The order of benefits is determined as follows:

1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but,
2) If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time;
3) However, if the other plan does not have the rule described in (1) above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in this Plan (the "birthday rule") will determine the order of benefits.

ii. Dependent Child/Separated or Divorced Parents

Unless a court order, of which HPHC has knowledge of, specifies one of the parents as responsible for the health care benefits of the child, the order of benefits is determined as follows:

1) First the plan of the parent with custody of the child;
2) Then, the plan of the spouse of the parent with custody of the child;
3) Finally, the plan of the parent not having custody of the child.

3. Active Employee or Retired or Laid-Off Employee

The benefits of a plan that covers the person as an active employee or as a dependent of an active employee are determined before those of the plan that covers the person as an individual who is retired or laid off or as a dependent of an individual who is retired or laid off.

4. COBRA or State Continuation

The benefits of a plan that covers the person as an employee, member, subscriber or retiree, or as a dependent thereof, are determined before those of the

plan that covers the person as an individual under COBRA or other right to continuation of coverage under state or federal law.

5. 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 you are 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.

B. PROVIDER PAYMENT WHEN PLAN COVERAGE IS SECONDARY

When your Plan coverage is secondary to your coverage under another Health Benefit Plan, payment to a provider of services may be suspended 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. The Plan may recover any payments made for services in excess of the Plan's liability as the secondary plan, either before or after payment by the primary plan.

C. WORKERS' COMPENSATION/GOVERNMENT PROGRAMS

If HPHC has information indicating that services provided to you are covered under Workers' Compensation, Employer's liability or other program of similar purpose, or by a federal, state or other government agency, payment may be suspended for such services until a determination is made whether payment will be made by such program. If payment is made 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, the Plan 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.

D. SUBROGATION AND REIMBURSEMENT FROM RECOVERY

Subrogation is a means by which health plans recover expenses of services where a third party is legally responsible or alleged to be legally responsible for a Member's injury or illness.

If another person or entity is, or is alleged to be, liable to pay for services related to a Member's illness or injury which have been paid for or provided by the Plan, the Plan will be subrogated and succeed to all rights to recover against such person or entity for the value of the services paid for or provided by the Plan. The Plan will also have the right to be reimbursed from any recovery a Member obtains from such person or entity for the value of the services paid for or provided by the Plan. The Plan will have the right to seek such recovery from, among others, the person or entity that caused or allegedly caused the injury or illness, his/her liability carrier or your own auto insurance carrier, in cases of uninsured or underinsured motorist coverage. The Plan's right to reimbursement from any recovery will apply even if the recovery the Member receives for the illness or injury is designated or described as being for injuries other than health care expenses or does not fully compensate the Member for his or her damages, fees or costs. Neither the "make whole rule" nor the "common fund doctrine" apply to the Plan's rights of subrogation and/or reimbursement from recovery. The Plan's reimbursement will be made from any recovery the Member receives from any insurance company or any third party and the Plan's reimbursement from any such recovery will not be reduced by any attorney's fees, costs or expenses of any nature incurred by, or for, the Member in connection with the Member's receiving such recovery, and the Plan will have no liability for any such attorney's fees, costs or expenses.

To enforce its subrogation and reimbursement rights under this Handbook, the Plan will have the right to take legal action, with or without your consent, against any party to secure reimbursement from the recovery for the value of services provided or paid for by the Plan for which such party is, or is alleged to be, liable.

Nothing in this Handbook will be construed to limit the Plan's right to utilize any remedy provided by law to enforce its rights to subrogation under this Handbook.

E. MEDICAL PAYMENT POLICIES

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 this 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 this 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 this Benefit Handbook shall not duplicate any benefits to which you are entitled under any medical payment policy or benefit. All sums payable for services provided under this Benefit Handbook to Members that are covered under any medical payment policy or benefit are payable to the Plan.

F. MEMBER COOPERATION

You agree to cooperate with the Plan in exercising its rights of subrogation and coordination of benefits. Such cooperation will include, but not be limited to, a) the provision of all information and documents requested by the Plan, b) the execution of any instruments deemed necessary by the Plan to protect its rights, c) the prompt assignment to the Plan of any monies received for services provided or paid for by the Plan, and d) the prompt notification to the Plan of any instances that may give rise to the Plan's rights. You further agree to do nothing to prejudice or interfere with the Plan's rights to subrogation or coordination of benefits.

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

G. THE PLAN'S RIGHTS

Nothing in this Handbook shall be construed to limit the Plan's right to utilize any remedy provided by law to enforce its rights to subrogation or coordination of benefits under this agreement.

H. MEMBERS ELIGIBLE FOR MEDICARE

When a Member is enrolled in Medicare and receives Covered Benefits that are eligible for coverage by Medicare as the primary payor, the claim must be submitted to Medicare before payment by the Plan. The Plan 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, the Plan will be the primary payor for Covered Benefits during the "coordination period" specified by federal regulations at 42 CFR Section 411.162. Thereafter, Medicare will be the primary payor. When Medicare is primary (or would be primary if the Member were timely enrolled), the Plan will pay for services only to the extent payments would exceed what would be payable by Medicare.

X. Plan Provisions and Responsibilities

A. IF YOU DISAGREE WITH RECOMMENDED TREATMENT

You enroll in the Plan with the understanding that, when you obtain In-Network services, Plan Providers are responsible for determining treatment appropriate for your care. You may disagree with the treatment recommended by Plan Providers for personal or religious reasons. You may demand treatment or seek conditions of treatment that Plan Providers judge to be incompatible with proper medical care. In the event of such a disagreement, you have the right to refuse the recommendations of Plan Providers. In such a case, the Plan shall have no further obligation to provide In-Network coverage for the care in question. If you obtain care from Non-Plan Providers because of such disagreement you do so with the understanding that the Plan has no responsibility for the outcome of such care.

Nothing in this subsection shall be deemed to provide benefits for any product or service not expressly stated as a Covered Benefit under the Plan.

B. LIMITATION ON LEGAL ACTIONS

Any legal action against the Plan for failing to provide Covered Benefits must be brought within two years of the initial denial of any benefit.

C. ACCESS TO INFORMATION

You agree that, except where restricted by law, HPHC and the Plan Sponsor may have access to (1) all health records and medical data from health care providers providing services covered under this Handbook and (2) information concerning health coverage or claims from all providers of motor vehicle insurance, medical payment policies, home-owners' insurance and all types of health benefit plans. HPHC and the Plan Sponsor will comply with all laws restricting access to special types of medical information including, but not limited to, HIV test data, and substance use disorder rehabilitation and mental health and substance use disorder treatment records. Information from a Member's medical record and information about a Member's physician patient and hospital patient relationships will be kept confidential and will not be disclosed without the Member's consent, except for:

- use in connection with the delivery of care under this Handbook or in the administration of this Handbook, including utilization review and quality assurance;
- use in bona fide medical research in accordance with regulations of the U.S. Department of Health and Human Services and the Food and Drug Administration for the protection of human subjects;
- use in education within HPHC facilities; and
- where required or permitted by law.

You can obtain a copy of HPHC's Notice of Privacy Practices through the Harvard Pilgrim website, **www.harvardpilgrim.org/atriushealth** or by calling the Member Services Department at **1-888-333-4742**.

D. SAFEGUARDING CONFIDENTIALITY

HPHC is committed to ensuring and safeguarding the confidentiality of our Members' information in all settings, including personal and medical information. Our staff access, use and disclose Member information only in connection with providing services and benefits and in accordance with our confidentiality policies. We permit only designated employees, who are trained in the proper handling of Member information, to have access to and use of your information. We sometimes contract with other organizations or entities to assist with the delivery of care or administration of benefits. Any such entity must agree to adhere to our confidentiality and privacy standards.

When you enrolled in the Plan, you agreed to certain uses and disclosures of information which are necessary for us to provide and administer services and benefits, such as: coordination of care, including Referrals and authorizations; conducting quality activities, including member satisfaction surveys and disease management programs; verifying eligibility; fraud detection and certain oversight reviews, such as accreditation and regulatory audits. When we disclose Member information, we do so using the minimum amount of information necessary to accomplish the specific activity.

HPHC discloses Members' personal information only: (1) in connection with the delivery of care or administration of benefits, such as utilization review, quality assurance activities and third-party reimbursement by other payers, including self-insured

employer groups; (2) when you specifically authorize the disclosure; (3) in connection with certain activities allowed under law, such as research and fraud detection; (4) when required by law; or (5) as otherwise allowed under the terms of your Benefit Handbook. Whenever possible, we disclose Member information without Member identifiers and in all cases only disclose the amount of information necessary to achieve the purpose for which it was disclosed. We will not disclose to other third parties, such as employers, Member-specific information (i.e. information from which you are personally identifiable) without your specific consent unless permitted by law or as necessary to accomplish the types of activities described above.

In accordance with applicable law, we, and all of our contracted health care providers, agree to provide Members access to, and a copy of, their medical records upon a Member's request. In addition, your medical records cannot be released to a third party without your consent or unless permitted by law.

You can request a copy of the Notice of Privacy Practices by calling the Member Services Department at **1-888-333-4742** or through the Harvard Pilgrim website, **www.harvardpilgrim.org/atriushealth**.

E. NOTICE

Any notice to a Member may be sent to the last address of the Member on file with HPHC. Notice to HPHC, other than a request for a Member appeal, should be sent to:

HPHC Member Services Department
1600 Crown Colony Drive
Quincy, MA 02169

For the addresses and telephone numbers for filing appeals, please see section *VI. Appeals and Complaints*.

F. MODIFICATION OF THIS HANDBOOK

This Benefit Handbook, the Schedule of Benefits, and any applicable riders or amendments comprise the entire Plan as agreed to by HPHC and the Plan Sponsor. They can only be amended by HPHC and the Plan Sponsor as stated below. No other action by HPHC or the Plan Sponsor, including the deliberate non-enforcement of any benefit limit, shall be deemed to waive or alter any part of these documents.

This Benefit Handbook, the Schedule of Benefits, and any applicable riders and amendments may be amended by agreement, in writing, between HPHC and the Plan Sponsor or, if required by law, by HPHC upon written notice to the Plan Sponsor. Amendments do not require the consent of Members.

G. HPHC'S RELATIONSHIP WITH PLAN PROVIDERS

HPHC's relationship with Plan Providers is governed by separate agreements. They are independent contractors. Such Providers may not modify this Handbook or Schedule of Benefits, and any applicable riders, or create any obligation for the Plan. We are not liable for statements about this Handbook by them, their employees or agents. HPHC may change our arrangements with service providers, including the addition or removal of providers, without notice to Members.

H. IN THE EVENT OF A MAJOR DISASTER

HPHC will try to provide or arrange for services in the case of a major disaster. This might include war, riot, epidemic, public emergency, or natural disaster. Other causes include the partial or complete destruction of our facility(ies) or the disability of service providers. If the Plan cannot provide or arrange services due to a major disaster, it is not responsible for the costs or outcome of this inability.

I. EVALUATION OF NEW TECHNOLOGY

HPHC has dedicated staff that evaluates new diagnostics, testing, interventional treatment, therapeutics, medical/behavioral therapies, surgical procedures, medical devices and drugs as well as ones with new applications. The team manages the evidence-based evaluation process from initial inquiry to final policy recommendation in order to determine whether it is an accepted standard of care or if the status is Experimental, Investigational or Unproven. The team researches the safety and effectiveness of these new technologies by reviewing published peer reviewed medical reports and literature, consulting with expert practitioners, and benchmarking. The team presents its recommendations to internal policy committees responsible for making decisions regarding coverage of the new technology under the Plan. The evaluation process includes:

- Determination of the FDA approval status of the device/product/drug in question,
- Review of relevant clinical literature, and

- Consultation with actively practicing specialty care providers to determine current standards of practice.

The team presents its recommendations to internal policy committees responsible for making decisions regarding coverage of the new technology under the Plan.

J. UTILIZATION REVIEW PROCEDURES

HPHC uses the following utilization review procedures to evaluate the medical necessity of selected health care services using clinical criteria, and to facilitate clinically appropriate, cost-effective management of your care. This process applies to guidelines for both physical and mental health services.

- **Prospective Utilization Review (Prior Approval).** HPHC reviews selected elective inpatient admissions (including admissions to acute rehabilitation hospitals and skilled nursing facilities), surgical day care, and outpatient/ambulatory procedures to determine whether proposed services meet clinical criteria for coverage. Please see section *I.F. PRIOR APPROVAL* for further information on HPHC's Prior Approval requirements, including procedures for which Prior Approval is required. Prospective utilization review determinations will be made within two working days of obtaining all necessary information. In the case of a determination to approve an admission, procedure or service, HPHC will give notice via the HPHC provider portal within 24 hours of the decision and will send written confirmation to you and the provider within two working days. In the case of a determination to deny or reduce benefits ("an adverse determination"), HPHC will notify the provider rendering the service by telephone within 24 hours of the decision and will send a written or electronic confirmation of the telephone notification to you and the provider within one working day thereafter.

  Please note that Prior Approval is not required to obtain Acute Treatment Services or Clinical Stabilization Services from either a Plan Provider or a Non-Plan Provider. For more information on utilizing Non-Plan Providers, please refer to your Out-of-Network benefits. The terms "Acute Treatment Services" and "Clinical Stabilization Services" are defined in the Glossary at Section II of this Benefit Handbook.

- **Concurrent Utilization Review.** HPHC reviews selected ongoing admissions for selected services at hospitals, including acute care hospitals. rehabilitation hospitals, skilled nursing facilities, skilled home health providers and behavioral health and substance use disorder treatment facilities to assure that the services being provided meet clinical criteria for coverage. Concurrent review decisions will be made within one working day of obtaining all necessary information. In the case of either a determination to approve additional services or an adverse determination, we will notify the provider rendering the service by telephone within 24 hours of the decision. We will send a written or electronic confirmation of the telephone notification to you and the provider within one working day. In the case of ongoing services, coverage will be continued without liability to you until you have been notified of the adverse determination.

  Active case management and discharge planning is incorporated as part of the concurrent review process and may also be provided upon the request of your provider.

- **Retrospective Utilization Review.** Retrospective utilization review may be used in circumstances where services were provided before authorization was obtained. This will include the review of emergency medical admissions for appropriateness of level of care.

If you wish to determine the status or outcome of a clinical review decision you may call the Member Services Department toll free at **1-888-333-4742**. For information about decisions concerning mental health and substance use disorder treatment, you may call the Behavioral Health Access Center at **1-888-777-4742**.

In the event of an adverse determination involving clinical review, your treating provider may discuss your case with a physician reviewer or may seek reconsideration from HPHC. The reconsideration will take place within one working day of your provider's request. If the adverse determination is not reversed on reconsideration you may appeal. Your appeal rights are described in section *VI. Appeals and Complaints*. Your right to appeal does not depend on whether or not your provider sought reconsideration.

K. QUALITY ASSURANCE PROGRAMS

The goal of our quality program is to ensure the provision of consistently excellent health care, health information and service to our Members, enabling

them to maintain and improve their physical and behavioral health and well-being. Some components of the quality program are directed to all Members and others address specific medical issues and providers.

Examples of quality activities in place for all Members include a systematic review and re-review of the credentials of Plan Providers and contracted facilities, as well as the development and dissemination of clinical standards and guidelines in areas such as preventive care, medical records, appointment access, confidentiality, and the appropriate use of drug therapies and new medical technologies.

Activities affecting specific medical issues and providers include disease management programs for those with chronic diseases like asthma, diabetes and congestive heart failure, and the investigation and resolution of quality-of-care complaints registered by individual Members.

Please Note: Please note that some Plan Sponsors do not cover all these disease management programs. Please check with your Plan Sponsor for a description of programs available under your Plan.

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

HPHC uses a standardized process to evaluate inquiries and requests for coverage received from internal and/or external sources, and/or identified through authorization or payment inquiries. The evaluation process includes:

- Determination of the FDA approval status of the device/product/drug in question,
- Review of relevant clinical literature, and
- Consultation with actively practicing specialty care providers to determine current standards of practice.

Decisions are formulated into recommendations for changes in policy, and forwarded to our management for review and final implementation decisions.

M. PROCESS TO DEVELOP CLINICAL GUIDELINES AND UTILIZATION REVIEW CRITERIA

HPHC uses clinical review criteria and guidelines to make fair and consistent utilization management decisions. Criteria and guidelines are developed in accordance with standards established by The National Committee for Quality Assurance (NCQA), and reviewed (and revised, if needed) at least biennially, or more often if needed to accommodate current standards of practice. This process applies to guidelines for both physical and mental health and substance use disorder treatment services.

HPHC uses the nationally recognized InterQual criteria to review elective surgical day procedures, and services provided in acute care hospitals. InterQual criteria are developed through the evaluation of current national standards of medical practice with input from physicians and clinicians in medical academia and all areas of active clinical practice. InterQual criteria are reviewed and revised annually.

Criteria and guidelines used to review other services are also developed with input from physicians and other clinicians with expertise in the relevant clinical area. The development process includes review of relevant clinical literature and local standards of practice.

HPHC Clinician Advisory Committees, comprised of actively practicing physicians from throughout the network, serve as the forum for the discussion of specialty-specific clinical programs and initiatives, and provide guidance on strategies and initiatives to evaluate or improve care and service.

N. NON-ASSIGNMENT OF BENEFITS

You may not assign or transfer your rights to benefits, monies, claims or causes of action provided under this Plan to any person, health care provider, company or other organization without written consent from Harvard Pilgrim. Additionally, you may not assign any benefits, monies, claims, or causes of action resulting from a denial of benefits without the written consent from Harvard Pilgrim.

O. NEW TO MARKET DRUGS

New prescription drugs that are introduced into the market are reviewed by the Plan prior to coverage to ensure that the drug is safe and effective. New to market drugs will be reviewed by Harvard Pilgrim's Medical Policy Department within the first 180 days of their introduction to the market. If the new to market drug is covered by the Plan, Prior Authorization and coverage limitations may apply.

Please Note: Your coverage under this Benefit Handbook is limited to Medical Drugs. Your Plan does not provide coverage for outpatient prescription drugs through Harvard Pilgrim. For information on coverage

of outpatient prescription drugs please contact your pharmacy administrator.

XI. MEMBER RIGHTS & RESPONSIBILITIES

Members have a right to receive information about HPHC, its services, its practitioners and providers, and Members' rights and responsibilities.

Members have a right to be treated with respect and recognition of their dignity and right to privacy.

Members have a right to participate with practitioners in decision-making regarding their health care.

Members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

Members have a right to voice complaints or appeals about HPHC or the care provided.

Members have a right to make recommendations regarding the organization's members' right and responsibilities policies.

Members have a responsibility to provide, to the extent possible, information that HPHC and its practitioners and providers need in order to care for them.

Members have a responsibility to follow the plans and instructions for care that they have agreed on with their practitioners.

Members have a responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

Harvard Pilgrim Health Care, Inc.
1600 Crown Colony Drive
Quincy, MA 02169
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