



Harvard Pilgrim
Health Care

Benefit Handbook

PPO

MASSACHUSETTS

INTRODUCTION

Welcome to the PPO(the Plan) offered by Harvard Pilgrim Health Care, Inc. and thank you for choosing us to help meet your health care needs.

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

To use the Plan effectively, you will want to review this Handbook and the Schedule of Benefits, which describe your In-Network, and Out-of-Network benefits. This Plan has been designed to offer you the flexibility of obtaining Covered Benefits through the Plan’s network of Plan Providers or the Non-Plan Provider of your choice. Benefits are covered both In-Network and Out-of-Network. However, in most cases, your In-Network benefits provide you with a higher level of coverage with lower out of pocket costs.

All In-Network care must be provided by the Plan’s network of Plan Providers, except in a Medical Emergency.

If you choose to receive Covered Benefits from a provider or at a facility which is not a Plan Provider, your benefits will be covered at the Out-of-Network level.

Some benefits have limits on the amount of coverage provided in a Plan Year or Calendar Year. Please see your Schedule of Benefits to determine which type of year your Plan utilizes. If a Covered Benefit has a benefit limit, your In-Network and Out-of-Network services are usually combined and count against each other to reach your benefit limit. Please see your Schedule of Benefits for detailed information regarding benefit limits on your coverage.

When you enroll, you receive the covered health care services described in this Handbook, the Schedule of Benefits, the Prescription Drug Brochure (if your Plan includes our outpatient pharmacy coverage) and any riders or amendments to those documents.

The Massachusetts Managed Care Reform Law requires disclosure of premium information and information concerning HPHC’s voluntary and involuntary disenrollment rate. This information will be sent to you in a separate letter. Please keep that letter with this Handbook for your records.

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

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, and Deductible status, and view Prior Approval activities. You can also learn how your Plan covers preventive care and conditions such as asthma, diabetes, COPD and high blood pressure.

The cost transparency tool allows you to compare cost and quality on many types of health care services including surgical procedures and office visits. 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.

When you receive Covered Benefits under the Plan, you will receive an explanation of those Covered Benefits, called an Activity Statement (also known as a Summary of Payment). The Activity Statement will list the Covered Benefits, the cost for those Covered Benefits, and your Member Cost Sharing. You have the right to request that your Activity Statement be sent to you at a specific mailing address, or electronically such as through your secure online account, or be sent to an authorized third party on your behalf. In certain circumstances, you may also request that we not send an Activity Statement related to a specific service. You may contact Member Services to make these requests.

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 Plan Providers
- Your Benefit Handbook
- Your In-Network and Out-of-Network benefits
- Your enrollment
- Your claims
- Pharmacy management procedures
- Provider information
- Requesting a Provider Directory
- Requesting a Member Kit
- Requesting ID cards
- Registering a complaint

We can 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 service, 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, Inc.
Member Services Department
1600 Crown Colony Drive
Quincy, MA 02169
1-888-333-4742
www.harvardpilgrim.org

The Office of Patient Protection. The Office of Patient Protection of the Health Policy Commission is the agency responsible for enforcing the Massachusetts laws concerning

managed care grievance rights and for administering appeals to external review organizations. The Office of Patient Protection can be reached at:

**Health Policy Commission
Office of Patient Protection
50 Milk Street, 8th Floor
Boston, MA 02109
1-800-436-7757
Fax: 1-617-624-5046
HPC-OPP@state.ma.us
<http://www.mass.gov/hpc/opp>**

The following information is available to consumers from the Office of Patient Protection:

- A list of sources of independently published information assessing insureds' satisfaction and evaluating the quality of health care services offered by a carrier;
- The percentage of physicians who voluntarily and involuntarily terminated participation contracts with the carrier during the previous Plan Year or Calendar Year for which such data has been compiled and the three most common reasons for voluntary and involuntary physician disenrollment;
- The percentage of premium revenue expended by the carrier for health care services provided to insureds for the most recent year for which information is available;
- A report detailing, for the previous calendar year, the total number of: a) filed grievances, grievances that were approved internally, grievances that were denied internally, and grievances that were withdrawn before resolution; and b) external appeals pursued after exhausting the internal grievance process and the resolution of all such external appeals.

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**.

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

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

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

ខ្មែរ (Cambodian) ជូនស្តីជូនដំណឹង: បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ជូរ ជូរស្តី 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, ໂດຍບໍ່ເສັຽຄ່າ, ຈະມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-333-4742 (TTY: 711).

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

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

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General Notice About Nondiscrimination and Accessibility Requirements

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

HPHC:

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

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

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Compliance Officer, 93 Worcester St, Wellesley, MA 02481, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@harvardpilgrim.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

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

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



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

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I. How the Plan Works

This section describes how to use your Benefit Handbook and how your coverage works under the PPO (the Plan). The Plan provides you with two levels of benefits known as In-Network coverage and Out-of-Network coverage. You receive In-Network coverage when you obtain Covered Benefits from Providers participating in the Plan. These Providers are referred to as “Plan Providers” and they have agreed to accept our payment minus the Member Cost Sharing as payment in full.

In Massachusetts, Maine, New Hampshire, Connecticut and Rhode Island there are certain specialized services that must be received at designated Plan Providers, referred to as “Centers of Excellence” to receive In-Network coverage. Please see section *I.D.5. Centers of Excellence* for further information.

You receive Out-of-Network coverage when you obtain Covered Benefits from Non-Plan Providers. The Plan does not have agreements or contracts with these Providers. We pay a percentage of the cost of care you receive from Non-Plan Providers, up to the Allowed Amount for the service. If a Non-Plan Provider charges any amount in excess of the Allowed Amount, you are responsible for the excess amount. Your In-Network and Out-of-Network coverage is described further below.

A. HOW TO USE THIS BENEFIT HANDBOOK

1. Why This Benefit Handbook Is Important

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

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

- How to obtain benefits with the lowest out-of-pocket expense
- Covered Benefits
- Exclusions

- The requirements for In-Network and Out-of-Network coverage

You can view your Benefit Handbook, Schedule of Benefits, Prescription Drug Brochure (if your Plan includes our outpatient pharmacy coverage), and any applicable riders and amendments online by using **your secure online account** at www.harvardpilgrim.org.

2. Words With Special Meaning

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

3. How To Find What You Need To Know

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

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

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

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

B. HOW TO USE YOUR PROVIDER DIRECTORY

The Provider Directory lists the Plan Providers you may use to obtain In-Network Benefits. You may view the Provider Directory online at our website, www.harvardpilgrim.org. You can also get a paper copy of the Provider Directory, free of charge, by calling the Member Services Department at **1-888-333-4742**.

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

You may access the physician profiling site maintained by the Commonwealth of Massachusetts Board of Registration in Medicine at www.mass.gov/orgs/board-of-registration-in-medicine.

Please Note: The physicians and other medical professionals in the Plan's provider network participate through contractual arrangements that can be terminated either by a Provider or by us. In addition, a Plan 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.

C. MEMBER OBLIGATIONS

1. Show Your Identification Card

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

2. Share Costs

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

- Copayments
- Coinsurance
- Deductibles

Your Plan 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 section *I.E. MEMBER COST SHARING* for more information on Copayments, Coinsurance, Deductibles and Out-of-Pocket Maximums.

3. 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.

4. 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) The Plan provides you with two levels of benefits known as In-Network benefits and Out-of-Network benefits.
- 2) In-Network benefits are available for Covered Benefits received from Plan Providers.
- 3) Plan Providers are providers that are under contract with HPHC to provide services to Members.
- 4) Out-of-Network benefits are available for Covered Benefits received from Non-Plan Providers.
- 5) Some services require Prior Approval by the Plan.
- 6) In the event of a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number.

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

1. How Your In-Network Benefits Work

In-Network benefits are available when you receive Covered Benefits from a Plan Provider. Your Member Cost Sharing is generally lower for In-Network benefits. In-Network coverage applies to Plan Providers in Massachusetts, Maine, New Hampshire, Rhode Island, Vermont, Connecticut and a large number of providers in HPHC's affiliated national network around the country. Since we pay Plan Providers directly, you do not have to file a claim when you use your In-Network benefits.

Plan Providers are under contract to provide Covered Benefits to Members of the Plan. They are listed in the Plan Provider Directory. Although every effort is made to keep the Provider Directory up-to-date, changes may occur for a variety of reasons. Members should contact the Member Services Department at **1-888-333-4742** to verify a Provider's status. Members are responsible for advising Providers of their membership in the Plan by showing them their identification card before receiving services.

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.

Please Note: In Massachusetts, Maine, New Hampshire, Connecticut and Rhode Island there are certain specialized services that must be received from designated Plan Providers, referred to as “Centers of Excellence” to receive In-Network coverage. Please see section *I.D.5. Centers of Excellence* for further information.

2. How Your Out-of-Network Benefits Work

Out-of-Network Benefits are available when you receive Covered Benefits from Non-Plan Providers. 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.

3. Selecting a Plan Provider

To obtain In-Network benefits you must receive services from a Plan Provider. Your Out-of-Pocket costs will almost always be lower if you use your In-Network benefits by using a Plan Provider. Plan Providers include a large number of specialists and health care institutions in Massachusetts and surrounding states. In addition, HPHC offers a large national network of Plan Providers across the United States. You may use the Harvard Pilgrim Provider Directory to find Plan Providers. The Provider Directory identifies the Plan’s participating specialists, hospitals and other providers. It lists providers by state and town, specialty, and languages spoken. You may view the Provider Directory online at our website, www.harvardpilgrim.org. You can also get a paper copy of the Provider Directory, free of

charge, by calling the Member Services Department at **1-888-333-4742**.

If you have 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.

Please Note: The physicians and other medical professionals in the Plan’s provider network participate through contractual arrangements that can be terminated either by a provider or by us. In addition, a provider may leave the network because of retirement, relocation or other reasons. This means that we cannot guarantee that the physician you choose will continue to participate in the network for the duration of your membership.

4. Flex Providers

Some Plans may include Flex Providers. A Flex Provider is a Plan Provider that provides certain outpatient services with lower Member Cost Sharing. When you receive certain Covered Benefits from a Flex Provider you will pay a lower Member Cost Sharing amount than if you received the same Covered Benefit from a provider that is not a Flex Provider.

 **FOR EXAMPLE:** An example of a Covered Benefit that may be available through a Flex Provider is outpatient surgery. If your Plan includes Flex Providers and you receive outpatient surgery at an outpatient surgical center designated as a Flex Provider, your Member Cost Sharing will be less than outpatient surgery received at a hospital surgical center that is not designated as a Flex Provider.

If your Plan includes Flex Providers, your Schedule of Benefits will list the Member Cost Sharing amounts for both Plan Providers and Flex Providers under the applicable outpatient Covered Benefits.

If your Plan includes Flex Providers, they will be listed in your Provider Directory. For a complete list of Plan Providers, please see your Provider Directory which may be found at www.harvardpilgrim.org.

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, New Hampshire, Connecticut and Rhode Island. The following specialized services 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 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, New Hampshire, Connecticut and Rhode Island, 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, New Hampshire, Connecticut or Rhode Island, for the above services 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 services listed above outside of Massachusetts, Maine, New Hampshire, Connecticut or Rhode Island, 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 chose to receive care for the above services at a facility other than a Plan Provider, coverage will be at the Out-of-Network benefit level.

6. Covered Benefits from Our Affiliated National Network of Providers

HPHC offers a comprehensive network of Plan Providers located in Massachusetts, New Hampshire, Rhode Island, Vermont, Connecticut or Maine. In addition, HPHC's national provider network allows Members to obtain In-Network benefits outside of those states. As of the issuance of this

Handbook, the national network includes nearly 450,000 physicians and over 4,000 hospitals. To locate one of these Providers, log onto our website at www.harvardpilgrim.org or call Member Services at **1-888-333-4742**.

7. How to get Care After Hours

Either your doctor or a covering provider is available to direct your care 24-hours a day. Talk to your doctor to find out what arrangements are available for care after normal business hours. Some doctors may have covering physicians after hours and others may have extended office/clinic hours. In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number.

8. 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 or PCP by an attending emergency physician no further notice is required.

E. MEMBER COST SHARING

Below are descriptions of Member Cost Sharing that may apply when using Plan or Non-Plan Providers. Member Cost Sharing under your Plan may apply to services received In-Network, Out-of-Network or both. See your Schedule of Benefits for Cost Sharing details that are specific to your Plan.

Please Note: If you receive Covered Benefits at a location that is a Plan Provider but some or all of such 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 such Covered Benefits from a Plan Provider.

1. Copayment

A Copayment is a fixed dollar amount you must pay for certain Covered Benefits. Copayments are due at the time of service or when billed by the Provider. There may be two types of office visit Copayments that apply to your Plan: a lower Copayment known as "Level 1" and a higher Copayment known as "Level 2."

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

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

2. Deductible

A Deductible is a specific dollar amount that is payable by the Member for Covered Benefits received each Plan Year or Calendar Year before any benefits subject to the Deductible are payable by the Plan. Please see your Schedule of Benefits to determine which type of year your Plan utilizes. If a family Deductible applies, it is met when any combination of Members in a covered family incur expenses for services to which the Deductible applies. Deductible amounts are incurred on the date of service. You may have different Deductibles that apply to different Covered Benefits under your Plan. If a Deductible applies to your plan, it will be listed in your Schedule of Benefits.

If your Plan has a Deductible, it will have both an individual Deductible and a family Deductible. However, please note that a family Deductible only applies if you have Family Coverage. Unless a family Deductible applies, you are responsible for the individual Deductible for Covered Benefits each Plan Year or Calendar Year. If you are a Member with Family Coverage, the Deductible can be satisfied 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 for Covered Benefits for the remainder of the Plan Year or Calendar Year.
- b. If any number of Members in a covered family collectively meet the family Deductible, then all Members of the covered family have no additional Deductible Member Cost Sharing for Covered Benefits for the remainder of the Plan Year or Calendar Year. No one family member may contribute more than the individual Deductible amount to the family Deductible.

Once a Deductible is met, coverage by the Plan is subject to any other Member Cost Sharing that may apply.

If a Member changes to Family Coverage from Individual Coverage or to Individual Coverage from

Family Coverage within a Plan Year or Calendar Year, expenses that Member incurred for Covered Benefits toward the Deductible under the prior coverage will apply toward the Deductible limit under his/her new coverage. If the previously incurred Deductible amount is greater than the new Deductible limit, the Member or family will only be responsible for applicable Copayment or Coinsurance amounts listed in his/her Schedule of Benefits.

Some Plans include a Deductible Rollover. A Deductible Rollover allows you to apply any Deductible amount incurred for Covered Benefits during the last three (3) months of a year toward the Deductible for the next year. In order for a Deductible Rollover to apply, the Member (or Family) must have had continuous coverage under the Plan through the same Employer Group at the time the charges for the prior year were incurred. If a Deductible Rollover applies, it will be stated in your Schedule of Benefits.

3. Coinsurance

After the appropriate Deductible amount is met, you may be responsible for paying a Coinsurance amount, which is a percentage of the Allowed Amount. When using Plan Providers, the Allowed Amount is based on the contracted rate between HPHC and the Provider. When using Non-Plan Providers, the Allowed Amount is based on the Providers charge for the service up to the Allowed Amount for the service. In general higher Coinsurance amounts will apply to Out-of-Network services. Coinsurance amounts are listed in your Schedule of Benefits.

4. Out-of-Pocket Maximum

Your coverage includes an Out-of-Pocket Maximum. An Out-of-Pocket Maximum is the total amount of Copayments, Deductible or Coinsurance payments for which a Member or a family is responsible in a Plan Year or Calendar Year. Once the Out-of-Pocket Maximum has been reached, no further Copayment, Deductible or Coinsurance amounts will be payable by the Member and HPHC will pay 100% of the Allowed Amount for the remainder of the Plan Year or Calendar Year. Once a family Out-of-Pocket Maximum has been met in a Plan Year or Calendar Year, the Out-of-Pocket Maximum is deemed to have been met by all Members in a family for the remainder of the Plan Year or Calendar Year.

Certain expenses do not apply to the Out-of-Pocket Maximum. Penalty amounts and charges above the Allowed Amount never apply to the Out-of-Pocket maximum.

In most cases where an Out-of-Pocket Maximum is included in the Plan, you have both an individual Out-of-Pocket Maximum and a family Out-of-Pocket Maximum. If you are a Member with Family Coverage, your Out-of-Pocket Maximum can be reached 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 for the remainder of the Plan Year or Calendar Year.
- b. If any number of Members in a covered family collectively meet the family Out-of-Pocket Maximum, then all Members of the covered family have no additional Member Cost Sharing for the remainder of the Plan Year or Calendar Year.

If a Member changes to Family Coverage from Individual Coverage or to Individual Coverage from Family Coverage within a Plan Year or Calendar Year, expenses that Member incurred for Covered Benefits toward the Out-of-Pocket Maximum under the prior coverage will apply toward the Out-of-Pocket Maximum limit under his/her new coverage. If the incurred Out-of-Pocket Maximum amount is greater than the new Out-of-Pocket Maximum limit, the Member will have no additional Member Cost Sharing for that Plan Year or Calendar Year.

5. 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 **1-800-637-8257** for TTY service if you have questions about the maximum Allowed Amount that may be permitted by HPHC for a service.

6. Penalty

The amount that a Member is responsible to pay 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.

7. 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 a 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.

F. PRIOR APPROVAL

Prior Approval must be obtained before receiving certain medical services, Medical Drugs or mental health and substance use disorder treatment from a Non-Plan Provider or Plan Provider outside the Service Area. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. This section explains when Prior Approval is required and the procedures to follow to meet those requirements.

Important Notice: For a detailed list of services that require Prior Approval, please visit our website at www.harvardpilgrim.org. If you have questions regarding services that require Prior Approval, please contact Member Services at **1-888-333-4742.**

Please Note: 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.

- 1) **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.L. UTILIZATION REVIEW PROCEDURES* of this Handbook.

- 2) **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 services require Prior Approval when obtained from a Non-Plan Provider:

- **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**
- **Transcranial Magnetic Stimulation (TMS)**

For a detailed list of services that require Prior Approval, please visit our website at www.harvardpilgrim.org. If you have questions regarding services that require Prior Approval, please contact Member Services at **1-888-333-4742**.

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.

- 3) **For Medical Services from a Non-Plan Provider or Plan Provider Outside the Service Area**

Prior Approval must be obtained before receiving certain medical services or Medical Drugs from a Non-Plan Provider or Plan Provider outside the Service Area. To obtain Prior Approval for medical services you should call **1-800-708-4414**. To obtain Prior Approval for Medical Drugs, you should call **1-844-387-1435**.

The following services require Prior Approval when obtained from a Non-Plan Provider or Plan Provider Outside the Service Area:

- **Inpatient services**
- **Outpatient services and treatments** including but not limited to: infertility treatment; genetic testing; home health care; advanced radiology; and pain management. Please see the detailed list of all the services and treatments that require Prior Approval, on our website at www.harvardpilgrim.org
- **Outpatient surgery**

- **Medical Drugs**
- **Diabetic equipment**
- **Non-emergency transportation**
Please note, Prior Approval is not required for transportation provided by a wheelchair van.
- **Prosthetic arms and legs**
- **Dental services**
Please note, 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.)

For a detailed list of services that require Prior Approval, please visit our website at www.harvardpilgrim.org. If you have questions regarding services that require Prior Approval, please contact Member Services at **1-888-333-4742**.

Please Note: Not all plans cover every service listed on the Prior Approval List. Please see your Schedule of Benefits to determine if your Plan provides coverage for a specific benefit or call the Member Services Department at **1-888-333-4742**.

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 from 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.X.L. 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 Prior Approval 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 the level of care, place of service and 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 HPHC'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 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. 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.

2. 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.

3. New Membership

If you are a new Member, we will provide In-Network coverage for services delivered by a physician or nurse practitioner who is not a 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 Employer only offers employees a choice of plans in which the physician or nurse practitioner is a Non-Plan Provider, and
- The physician or nurse practitioner is providing you with an ongoing course of treatment.

4. 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 (or, in the case of a new Member, our applicable rate) 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 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 Plan Providers to be available by telephone 24-hours a day. However, the Plan does require Plan Primary Care Providers (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.

K. WELLNESS CARE PROGRAMS

Harvard Pilgrim offers certain wellness care programs to Members receiving care covered under the Plan. These services may include telephone or video counseling sessions designed to treat depression, anxiety or stress that may accompany chronic conditions or life events. These counseling sessions may be available to you at lower Member Cost Sharing. Please log into your secure online account at www.harvardpilgrim.org or call the Member Services Department at **1-888-333-4742** for more information concerning these programs and their Member Cost Sharing obligations.

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 that we 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, Vermont or Connecticut, 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:

An amount that is consistent, in the judgement 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 provided 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 Massachusetts, New Hampshire, Maine, Rhode Island, Vermont and Connecticut 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 services and substance use disorder services will be 80% of the billed charge.

Pricing of the Allowed Amount will be conducted by UnitedHealthcare, Inc. UnitedHealthcare, 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 Employer Group upon which the yearly Employer Group premium rate is adjusted and benefit changes normally become effective. This Benefit Handbook, Schedule of Benefits, Prescription Drug Brochure (if applicable) and any applicable riders, and the Employer Group agreement 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.

Behavioral Health Access Center The organization, designated by us, 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 Plan Year or Calendar Year for physical therapy services, once you reach your 30 visit limit for that Plan Year or 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 either a Plan Year or Calendar Year basis. Please see your Schedule of Benefits to determine which type of year your Plan utilizes.

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, New Hampshire, Connecticut or Rhode

Island 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 are in addition to any Deductible and any applicable Copayment. 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 we pay the remaining 80%. (In the case of Out-of-Network services, we only pay up to the Allowed Amount.)

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.

There may be two types of office visit Copayments that apply to your Plan: a lower Copayment known as “Level 1” and a higher Copayment known as “Level 2.” Your specific Copayment amounts, and the services to which they apply, are listed 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(s) 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 a Member for Covered Benefits received each Plan Year or Calendar Year before any benefits subject to the Deductible are payable by the Plan. There may be an individual Deductible and a family Deductible, and you may have different Deductibles that apply to different Covered Benefits under your Plan. If a Deductible applies to your Plan, it will be stated in the Schedule of Benefits.

✓ FOR EXAMPLE: If your Plan has a \$500 Deductible and you have a claim with the Allowed Amount of \$1,000, you will be responsible for the first \$500 to satisfy your Deductible requirement before the Plan begins to pay benefits.

Deductible Rollover A Deductible Rollover allows you to apply any Deductible amount incurred for Covered Benefits during the last three months of a Plan Year or Calendar Year toward the Deductible for the next Plan Year or Calendar Year. To be eligible for a Deductible Rollover, a Member must have had continuous coverage with us through the same Employer Group at the time the prior Plan Year or 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 Plan Year or 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 and (2) is enrolled in the Plan.

Employer Group or Employer An organization that has contracted with us to provide health care coverage for its employees under the Plan.

Evidence of Coverage The legal documents, including the Benefit Handbook, Schedule of Benefits, Prescription Drug Brochure (if applicable), and any applicable riders and amendments which describe the services covered by the Plan, and other terms and conditions of coverage.

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). (c) For purposes of the treatment of infertility only, the service, procedure, drug or device has not been recognized as a "non-experimental infertility procedure" under the Massachusetts Infertility Benefit Regulations at 211 CMR Section 37.00 et. seq.

Please Note: Autologous bone marrow transplants for the treatment of breast cancer, as required by law, are not considered Experimental or Unproven when they satisfy the criteria identified by the Massachusetts Department of Public Health.

Family Coverage Coverage for a Member and one or more Dependents.

Flex Provider An outpatient provider that provides certain Covered Benefits with lower Member Cost Sharing. When you receive certain Covered Benefits from a Flex Provider you will pay a lower Member Cost Sharing amount than if you received the same Covered Benefits from a provider that is not a Flex Provider. If your Plan includes Flex Providers, they will be listed in your Provider Directory. For a complete list of Plan Providers, please see your Provider Directory which may be found at www.harvardpilgrim.org.

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) Harvard Pilgrim Health Care, Inc. is an insurance company that underwrites the health care benefits described in this Handbook under an agreement with the Employer Group.

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 HPHC.

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

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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 is 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.

Non-Plan Provider A Provider who does not have an agreement or contract with HPHC or its affiliates to provide care to Members. Payments for services received from Non-Plan Providers are limited to the Allowed Amount. When care is received from a Non-Plan Provider, Member's are responsible for the applicable Deductible and Coinsurance plus any amounts in excess of the Allowed Amount. The Deductible and Coinsurance amounts are described in your Schedule of Benefits.

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

Out-of-Pocket Maximum An Out-of-Pocket Maximum is a limit on the amount of Deductibles, Copayments and Coinsurance that a Member must pay for certain Covered Benefits in a Plan Year or Calendar Year. The Out-of-Pocket Maximum is stated in your Schedule of Benefits.

Please Note: Penalty payments and charges above the Allowed Amount never apply to the Out-of-Pocket Maximum.

✓ FOR EXAMPLE: If your plan has an individual Out-of-Pocket Maximum of \$1,000, this is the most Member Cost Sharing you will pay for out-of-pocket costs for that Plan Year or Calendar Year. As an example, the Out-of-Pocket Maximum can be reached by the following: \$500 in Deductible expenses, \$400 in Coinsurance expenses and \$100 in Copayment expenses.

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 offered by Harvard Pilgrim Health Care, Inc.

Plan Provider Providers who are under contract to provide In-Network services to Plan Members, and have agreed to charge Members only the applicable Copayments, Coinsurance and Deductible amounts for Covered Benefits. Plan Providers are listed in the Provider Directory.

Plan Year The one-year period for which benefits are purchased and administered. Benefits for which limited yearly coverage is provided renew at the beginning of the Plan Year. Benefits for which limited coverage is provided every two years renew at the beginning of every second Plan Year. Generally, the Plan Year begins on the Plan's Anniversary Date. Benefits under your Plan are administered on either a Plan Year or Calendar Year basis. Please see your Schedule of Benefits to determine which type of year your Plan utilizes.

✓ FOR EXAMPLE: A Plan Year could begin on April 1st and end on March 31st or begin on January 1st and end on December 31st.

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Premium A payment made to us for health coverage under the Plan.

Primary Care Provider (PCP) A Plan Provider who provides, coordinates, or helps a Member access a range of health care services. A PCP may be a physician, nurse practitioner or a physician's assistant practicing in any of the following medical specialties: internal medicine, family practice, adult medicine, pediatrics, adolescent medicine or geriatrics.

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) to arrange for the payment of benefits.

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

Provider A Provider is defined as: a hospital or facility that is licensed to provide inpatient medical, surgical, or rehabilitative services; a Skilled Nursing Facility; and medical professionals including but not limited to: physicians, psychologists, psychiatrists, podiatrists, nurse practitioners, advanced practice registered nurses, physician's assistants, psychiatric social workers, licensed nurse mental health clinical specialist, psychotherapists, psychologists, licensed independent clinical social workers, licensed mental health counselors, level I licensed alcohol and drug counselors, physicians with recognized expertise in specialty pediatrics (including mental health and substance use disorder treatment), nurse midwives, nurse anesthetists, chiropractors, acupuncturists, optometrists, speech-language pathologists and audiologists, and early intervention specialists who are credentialed and certified by the Massachusetts Department of Public Health. Dentists may also be Providers when providing services under this Plan. (Please note that coverage for dental services is very limited.) Plan Providers are listed in the Provider Directory.

Provider Directory A directory that identifies Plan Providers. We may revise the Provider Directory from time to time without notice to Members. The most current listing of Plan Providers is available on www.harvardpilgrim.org.

Rehabilitation Services Rehabilitation Services are treatments for disease or injury that restore or move an individual toward functional capabilities 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 Employer and covered under your Plan are listed in the Schedule of Benefits. A more detailed description of the benefits is in this Benefit Handbook. 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, Maine, New Hampshire, Rhode Island, Vermont and Connecticut.

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 describes all of the benefits available under the Plan. Please see your Schedule of Benefits for your specific Covered Benefits. If your Plan includes outpatient pharmacy coverage, that coverage is described in your Prescription Drug Brochure.

Some benefits have limits on the amount of coverage provided in a Plan Year or Calendar Year. If a Covered Benefit has a benefit limit, your In-Network or Out-of-Network benefits are combined and count toward your benefit limit. For example, if the Covered Benefit is limited to ten visits per Plan Year or Calendar Year and you receive nine visits In-Network and one visit Out-of-Network, then you have reached your benefit limit. That benefit will not be covered again until the next Plan Year or Calendar Year.

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 Plan Year or Calendar Year basis.

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

Basic Requirements for Coverage

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

- Listed as a Covered Benefit in this section.
- Medically Necessary.
- Not excluded in section *IV. Exclusions*.
- Received while an active Member of the Plan.
- In-Network services must be provided by a Plan Provider. The only exception is care needed in a Medical Emergency.
- Some services require Prior Approval by the Plan. Please see section *I.F. PRIOR APPROVAL* for information on the Prior Approval Program.
- In Massachusetts, Maine, New Hampshire, Connecticut and Rhode Island there are certain specialized services that must be received from designated Plan Providers, referred to as “Centers of Excellence,” to receive In-Network benefits. Please see section *I.D.5. Centers of Excellence* for a list of these services.

| Benefit | Description |
|--|---|
| 1 . Acupuncture Treatment for Injury or Illness | <p>The Plan may cover acupuncture treatment for illness or injury, including, electro-acupuncture, that is provided for the treatment of neuromusculoskeletal pain.</p> <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.</p> |

| Benefit | Description |
|---|---|
| <p>2 . Ambulance Transport</p> | <p>Emergency Ambulance Transport</p> <p>If you have a Medical Emergency (including an emergency related to a substance use disorder or mental health condition), your Plan covers ambulance transport (ground and air) to the nearest hospital that can provide you with Medically Necessary care.</p> <p>Non-Emergency Ambulance Transport</p> <p>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. Services must be arranged by a Provider.</p> <p>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>I.F. PRIOR APPROVAL</i> for more information.</p> |
| <p>3 . Autism Spectrum Disorders Treatment</p> | <p>Coverage is provided for the diagnosis and treatment of Autism Spectrum Disorders, as defined below. Covered Benefits include the following:</p> <ul style="list-style-type: none"> • 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 Providers. This includes care 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. • Prescription drug coverage (if you have the Plan's optional coverage for outpatient prescription drugs). If you have the Plan's outpatient prescription drug coverage, please see your Prescription Drug Brochure for information on this benefit. <p>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.</p> <p>Applied behavior analysis is defined by Massachusetts law 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.</p> <p>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.</p> |

| Benefit | Description |
|---|---|
| 4 . Cardiac Rehabilitation Therapy | |
| | <p>The Plan covers cardiac rehabilitation as required by Massachusetts law. Coverage includes only Medically Necessary services for Members with established coronary artery disease or unusual and serious risk factors for such disease.</p> |
| 5 . Chemotherapy and Radiation Therapy | |
| | <p>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.</p> <p>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>I.F. PRIOR APPROVAL</i> for more information.</p> |
| 6 . Clinical Trials for the Treatment of Cancer or Other Life-Threatening Diseases | |
| | <p>The Plan covers services for Members enrolled in a qualified clinical trial of a treatment for any form of cancer or other life-threatening disease under the terms and conditions 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.</p> |
| 7 . Dental Services | |
| | <p>Important Notice: The Plan does not provide dental insurance. It covers only the limited Dental Care described below. No other Dental Care is covered.</p> <p>Cleft Palate:</p> <p>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 <i>III. Covered Benefits, Reconstructive Surgery</i>, for information on this benefit.</p> <p>Emergency Dental Care:</p> <p>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:</p> <ul style="list-style-type: none"> • 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 <p>Extraction of Teeth Impacted in Bone:</p> <p>The Plan may cover extraction of teeth impacted in bone. If covered under your plan, only the following services are covered:</p> <ul style="list-style-type: none"> • Extraction of teeth impacted in bone |

| Benefit | Description |
|--|--|
| <p>Dental Services (Continued)</p> | <ul style="list-style-type: none"> • Pre-operative and post-operative care, immediately following the procedure • Anesthesia • X-rays <p>Prior Approval Required: You must obtain Prior Approval for treatment of cleft palate and 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>I.F. PRIOR APPROVAL</i> for more information.</p> <p>Please Note: Your Plan may provide coverage for pediatric dental services. Please see your Schedule of Benefits and any associated riders to determine if your Plan provides coverage for this benefit.</p> |
| <p>8 . Diabetes Services and Supplies</p> | <p>Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care:</p> <p>The Plan covers outpatient self-management education and training for the treatment of diabetes, including medical nutrition therapy services, used to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes. Services must be provided on an individual basis. Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care. The following items are also covered:</p> <p>Diabetes Equipment:</p> <ul style="list-style-type: none"> • Blood glucose monitors • Dosage gauges • Injectors • Insulin pumps (including supplies) and infusion devices • Lancet devices • Therapeutic molded shoes and inserts • Visual magnifying aids • Voice synthesizers <p>Pharmacy Supplies:</p> <ul style="list-style-type: none"> • Blood glucose strips • Flash glucose monitors (including supplies) • Insulin, insulin needles and syringes • Lancets • Oral agents for controlling blood sugar • Urine and ketone test strips <p>For coverage of pharmacy items listed above, you must get a prescription from your Provider and present it at a participating pharmacy. You can find participating pharmacies by logging into your secure online account at www.harvardpilgrim.org or by calling the Member Services Department at 1-888-333-4742.</p> <p>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</p> |

| Benefit | Description |
|---|--|
| Diabetes Services and Supplies (Continued) | Approval process is initiated by calling: 1-800-708-4414 . Please see section <i>I.F. PRIOR APPROVAL</i> for more information. |
| 9 . Dialysis | <p>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 cover only those costs that exceed what would be payable by Medicare.</p> <p>Coverage for dialysis in the home includes non-durable medical supplies, and drugs and equipment necessary for dialysis.</p> <p>Prior Approval Required: You must obtain Prior Approval for any planned inpatient admission or any service provided in the home. If you use a Plan Provider located within the Service Area, he or she will seek Prior Approval for you. The Prior Approval process is initiated by calling: 1-800-708-4414. Please see section <i>I.F. PRIOR APPROVAL</i> for more information.</p> |
| 10 . Drug Coverage | <p>You have limited coverage for drugs received during inpatient and outpatient treatment and also for certain medical supplies you purchase at a pharmacy under this Benefit Handbook. This coverage is described in Subsection 1, below. You may also have coverage for outpatient prescription drugs you purchase at a pharmacy under the Plan’s outpatient prescription drug coverage. Subsection 2, below, explains more about this coverage.</p> <p>1) Your Coverage under this Benefit Handbook</p> <p>This Benefit Handbook covers the following:</p> <p>a 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.</p> <p>b Drugs Received During Outpatient or Home Care. The drugs known as “Medical Drugs.” A Medical Drug is administered to you either (1) in a doctor’s office or other outpatient medical facility, or (2) at home while you are receiving home care services or receiving drugs administered by home infusion services.</p> <p>Medical Drugs cannot be self-administered .The words “cannot be self-administered” mean that the active participation of skilled medical personnel is always required to take the drug. When a Member is receiving drugs in the home, the words “cannot be self-administered” will also include circumstances in which a family member or friend is trained to administer the drug and ongoing supervision by skilled medical personnel is required. An example of a drug that cannot be self-administered is a drug that must be administered intravenously. Examples of drugs that can be self-administered are drugs that can be taken in pill form and drugs that are typically self-injected by the patient.</p> <p>c Drugs and supplies required by law. Coverage is provided for:</p> <ul style="list-style-type: none"> • certain diabetes supplies. • syringes and needles you purchase at a pharmacy. • certain orally administered medications for the treatment of cancer. There is no Member Cost Sharing for orally administered medications for the treatment of cancer. |

| Benefit | Description |
|--|---|
| <p>Drug Coverage (Continued)</p> | <ul style="list-style-type: none"> • long-term antibiotic therapy for a Member diagnosed with Lyme disease as required by law. Please note: the plan will provide coverage for a long-term antibiotic drug, including an experimental drug, for an off-label use in the treatment of Lyme disease if the drug has been approved by the United States Food and Drug Administration. <p>Please see the benefits for “Diabetes Services and Supplies” and “Hypodermic Syringes and Needles” for the details of those benefits.</p> <p>No coverage is provided under this Benefit Handbook for (1) drugs that have not been approved by the United States Food and Drug Administration; (2) drugs the Plan excludes or limits, including, but not limited to, drugs for cosmetic purposes; and (3) any drug that is obtained at an outpatient pharmacy except (a) covered diabetes supplies and (b) syringes and needles, as explained above.</p> <p>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>I.F. PRIOR APPROVAL</i> for more information.</p> <p>2) Outpatient Prescription Drug Coverage</p> <p>In addition to the coverage provided under this Benefit Handbook, you may also have the Plan’s outpatient prescription drug rider. That rider provides coverage for most prescription drugs purchased at an outpatient pharmacy.</p> <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p> <p>If you have outpatient prescription drug coverage, your Member Cost Sharing for prescription drugs purchased at a pharmacy will be listed on your outpatient prescription drug flyer and Summary of Benefits and Coverage. Please see the Prescription Drug Brochure for a detailed explanation of your benefits.</p> |
| <p>11 . Durable Medical Equipment (DME)</p> | <p>The Plan covers DME when Medically Necessary and ordered by a Provider. We will rent or buy all equipment. The cost of the repair and maintenance of covered equipment is also covered.</p> <p>In order to be covered, all equipment must be:</p> <ul style="list-style-type: none"> • Able to withstand repeated use; • Not generally useful in the absence of disease or injury; • Normally used in the treatment of an illness or injury or for the rehabilitation of an abnormal body part; and • Suitable for home use. <p>Coverage is only available for:</p> <ul style="list-style-type: none"> • The least costly equipment adequate to allow you to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports; and • One item of each type of equipment. No back-up items or items that serve a duplicate purpose are covered. For example, the Plan covers a manual or an electric wheelchair, not both. <p>Covered equipment and supplies include:</p> <ul style="list-style-type: none"> • Canes |

| Benefit | Description |
|--|---|
| Durable Medical Equipment (DME) (Continued) | |
| | <ul style="list-style-type: none"> • Certain types of braces • Crutches • Hospital beds • Oxygen and oxygen equipment • Respiratory equipment • Walkers • Wheelchairs <p>Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan.</p> |
| 12 . Early Intervention Services | |
| | <p>The Plan covers early intervention services provided for Members until three years of age. Covered Benefits include:</p> <ul style="list-style-type: none"> • Nursing care • Physical, speech, and occupational therapy • Psychological counseling • Screening and assessment of the need for services |
| 13 . Emergency Room Care | |
| | <p>If you have a Medical Emergency, you are covered for care in a hospital emergency room. Please remember the following:</p> <ul style="list-style-type: none"> • If you need follow-up care after you are treated in an emergency room, you must get your care from a Plan Provider for coverage to be at the In-Network benefit payment level. • 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. |
| 14 . Family Planning Services | |
| | <p>The Plan covers family planning services, including the following:</p> <ul style="list-style-type: none"> • Contraceptive monitoring • Family planning consultation • Pregnancy testing • Genetic counseling • FDA approved birth control drugs, implants or devices.* • Professional services relating to the injection of birth control drugs and the insertion or removal of birth control implants or devices. <p>*If you are covered under a Grandfathered plan, coverage for FDA approved birth control drugs, implants or devices that must be obtained at an outpatient pharmacy may only be covered if your plan includes optional outpatient pharmacy coverage. Please see your Schedule of Benefits or talk to your Employer Group to determine if you are covered under a Grandfathered plan that limits this coverage.</p> <p>Please Note: An exclusion for Family Planning Services may apply when coverage is provided by a religious diocese, as allowed by law. Please check with your Employer Group to see if this exclusion applies to your Plan.</p> |

| Benefit | Description |
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| <p>15 . Hearing Aids</p> | <p>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.</p> <p>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.</p> <p>Covered Benefits include the following:</p> <ul style="list-style-type: none"> • 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. <p>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 seek Prior Approval for you. The Prior Approval process is initiated by calling: 1-800-708-4414. Please see section <i>I.F. PRIOR APPROVAL</i> for more information.</p> |
| <p>16 . Home Health Care</p> | <p>If you are homebound for medical reasons, you are covered for home health care services listed below. To be eligible for home health care, your Provider must determine that skilled nursing care or physical therapy is an essential part of active treatment. There must also be a defined medical goal that your Plan Provider expects you will meet in a reasonable period of time.</p> <p>When you qualify for home health care services as stated above, the Plan covers the following services when Medically Necessary:</p> <ul style="list-style-type: none"> • Durable medical equipment and supplies (must be a component of the home health care being provided) • Medical and surgical supplies • Medical social services • Nutritional counseling • Physical therapy • Occupational therapy • Palliative care • Services of a home health aide • Skilled nursing care • Speech therapy <p>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>I.F. PRIOR APPROVAL</i> for more information.</p> |

| Benefit | Description |
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| <p>17 . Hospice Services</p> | <p>The Plan covers hospice services for terminally ill Members who need the skills of qualified technical or professional health personnel for palliative care. Care may be provided at home or on an inpatient basis. Inpatient respite care is covered for the purpose of relieving the primary caregiver and may be provided up to 5 days every 3 months not to exceed 14 days per Plan Year or 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:</p> <ul style="list-style-type: none"> • Care to relieve pain • Counseling • Drugs that cannot be self-administered • Durable medical equipment appliances • Home health aide services • Medical supplies • Nursing care • Physician services • Occupational therapy • Physical therapy • Speech therapy • Respiratory therapy • Respite care • Social services <p>Prior Approval Required: You must obtain Prior Approval for home hospice care. If you use a Plan Provider located within the Service Area, he or she will seek Prior Approval for you. The Prior Approval process is initiated by calling: 1-800-708-4414. Please see section <i>I.F. PRIOR APPROVAL</i> for more information.</p> |
| <p>18 . Hospital – Inpatient Services</p> | <p>The Plan covers acute hospital care including, but not limited to, the following inpatient services:</p> <ul style="list-style-type: none"> • Semi-private room and board • Doctor visits, including consultation with specialists • Medications • Laboratory, radiology and other diagnostic services • Intensive care • Surgery, including related services • Anesthesia, including the services of a nurse-anesthetist • Radiation therapy • Physical therapy • Occupational therapy • Speech therapy <p>Please Note: In Massachusetts, Maine, New Hampshire, Connecticut and Rhode Island there are certain specialized services that must be received from designated Plan Providers, referred to as “Centers of Excellence” to receive</p> |

PPO - MASSACHUSETTS

| Benefit | Description |
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| Hospital – Inpatient Services (Continued) | |
| | <p>In-Network coverage. Please see section <i>I.D.5. Centers of Excellence</i> for further information.</p> <p>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>I.F. PRIOR APPROVAL</i> for more information.</p> |
| 19 . House Calls | |
| | The Plan covers house calls. |
| 20 . Human Organ Transplant Services | |
| | <p>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.</p> <p>The Plan covers the following services when the recipient is a Member of the Plan:</p> <ul style="list-style-type: none"> • Care for the recipient • Donor search costs through established organ donor registries • Donor costs that are not covered by the donor's health plan <p>If a Member is a donor for a recipient who is not a Member, then the Plan will cover the donor costs for the Member, when they are not covered by the recipient's health plan.</p> <p>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>I.F. PRIOR APPROVAL</i> for more information.</p> |
| 21 . Hypodermic Syringes and Needles | |
| | <p>The Plan covers hypodermic syringes and needles to the extent Medically Necessary, as required by Massachusetts law.</p> <p>You must get a prescription from your Provider and present it at a participating pharmacy for coverage. You can get more information on participating pharmacies by logging into your secure online account at www.harvardpilgrim.org or by calling the Member Services Department at 1-888-333-4742.</p> |
| 22 . Infertility Services and Treatment | |
| | <p>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:</p> <ul style="list-style-type: none"> • Consultation • Evaluation • Laboratory tests <p>When the Member meets Medically Necessary criteria, the Plan covers the following infertility treatment:</p> <ul style="list-style-type: none"> • Therapeutic artificial insemination (AI), including related sperm procurement and banking |

| Benefit | Description |
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| Infertility Services and Treatment (Continued) | |
| | <ul style="list-style-type: none"> • 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 and embryo transfer (IVF) • Zygote intrafallopian transfer (ZIFT) • Preimplantation genetic diagnosis (PGD) • Microsurgical epididymal 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 <p>Important Notice: We use evidence based clinical criteria 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.</p> <p>Please Note: Not all Plans cover this benefit. An exclusion for Infertility Services and Treatment may apply when coverage is provided by a religious diocese, as allowed by law. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.</p> <p>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>I.F. PRIOR APPROVAL</i> for more information.</p> |
| 23 . Laboratory, Radiology and Other Diagnostic Services | |
| | <p>The Plan covers laboratory and radiology services (including Advanced Radiology), and other diagnostic services on an outpatient basis. The term “Advanced Radiology” means CT scans, PET Scans, MRI and MRA, and nuclear medicine services. Coverage includes:</p> <ul style="list-style-type: none"> • The facility charge and the charge for supplies and equipment. • The charges of anesthesiologists, pathologists and radiologists. <p>In addition, the Plan covers the following:</p> <ul style="list-style-type: none"> • 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 as required by law 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. |

| Benefit | Description |
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| Laboratory, Radiology and Other Diagnostic Services (Continued) | |
| | <p>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>I.F. PRIOR APPROVAL</i> for more information.</p> |
| 24 . Low Protein Foods | |
| | <p>The Plan covers food products modified to be low-protein ordered for the treatment of inherited diseases of amino acids and organic acids to the extent required by Massachusetts law.</p> |
| 25 . Maternity Care | |
| | <p>The Plan covers the following maternity services:</p> <ul style="list-style-type: none"> • Routine outpatient prenatal care, including evaluation and progress screening, physical exams, recording of weight and blood pressure monitoring. • Prenatal genetic testing. • 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 <i>VII.E. ADDING A DEPENDENT</i> for more enrollment information. • Routine outpatient postpartum care for the mother up to six weeks after delivery. <p>The plan may reimburse you up to the Benefit Limit stated in your Schedule of Benefits for fees paid for one childbirth course (or refresher course) for each pregnancy. Members are expected to attend childbirth classes recommended by their physician, nurse midwife or health care facility. You will receive reimbursement for the course following completion unless delivery occurs before the course ends.</p> <p>To request reimbursement, you will need to complete a reimbursement form and provide the Plan with proof of payment. Please submit your documents along with the reimbursement form to the following address:</p> <p>Harvard Pilgrim Health Care P.O. Box 9185 Quincy, MA 02269</p> <p>To obtain a reimbursement form, please contact our Member Services Department at 1-877-907-4742 or visit HPHC online at www.harvardpilgrim.org.</p> <p>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 seek Prior Approval for you. The Prior Approval process is initiated by calling: 1-800-708-4414. Please see section <i>I.F. PRIOR APPROVAL</i> for more information.</p> |

| Benefit | Description |
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| <p>26 . Medical Formulas</p> | <p>The Plan covers the following to the extent required by Massachusetts law:</p> <ul style="list-style-type: none"> • 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, homocystinuria, maple syrup urine disease, propionic acidemia or methylmalonic acidemia in infants and children or to protect the unborn fetuses of pregnant women with phenylketonuria. <p>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>I.F. PRIOR APPROVAL</i> for more information.</p> |
| <p>27 . Mental Health and Substance Use Disorder Treatment</p> | <p>The Plan covers both inpatient and outpatient mental health and substance use disorder treatment to the extent Medically Necessary as outlined below. 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.</p> <p>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 <i>X.L. UTILIZATION REVIEW PROCEDURES</i> of this Handbook.</p> <p>The following is a list of the mental health services that require Prior Approval when obtained from a Non-Plan Providers:</p> <ul style="list-style-type: none"> • 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 <p>Even when Prior Approval is not required, mental health and substance use disorder treatment 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</p> |

| Benefit | Description |
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| | <p>Mental Health and Substance Use Disorder Treatment (Continued)</p> <p>staffed by licensed mental health clinicians. A clinician will assist you in finding an appropriate Provider and arranging the services you require.</p> <p>In a Medical Emergency you should go to the nearest emergency facility or call 911 or your local emergency number.</p> <p>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.</p> <p>Minimum Requirements for Covered Providers</p> <p>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 and substance use disorder treatment 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 and substance use disorder treatment. In addition to numbers (1) and (2) above, services to treat child-adolescent mental health disorders may be provided in the least restrictive clinically appropriate setting. This may include the Member’s home or a program in another community-based setting. Please see below for additional information on services to treat child-adolescent mental health disorders.</p> <p>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. If a provider of intermediate care or outpatient services to treat child-adolescent mental health disorders is not independently licensed at the Masters/PhD/MD level, then the supervisor – who must be a Masters Level independently Licensed Mental Health Professional – must sign off on the treatment plan whenever the child’s or adolescent’s condition changes. 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 counseling; psychiatric nursing; developmental or educational psychology; counselor education; or any other discipline deemed acceptable by the Plan.</p> <p>Coverage for Massachusetts Parity Conditions including Child-Adolescent Mental Health Disorders</p> <p>Under Massachusetts law, services for three categories of conditions must be covered to the same extent as medical services for physical illnesses. These</p> |

| Benefit | Description |
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| | <p>Mental Health and Substance Use Disorder Treatment (Continued)</p> <p>three categories are (1) services for “biologically-based mental disorders,” (2) services required as a result of rape, and (3) services for child-adolescent mental health disorders. Further information on the coverage provided for these conditions can be found below.</p> <p>1) Services Required to Treat Biologically-Based Mental Disorders</p> <p>The Plan covers services required to treat biologically based mental disorders. Biologically-based mental disorders are (1) schizophrenia, (2) schizoaffective disorders; (3) major depressive disorder; (4) bipolar disorder, (5) paranoia and other psychotic disorders, (6) obsessive-compulsive disorder, (7) panic disorder, (8) delirium and dementia, (9) affective disorders, (10) eating disorders, (11) post-traumatic stress disorders, (12) substance use disorders, and (13) autism.</p> <p>2) Services Required as a Result of Rape</p> <p>The Plan covers services required to diagnose and treat rape-related mental or emotional disorders for victims of rape or victims of an assault with the attempt to commit rape.</p> <p>3) Services for Child-Adolescent Mental Health Disorders</p> <p>The Plan covers services on a non-discriminatory basis for the diagnosis and treatment of child-adolescent mental health disorders that substantially interfere with or substantially limit the functioning and social interactions of a child or adolescent through the age of 18. Substantial interference with, or limitation of, function must be documented by the Member’s physician, primary pediatrician or HPHC licensed mental health provider, or when evidenced by conduct including, but not limited to:</p> <ul style="list-style-type: none"> • the inability to attend school as a result of the disorder • the need for hospitalization as a result of the disorder, or • a pattern of conduct or behavior caused by the disorder that poses a serious danger to self or others. <p>Child-adolescent mental health services shall take place in the least restrictive clinically appropriate setting and shall consist of a range of inpatient, intermediate, and outpatient services that shall permit Medically Necessary, active care expected to lead to improvement of the condition in a reasonable period of time. The covered services may be provided to the child, the child’s parent(s), and/or other appropriate caregivers.</p> <p>Coverage under this subsection shall continue after the child’s 19th birthday until either the course of treatment specified in the child’s treatment plan is completed or coverage under this Handbook is terminated, whichever comes first. If treatment of a 19 year old, as specified in his or her treatment plan, has not been completed at the time coverage under this Handbook is terminated, such treatment may be continued under a replacement plan issued by HPHC.</p> <p>Coverage for Other Conditions</p> <p>In addition to the coverage discussed above, the Plan will provide coverage for the care of all other conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. (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.) Services for all other conditions not identified above will be covered to the extent Medically Necessary.</p> <p>a) Mental Health and Substance Use Disorder Treatment</p> |

| Benefit | Description |
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| Mental Health and Substance Use Disorder Treatment (Continued) | |
| | <p>Subject to the Member Cost Sharing and any benefit limits stated in your Schedule of Benefits, the Plan provides coverage through the Behavioral Health Access Center for the following Medically Necessary mental health and substance use disorder treatment:</p> <ol style="list-style-type: none"> 1) Inpatient Services <ul style="list-style-type: none"> • Hospitalization, including detoxification 2) Intermediate Care Services <ul style="list-style-type: none"> • Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization • Intensive outpatient programs, partial hospitalization and day treatment programs 3) Intermediate Care Services for children and adolescents <ul style="list-style-type: none"> • Community-based acute treatment (CBAT) – intensive therapeutic services provided in a staff-secure setting on a 24-hour basis, with sufficient staffing to ensure safety, while providing intensive therapeutic services including but not limited to: daily medication monitoring; psychiatric assessment; nursing availability; specialing (as needed); individual group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from inpatient services. • Intensive community-based acute treatment (ICBAT) – provides the same services as CBAT but at a higher intensity, including more frequent psychiatric and psychopharmacological evaluation and treatment and more intensive staffing and service delivery. ICBAT programs have the capability to admit children and adolescents with more acute symptoms than those admitted to CBAT. ICBAT programs are able to treat Children and adolescents with clinical presentations similar to those referred to inpatient mental health services but who are able to be cared for safely in an unlocked setting. Children and adolescents may be admitted to an ICBAT directly from the community as an alternate to inpatient hospitalization. ICBAT is not used as a step-down placement following discharge from a locked, 24-hour setting. • Mobile crisis intervention – short-term, mobile, on-site, face-to-face therapeutic response service that is available 24 hours a day, 7 days a week to a child experiencing a behavioral health crisis to identify, assess, treat and stabilize a situation, to reduce the immediate risk of danger to the child or others, and to make referrals and linkages to all behavioral health services and supports and the appropriate level of care. The intervention shall be consistent with the child’s risk management or safety plan, if any. Mobile crisis intervention includes a crisis assessment and crisis planning, which may result in the development or update of a crisis safety plan. 4) Outpatient Services <ul style="list-style-type: none"> • Care by a Licensed Mental Health Professional • Detoxification • Medication management • Methadone maintenance • Psychological testing and neuropsychological assessment. |

| Benefit | Description |
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| Mental Health and Substance Use Disorder Treatment (Continued) | |
| | <p>5) Outpatient Services for children and adolescents</p> <ul style="list-style-type: none"> • Intensive care coordination (ICC) – a collaborative service that provides targeted case management services to children and adolescents with a serious emotional disturbance, including individuals with co-occurring conditions, in order to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual’s family, while promoting quality, cost effective outcomes. This service includes an assessment, the development of an individualized care plan, referrals to appropriate levels of care, monitoring of goals, and coordinating with other services and social supports and with state agencies, as indicated. The service shall be based upon a system of care philosophy and the individualized care plan shall be tailored to meet the needs of the individual. The service is delivered in office, home or other settings and shall include both face-to-face and telephonic meetings, as indicated and as clinically appropriate. • In-home behavioral services (IHBS) - a combination of behavior management therapy and behavior management monitoring. Services shall be available, when indicated, where the child resides, including in the child’s home, a foster home, a therapeutic foster home, or another community setting. In-home behavioral services include: <ul style="list-style-type: none"> • <i>Behavior management monitoring</i> of a child’s behavior, the implementations of a behavior plan and reinforcing implementation of a behavior plan by the child’s parent or other care giver. • <i>Behavioral management therapy</i> that addresses challenging behaviors that interfere with a child’s successful functioning. That therapy shall include a functional behavioral assessment and observation of the youth in the home and/or community setting, development of a behavior plan, and supervision and coordination of interventions to address specific behavioral objectives or performance, including the development of a crisis-response strategy and may include short-term counseling and assistance. • In-home therapy (IHT) - therapeutic clinical intervention or ongoing therapeutic training and support. The intervention or support shall be provided where the child resides, including in the child’s home, a foster home, a therapeutic foster home, or another community setting. <ul style="list-style-type: none"> • <i>Therapeutic clinical intervention</i> shall include: (i) a structured and consistent therapeutic relationship between a licensed clinician and a child and the child’s family to treat the child’s mental health needs, including improvement of the family’s ability to provide effective support for the child and promotion of healthy functioning of the child within the family; (ii) the development of a treatment plan; and (iii) the use of established psychotherapeutic techniques, working with the family or a subset of the family to enhance problem solving, limit setting, communication, emotional support or other family or individual functions. |

| Benefit | Description |
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| Mental Health and Substance Use Disorder Treatment (Continued) | |
| | <ul style="list-style-type: none"> • <i>Ongoing therapeutic training and support</i> of a treatment plan pursuant to therapeutic clinical intervention that includes but is not limited to, teaching the child to understand, direct, interpret, manage and control feelings and emotional responses to situation and assisting the family in supporting the child and addressing the child's emotional and mental health needs. <p>Please refer to your Schedule of Benefits for the Member Cost Sharing amounts that apply to your "inpatient," "intermediate" and "outpatient" mental health and substance use disorder treatment services.</p> |
| 28 . Observation Services | |
| | <p>The Plan covers observation services including short term treatment, assessment and reassessment for up to 48 hours in an acute care facility (i.e. hospital). Observation services determine if a Member needs to be admitted for additional treatment or if the Member is able to be discharged from the hospital.</p> |
| 29 . Ostomy Supplies | |
| | <p>The Plan covers ostomy supplies up to the Benefit Limit listed in the Schedule of Benefits. Only the following supplies are covered:</p> <ul style="list-style-type: none"> • Irrigation sleeves, bags and catheters • Pouches, face plates and belts • Skin barriers |
| 30 . Physician and Other Professional Office Visits | |
| | <p>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:</p> <ul style="list-style-type: none"> • 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 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: <ul style="list-style-type: none"> • At least six visits per Plan Year or Calendar Year are covered for a child from birth to age one. • At least three visits per Plan Year or Calendar Year are covered for a child from age one to age two. • At least one visit per Plan Year or Calendar Year is covered for a child from age two to age six. • School, camp, sports and premarital examinations • Health education and nutritional counseling • Palliative care • Sickness and injury care • Vision and Hearing screenings |

| Benefit | Description |
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| Physician and Other Professional Office Visits (Continued) | |
| | <ul style="list-style-type: none"> • Medication management • Consultations concerning contraception and hormone replacement therapy • Chemotherapy • Radiation therapy <p>Please Note: Some Plans may cover certain preventive services and tests with no Member Cost Sharing. Please see your Schedule of Benefits for the coverage that applies to your Plan.</p> |
| 31 . Prosthetic Devices | |
| | <p>The Plan covers prosthetic devices when ordered by a Provider. The cost of the repair and maintenance of a covered device is also covered.</p> <p>In order to be covered, all devices must be able to withstand repeated use. Coverage is only available for:</p> <ul style="list-style-type: none"> • The least costly prosthetic device adequate to allow you to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports; and • One item of each type of prosthetic device. No back-up items or items that serve a duplicate purpose are covered. <p>Covered prostheses include:</p> <ul style="list-style-type: none"> • Breast prostheses, including replacements and mastectomy bras • Prosthetic arms and legs (including myoelectric and bionic arms and legs) • Prosthetic eyes <p>Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan.</p> <p>Prior Approval Required: You must obtain Prior Approval for prosthetic arms and legs. If you use a Plan Provider located within the Service Area, he or she will seek Prior Approval for you. The Prior Approval process is initiated by calling: 1-800-708-4414. Please see section <i>I.F. PRIOR APPROVAL</i> for more information.</p> |
| 32 . Reconstructive Surgery | |
| | <p>The Plan covers reconstructive and restorative surgical procedures as follows:</p> <ul style="list-style-type: none"> • Reconstructive surgery is covered when the surgery can reasonably be expected to improve or correct a Physical Functional Impairment resulting from an accidental injury, illness, congenital anomaly, birth injury or prior surgical procedure. If reconstructive surgery is performed to improve or correct a Physical Functional Impairment, as stated above, Cosmetic Services that are incidental to that surgery are also covered. After a Physical Functional Impairment is corrected, no further Cosmetic Services are covered by the Plan. • Restorative surgery is covered to repair or restore appearance damaged by an accidental injury. (For example, this benefit would cover repair of a facial deformity following an automobile accident.) <p>Benefits are also provided for the following:</p> <ul style="list-style-type: none"> • Post mastectomy care, including coverage for: <ul style="list-style-type: none"> – Prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient; |

| Benefit | Description |
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| | <p>Reconstructive Surgery (Continued)</p> <ul style="list-style-type: none"> - Reconstruction of the breast on which the mastectomy was performed; and - Surgery and reconstruction of the other breast to produce a symmetrical appearance. • Treatment of cleft lip and cleft palate for children under the age of 18, including coverage for: <ul style="list-style-type: none"> - 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. • Treatment to correct or repair disturbances of body composition caused by HIV-associated lipodystrophy syndrome, including but not limited to coverage for: <ul style="list-style-type: none"> - Reconstructive surgery; - Restorative procedures; and - Dermal injections or fillers to treat facial lipoatrophy associated with HIV. <p>Benefits include coverage for procedures that must be done in stages, as long as you are an active Member. Membership must be effective on all dates on which services are provided.</p> <p>There is no coverage for Cosmetic Services or surgery except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care as described above.</p> <p>Important Notice: We use clinical guidelines to evaluate whether different types of reconstructive and restorative procedures are Medically Necessary. If you are planning to receive such treatment, you may review the current guidelines. To obtain a copy, please call 1-888-888-4742 ext. 38732.</p> <p>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>I.F. PRIOR APPROVAL</i> for more information.</p> |

| Benefit | Description |
|--|---|
| <p>33 . Rehabilitation Hospital Care</p> | <p>The Plan covers care in a facility licensed to provide rehabilitative care on an inpatient basis. Coverage is provided when you need daily Rehabilitation Services that must be provided in an inpatient setting. Rehabilitation Services include cardiac rehabilitation therapy, physical therapy, pulmonary rehabilitation therapy, occupational therapy and speech therapy. The Benefit Limit is listed in the Schedule of Benefits.</p> <p>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>I.F. PRIOR APPROVAL</i> for more information.</p> |
| <p>34 . Rehabilitation and Habilitation Services – Outpatient</p> | <p>The Plan covers the following outpatient Rehabilitation and Habilitation Services:</p> <ul style="list-style-type: none"> • Occupational therapy • Physical therapy • Pulmonary rehabilitation therapy <p>Outpatient Rehabilitation and Habilitation Services are covered up to the Benefit Limit listed in the Schedule of Benefits. Services are covered only:</p> <ul style="list-style-type: none"> • If, in the opinion of your Provider, there is likely to be significant improvement in your condition within the period of time benefits are covered; and • When needed to improve your ability to perform Activities of Daily Living. <p>Activities of Daily Living do not include special functions needed for occupational purposes or sports.</p> <p>Rehabilitation and Habilitation Services are also covered under your inpatient hospital and home health benefits.</p> <p>Prior Approval Required: You must obtain Prior Approval for coverage of outpatient physical, occupational and 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>I.F. PRIOR APPROVAL</i> for more information.</p> <p>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.</p> |
| <p>35 . Scopic Procedures – Outpatient Diagnostic</p> | <p>The Plan covers diagnostic scopic procedures and related services received on an outpatient basis.</p> <p>Diagnostic scopic procedures are those for visualization, biopsy and/or polyp removal. Scopic procedures are:</p> <ul style="list-style-type: none"> • Colonoscopy • Endoscopy • Sigmoidoscopy |

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| Benefit | Description |
|--|---|
| 36 . Skilled Nursing Facility Care | |
| | <p>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.</p> <p>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>I.F. PRIOR APPROVAL</i> for more information.</p> |
| 37 . Speech-Language and Hearing Services | |
| | <p>The Plan covers diagnosis and treatment of speech, hearing and language disorders to the extent Medically Necessary by speech-language pathologists and audiologists.</p> |
| 38 . Spinal Manipulative Therapy (including care by a chiropractor) | |
| | <p>The Plan may cover musculoskeletal adjustment or manipulation up to the Benefit Limit listed in the Schedule of Benefits.</p> |
| 39 . Surgery - Outpatient | |
| | <p>The Plan covers outpatient surgery, including related services. Outpatient surgery is defined as any surgery or procedure in a day surgery department, ambulatory surgery department or outpatient surgery center.</p> <p>In Massachusetts, Maine, New Hampshire, Connecticut and Rhode Island there are certain specialized services that must be received from designated Plan Providers, referred to as "Center of Excellence" to receive In-Network coverage. Please see section <i>I.D.5. Centers of Excellence</i> for further information.</p> <p>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>I.F. PRIOR APPROVAL</i> for more information.</p> |
| 40 . Telemedicine Virtual Visit Services | |
| | <p>The Plan covers Medically Necessary telemedicine virtual visit services for the purpose of diagnosis, consultation or treatment. Telemedicine virtual visit 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 Providers.</p> <p>Member Cost Sharing for telemedicine virtual visit services is the same as the Member Cost Sharing for the same type of service if it had been provided through an in-person consultation. Please refer to your Schedule of Benefits for specific information on Member Cost Sharing you may be required to pay.</p> |

| Benefit | Description |
|---|---|
| <p>41 . Temporomandibular Joint Dysfunction Services</p> | <p>The Plan covers medical treatment of Temporomandibular Joint Dysfunction (TMD). Only the following services are covered:</p> <ul style="list-style-type: none"> • 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 <p>Important Notice: No Dental Care is covered for the treatment of Temporomandibular Joint Dysfunction (TMD).</p> <p>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>I.F. PRIOR APPROVAL</i> for more information.</p> |
| <p>42 . Urgent Care Services</p> | <p>The Plan covers Urgent Care you receive at (1) a convenience care clinic or (2) an urgent care center.</p> <p>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 Provider Directory and search under “convenience care.”</p> <p>Urgent care centers provide treatment for illnesses and injuries that require urgent attention but are not life threatening. Urgent care centers are independent centers or certain hospital-owned centers 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 Provider Directory and search under “urgent care.”</p> <p>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 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.</p> <p>Coverage for Urgent Care is provided for services that are required to prevent deterioration to your health resulting from an unforeseen sickness or injury. Covered Benefits include but are not limited to the following:</p> <ul style="list-style-type: none"> • Care for minor cuts, burns, rashes or abrasions, including suturing • Treatment for minor illnesses and infections, including ear aches • Treatment for minor sprains or strains <p>Whenever possible, you should contact your PCP prior to obtaining Urgent Care. Your PCP may be able to provide the services you require at a lower out-of-pocket cost.</p> <p>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>I.D.8. Medical Emergency Services</i> for more information.</p> |

| Benefit | Description |
|---|--|
| <p>43 . Vision Services</p> | <p>Routine Eye Examinations:</p> <p>The Plan may cover routine eye examinations.</p> <p>Vision Hardware for Special Conditions:</p> <p>The Plan may provide coverage for contact lenses or eyeglasses needed for the following conditions:</p> <ul style="list-style-type: none"> • Keratonconus. One pair of contact lenses is covered per Plan Year or Calendar Year. The replacement of lenses, due to a change in the Member's condition, is limited to 3 per affected eye per Plan Year or 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 Plan Year or Calendar Year. Coverage up to \$50 per Plan Year or 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 Plan Year or 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 Plan Year or 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. |
| <p>44 . Voluntary Sterilization</p> | <p>The Plan may cover voluntary sterilization, including tubal ligation and vasectomy.</p> <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.</p> |
| <p>45 . Voluntary Termination of Pregnancy</p> | <p>The Plan may cover voluntary termination of pregnancy.</p> <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.</p> |
| <p>46 . Wellness Reimbursement Benefits</p> | <p>Members of small group plans, can receive reimbursement for certain fees paid when participating in fitness or weight management programs. Below is a description of those benefits.</p> <p>Fitness</p> <p>The Plan will reimburse you for monthly fees paid for an individual or family membership at a qualified fitness facility up to the Benefit Limit stated in your Schedule of Benefits.</p> <p>To be eligible for coverage, you must have (1) been enrolled as a Member of Harvard Pilgrim, and (2) belonged to the qualified fitness facility for at least four months during the calendar year for which reimbursement is sought.</p> |

| Benefit | Description |
|--|---|
| Wellness Reimbursement Benefits (Continued) | |
| | <p>A qualified fitness facility is either (1) a facility providing cardiovascular and strength-training equipment for exercising and improving physical fitness, including private health clubs and fitness centers, YMCA's, YWCA's, Jewish Community Centers, municipal fitness centers; or (2) a studio or facility with certified instructors providing yoga, pilates, Zumba, group aerobic classes, cycling or spinning classes, kickboxing, CrossFit, strength training, tennis, indoor rock climbing or personal training. No reimbursement is provided for initiation or termination fees.</p> <p>The fitness benefit does not apply to any fees or costs that you pay for classes, lessons or training provided outside of a qualified fitness facility as described above. Facilities and services that are not covered include: country clubs, private tennis clubs, social clubs (such as ski, riding or hiking clubs), gymnastics facilities, pool-only facilities, sports teams or leagues, spas, instructional dance studios, martial arts schools, home gyms, or personal training sessions.</p> <p>Weight Management Program</p> <p>The Plan will reimburse you up to the Benefit Limit stated in your Schedule of Benefits for monthly fees paid for Weight Watchers traditional meetings or Weight Watchers at Work programs.</p> <p>No coverage is provided for on-line weight management programs, individual nutritional counseling sessions, pre-packaged meals, books, videos, scales or other items or supplies bought by the member or any other items not included as part of a weight management class or weight management course.</p> <p>To request reimbursement for your fitness or weight management program, you will need to complete a reimbursement form and provide the Plan with proof of membership and proof of payment. Please submit your documents along with the reimbursement form to the following address:</p> <p>Harvard Pilgrim Health Care P.O. Box 9185 Quincy, MA 02269</p> <p>To obtain a reimbursement form, please contact our Member Services Department at 1-877-907-4742 or visit HPHC online at www.harvardpilgrim.org.</p> <p>You also have the option to request reimbursement online. If you have a secure online account, you can complete an online reimbursement form and submit your documents online. For details on how to register for a secure online account, log on to www.harvardpilgrim.org.</p> |
| 47 . Wigs and Scalp Hair Protheses | |
| | <p>The Plan covers wigs and scalp hair protheses 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.</p> |

If you reside and work in New Hampshire, you may be eligible for New Hampshire mandated benefits. Please contact Member Services for more details.

IV. Exclusions

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

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

| Exclusion | Description |
|---|--|
| 1 . Alternative Treatments | <ol style="list-style-type: none"> 1. Acupuncture care except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. 2. Acupuncture services that are outside the scope of standard acupuncture care. 3. Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for these benefits. 4. Aromatherapy, treatment with crystals and alternative medicine. 5. Any of the following types of programs: Health resorts, spas, recreational programs, camps, outdoor skills programs, therapeutic or educational boarding schools, educational programs for children in residential care, self-help programs, life skills programs, relaxation or lifestyle programs, and wilderness programs (therapeutic outdoor programs). 6. Massage therapy. 7. Myotherapy. |
| 2 . Dental Services | <ol style="list-style-type: none"> 1. Dental Care, except the specific dental services listed as Covered Benefits in this Benefit Handbook, your Schedule of Benefits and any associated riders. 2. All services of a dentist for Temporomandibular Joint Dysfunction (TMD). 3. Extraction of teeth, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits and any associated riders to determine if your Plan provides coverage for this benefit. 4. Pediatric dental care, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits and any associated riders to determine if your Plan provides coverage for this benefit. |
| 3 . Durable Medical Equipment and Prosthetic Devices | <ol style="list-style-type: none"> 1. Any devices or special equipment needed for sports or occupational purposes. 2. Any home adaptations, including, but not limited to home improvements and home adaptation equipment. 3. Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. 4. Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft. |

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| Exclusion | Description |
|---|--|
| 4 . Experimental, Unproven or Investigational Services | |
| | <ol style="list-style-type: none"> 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 | |
| | <ol style="list-style-type: none"> Foot orthotics, except for the treatment of severe diabetic foot disease. 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 | |
| | <ol style="list-style-type: none"> Planned home births. |
| 7 . Mental Health and Substance Use Disorder Treatment | |
| | <ol style="list-style-type: none"> Biofeedback. 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 or developmental functioning, (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. Any of the following types of programs: programs in which the patient has a pre-defined duration of care without the Plan's ability to conduct concurrent determinations of continued medical necessity, programs that only provide meetings or activities not based on individualized treatment plans, programs that focus solely on interpersonal or other skills rather than directed toward symptom reduction and functional recovery related to specific mental health disorders, and tuition based programs that offer educational, vocational, recreational, or personal developmental activities. Sensory integrative praxis tests. 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. 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. 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: <ul style="list-style-type: none"> Not consistent with prevailing national standards of clinical practice for the treatment of such conditions. Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome. Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. 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. |

| Exclusion | Description |
|---|--|
| <p>8 . Physical Appearance</p> | <ol style="list-style-type: none"> 1. Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of 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 and skin tags or any treatment to improve the appearance of the skin. 7. Treatment for spider veins. |
| <p>9 . Procedures and Treatments</p> | <ol style="list-style-type: none"> 1. Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial X-ray. 2. Spinal manipulative therapy (including care by a chiropractor), except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. 3. Commercial diet plans, weight loss programs and any services in connection with such plans or programs, except as provided in this Benefit Handbook under Wellness Reimbursement Benefits. <p>Please Note: Your employer may participate in other wellness and health improvement incentive programs offered by Harvard Pilgrim. Please review all your Plan documents for the amount of incentives, if any, available under your Plan.</p> 4. If a service received in Massachusetts, Maine, New Hampshire, Connecticut or Rhode Island is listed as requiring that it be provided at a Center of Excellence, no In-Network coverage will be provided under this Handbook if that service is received in Massachusetts, Maine, New Hampshire, Connecticut or Rhode Island from a Provider that has not been designated as a Center of Excellence. Please see <i>I.D.5. Centers of Excellence</i> for more information. 5. 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). 6. Physical examinations and testing for insurance, licensing or employment. 7. Services for Members who are donors for non-Members, except as described under Human Organ Transplant Services. 8. Testing for central auditory processing. 9. Group diabetes training, educational programs or camps. |

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| Exclusion | Description |
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| 10 . Providers | <ol style="list-style-type: none"> 1. Charges for services which were provided after the date on which your membership ends. 2. Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit under this Handbook. 3. Charges for missed appointments. 4. Concierge service fees. (See <i>I.I. PROVIDER FEES FOR SPECIAL SERVICES (CONCIERGE SERVICES)</i> 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. |
| 11 . Reproduction | <ol style="list-style-type: none"> 1. Any form of Surrogacy or services for a gestational carrier. 2. Infertility drugs if a Member is not in a Plan authorized cycle of infertility treatment. 3. Infertility drugs, if infertility services are not a Covered Benefit. 4. Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage. 5. Infertility treatment for Members who are not medically infertile. 6. Infertility treatment and birth control drugs, implants and devices. This exclusion may apply when coverage is provided by a religious diocese, as allowed by law. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. 7. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). 8. Sperm collection, freezing and storage except as described in the <i>Handbook</i> section <i>III. Covered Benefits, Infertility Services and Treatment</i>. 9. Sperm identification when not Medically Necessary (e.g., gender identification). 10. The following fees: wait list fees, non-medical costs, shipping and handling charges etc. 11. Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. 12. Voluntary termination of pregnancy, unless the life of the mother is in danger or unless it is specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. |
| 12 . Services Provided Under Another Plan | <ol style="list-style-type: none"> 1. Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. 2. Costs for services for which payment is required to be made by a Workers' Compensation plan or an Employer under state or federal law. |

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| Exclusion | Description |
|-----------------------------------|--|
| 13 . Telemedicine Services | |
| | <ol style="list-style-type: none"> 1. Telemedicine services involving e-mail, fax, texting, or audio-only telephone. 2. Provider fees for technical costs for the provision of telemedicine services. |
| 14 . Types of Care | |
| | <ol style="list-style-type: none"> 1. Custodial Care. 2. 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, except as provided in this Benefit Handbook under Wellness Reimbursement Benefits. 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. |
| 15 . Vision and Hearing | |
| | <ol style="list-style-type: none"> 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 occurring myopia, hyperopia and astigmatism. 4. Routine eye examinations, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. |
| 16 . All Other Exclusions | |
| | <ol style="list-style-type: none"> 1. Any service or supply furnished in connection with a non-Covered Benefit. 2. Any service or supply (with the exception of contact lenses) purchased from the internet. 3. Beauty or barber service. 4. Any drug or other product obtained at an outpatient pharmacy, except for pharmacy supplies covered under the benefit for diabetes services and hypodermic syringes and needles, as required by Massachusetts law, unless your Plan includes outpatient pharmacy coverage. 5. Diabetes equipment replacements when solely due to manufacturer warranty expiration. 6. Donated or banked breast milk. 7. Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law and prescribed for Members who meet HPHC policies for enteral tube feedings. |

| Exclusion | Description |
|--|--|
| <p>All Other Exclusions (Continued)</p> | <ol style="list-style-type: none"> 8. Guest services. 9. 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. 10. Services for non-Members. 11. Services for which no charge would be made in the absence of insurance. 12. Services for which no coverage is provided in this Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure (if applicable). 13. Services that are not Medically Necessary. 14. Taxes or governmental assessments on services or supplies. 15. Transportation other than by ambulance. 16. The following products and services: <ul style="list-style-type: none"> • Air conditioners, air purifiers and filters, dehumidifiers and humidifiers. • Car seats. • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners. • Electric scooters. • Exercise equipment. • Home modifications including but not limited to elevators, handrails and ramps. • Hot tubs, jacuzzis, saunas or whirlpools. • Mattresses. • Medical alert systems. • Motorized beds. • Pillows. • Power-operated vehicles. • Stair lifts and stair glides. • Strollers. • Safety equipment. • Vehicle modifications including but not limited to van lifts. • Telephone. • Television. |

V. Reimbursement and Claims Procedures

The information in this section applies when you wish to file a claim or seek reimbursement following receipt of Covered Benefits. In most cases, you should not receive bills from Plan Providers.

A. HOW TO FILE A CLAIM (PROOF OF LOSS)

Proof of loss is administered under this Handbook by filing a claim on HPHC claims forms. Such forms may be obtained from a Member's Employer Group or by calling HPHC's Member Services Department at **1-888-333-4742**.

Standard health care industry claim forms, known as the CMS 1500 and the UB04 will also be accepted. Such forms are also available at most hospitals and physician's offices. In order to be paid by HPHC, all claims must be filed in writing or electronically. (Providers should contact HPHC for instructions concerning electronic filing.). Claims for services must be submitted to the following addresses:

Claims for Mental Health and Substance Use Disorder Treatment:

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

Pharmacy Claims:

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

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**.

B. INFORMATION NEEDED FOR CLAIMS PROCESSING

To obtain reimbursement for a bill you have paid, other than for pharmacy items, you must submit an HPHC medical reimbursement form along 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 or national provider 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 (if reimbursement is sought)

Important Notice: We may need more information for some claims. If you have any questions about claims, please call our Member Services Department at **1-888-333-4742**.

A medical reimbursement form can be obtained online at www.harvardpilgrim.org or by calling the Member Services Department at **1-888-333-4742**.

1. International Claims

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

2. Pharmacy Claims

To obtain reimbursement for pharmacy bills you have paid, you must submit a Prescription Claim Form. The form can be obtained online at www.harvardpilgrim.org or by calling the Member Services Department at **1-888-333-4742**.

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

The following information must be on the Prescription Claim Form:

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

Important Notice: Reimbursement for prescription drugs will only be made if your plan includes optional outpatient pharmacy coverage. Please see your Prescription Drug Brochure (if applicable) for more information.

If you have a question regarding your reimbursement, you should contact the Member Services Department at **1-888-333-4742**.

C. TIME LIMITS ON FILING CLAIMS

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

Failure to file claims in a timely manner as provided in this Section may result in denial of benefits.

Claims will be reviewed within 45 days of the receipt. If a claim cannot be paid within that time, HPHC will either inform the Member:

- a Of any additional documentation necessary for payment; or
- b That the claim is denied, in whole or in part, and the reasons for denial.

D. PAYMENT LIMITS

We limit the amount we will pay for services that are not rendered by Plan Providers. The maximum amount we will pay for services by Non-Plan Providers will be based on the Allowed Amount. If a service is provided by a Non-Plan Provider, you are responsible for any amount in excess of the Allowed Amount.

 FOR EXAMPLE: If the Allowed Amount is \$1,000 and the applicable Member Cost Sharing for the service is 20% Coinsurance, the maximum amount we will pay is \$800.

E. NOTICE OF CLAIM

The Member is not required to give notice to HPHC prior to the filing of a claim, except for the Prior Approval requirements applicable to certain services. Please see section *I.F. PRIOR APPROVAL* for more information.

F. MISCELLANEOUS CLAIMS PROVISIONS

Benefits will be paid to the Member who received the services for which a claim is made unless such Member is a minor. In such case, benefits will be paid to the parent or custodian with whom the child resides. The Member may authorize HPHC to pay benefits directly to the health care provider whose charge is the basis for the claim.

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

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

VI. Appeals and Complaints

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

A. ABOUT OUR APPEAL AND COMPLAINT PROCEDURES

What are “Appeals” and “Complaints”? We divide grievances into two types, “appeals” and “complaints” as follows:

- An appeal may be filed whenever a Member is denied coverage. This includes either the denial of a health service sought by a Member or the denial of payment for a health service that a Member has received.
- A complaint may be filed when a Member seeks redress of any action taken by us or any aspect of our services, other than a denial of coverage for health services.

Both appeals and complaints should be filed at the addresses or telephone numbers listed in this section.

1. Member Representation

A Member’s authorized representative may file an appeal or complaint and participate in any part of the appeal or complaint process. Any notice referred to in this section will be provided to the Member or, upon request, the Member’s representative.

A Member’s representative may be the Member’s guardian, conservator, agent under a power of attorney, health care agent under a health care proxy, family member or any other person appointed in writing to represent the Member in a specific appeal or complaint. We may require documentation that a representative meets one of the above criteria.

2. Report on Appeals and Complaints

We will file an annual report on appeals and complaints with the Office of Patient Protection. After filing, the report for the prior year will be available to Members upon request. A copy may be requested from the Member Services Department at the address or telephone number listed in section VI.B. *HOW TO FILE AN APPEAL*.

3. Membership Required for Coverage

To be eligible for coverage, a Member must be enrolled under the Plan on the date a service is received. A response to an informal inquiry or

an appeal decision approving coverage will not be valid for services received after the termination of membership. However, payment may be made after the termination of membership for services received while membership was effective.

B. HOW TO FILE AN APPEAL

Any appeal may be filed in person, by mail, by fax or by telephone.

Appeals, other than those concerning mental health and substance use disorder treatment, should be submitted to:

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

Appeals or complaints concerning mental health and substance use disorder treatment should be submitted to:

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

1. Time Limit for Filing Appeals

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

2. Appeals Involving Medical Necessity Determinations

Special rights apply to appeals involving a medical necessity determinations. These appeals could involve a decision that a service (1) is not Medically Necessary, (2) is not being provided in an appropriate health care setting or level of care, (3) is not effective for treatment of the Member’s condition, or (4) is Experimental, Unproven or Investigational. These include the right to appeal to an external review organization under contract with the Office of Patient Protection. The procedure for obtaining external review is summarized below in section VI.F. *WHAT YOU MAY DO IF YOUR APPEAL IS DENIED*.

3. The Office of Patient Protection

The Office of Patient Protection is the agency responsible for enforcing the Massachusetts laws concerning managed care grievance rights and for administering appeals to external review organizations. The Office of Patient Protection also enforces health care standards for managed care organizations, answers questions of consumers about managed care and monitors quality-related health insurance information relating to managed care practices. The Office of Patient Protection can be reached at:

**Health Policy Commission
Office of Patient Protection
50 Milk Street, 8th Floor
Boston, MA 02109
1-800-436-7757
Fax: 1-617-624-5046
HPC-OPP@state.ma.us
<http://www.mass.gov/hpc/opp>**

C. THE INFORMAL INQUIRY PROCESS

Most appeals and complaints result from a misunderstanding with a provider or a claim processing error. Since these problems can be easy to resolve, most appeals and complaints will first be considered in our informal inquiry process. However, the informal inquiry process will not be used to review a denial of coverage involving a medical necessity determination. Coverage decisions involving medical necessity determinations will be transferred directly to the formal appeal process described below in “The Formal Appeal Process.”

During the informal inquiry process a Member Services Representative will investigate an appeal or complaint and attempt to resolve it to the Member’s satisfaction. Whenever possible, the Member Services Representative will provide the Member with a response within 3 business days of receipt of the inquiry. This response will normally be communicated by telephone.

If the Member Services Representative responds to an inquiry within 3 business days of receipt but the inquiry is not resolved to the Member’s satisfaction, the Member may either file a formal complaint or appeal, as appropriate.

If the Member Services Representative cannot respond to the inquiry within 3 business days, we will transfer the inquiry to the formal appeal or formal complaint process, as appropriate.

D. THE FORMAL APPEAL PROCESS

Our internal appeal process is available whenever a Member is denied coverage. This includes either the denial of a health service sought by a Member or the denial of payment for a health service that a Member has received. If a denial involves a medical necessity determination, an appeal may be filed immediately. All other appeals will be considered in the informal inquiry process, described above.

1. How to File an Appeal

Appeals may be filed in person, by mail, by fax or by phone at the addresses or phone numbers listed in section VI.B. *HOW TO FILE AN APPEAL*. After an appeal is filed, we will appoint an Appeals and Grievances Analyst who will be responsible for the appeal during the appeal process.

2. Documentation of Oral Appeals

If an appeal is filed by telephone, an Member Services Representative will write a summary of the appeal and forward it to the Appeals and Grievances Department. The Appeals and Grievances analyst will send an acknowledgement letter to the Member within 48 hours of receipt. This time limit may be extended by written mutual agreement between the Member and us.

3. Acknowledgment of Appeals

Appeals will be acknowledged in writing within 15 days of receipt. This time limit may be extended by written mutual agreement between the Member and us. No acknowledgment of an appeal will be sent if an Appeals and Grievances Analyst has previously sent a summary of an appeal submitted by telephone.

4. Release of Medical Records

Any appeal that requires the review of medical information must include a signed authorization to release or obtain protected health information. This form must be signed and dated by the Member or the Member’s authorized representative. (When signed by an authorized representative, appropriate proof of authorization to release or obtain protected health information must be provided). If an authorization to release or obtain protected health information is not provided when the appeal is filed, the Appeals and Grievances Analyst will promptly send a blank form to the Member or the Member’s representative. If a signed authorization to release or obtain protected health information is not received within 30 days of the date the appeal is received, we may issue a decision based on the information already in the file.

5. What are “Pre-Service” and “Post-Service” Appeals?

We divide appeals into two types, “Pre-Service Appeal” and “Post-Service Appeal” as follows:

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

6. Time Limit for Processing Appeals

For Pre-Service Appeals, Members will be provided with a written appeal decision within 30 days of the date the appeal was received. For Post-Service Appeals, Members will be provided with a written appeal decision within 30 days of the date the appeal was received. These time limits may be extended by mutual agreement, in writing, between the Member and us. Any extension will not exceed 30 days from the date of the agreement. We may decline to extend the review period for an appeal if a service has been continued pending an appeal.

If an appeal requires the review of medical information, the date of receipt will be the date we receive a signed authorization to release or obtain protected health information. If we do not respond to an informal inquiry within 3 business days, the date of receipt will be the 4th business day following the date we received the inquiry or the date we receive the signed authorization to release or obtain protected health information, whichever is later. No appeal will be deemed received until actual receipt of the appeal at the appropriate address or phone number listed in section VI.B. *HOW TO FILE AN APPEAL*.

If we do not act on an appeal within 30 days plus any extension of time mutually agreed upon in writing by the Member and us, the appeal will be deemed to be resolved in favor of the Member.

7. Medical Records and Information

The Appeals and Grievances Analyst will try to obtain all information, including medical records, relevant to the appeal. Due to the limited time available for the processing of appeals, Members may be asked to assist the Appeals and Grievances Analyst in obtaining any missing information or to extend the appeal time limit until this information can be obtained. If information cannot be obtained by the 15th day following the receipt of the authorization to release or obtain protected health information and no agreement can be reached on extending the appeal time limit, the appeal may be decided without the missing information.

8. The Appeal Process

Upon receipt of an appeal, we will review, investigate and decide an appeal within the applicable time limit unless the time limit is extended by mutual agreement.

The Appeals and Grievances Analyst will investigate the appeal and determine if additional information is required from the Member. This information may include medical records, statements from doctors, and bills and receipts for services the Member has received. The Member may also provide us with any written comments, documents, records or other information related to the claim. Should we need additional information to decide an appeal, the Appeals and Grievances Analyst will contact the Member and request the specific information needed.

Appeals that involve a medical necessity determination will be reviewed by a health care professional in active practice in a specialty that is the same as, or similar to, the medical specialty that typically treats the medical condition that is the subject of the appeal. The health care professional conducting the review must not have either participated in any prior decision on the Member’s appeal or be the subordinate of such a person.

We will make a decision following the investigation and review of the appeal. In making a decision, we will consider the following review criteria (1) the benefits and the terms and conditions of coverage stated in this Handbook and Schedule of Benefits, (2) the views of medical professionals who have cared for the Member, (3) the views of any specialist who has reviewed the appeal, (4) any relevant records or other documents provided by the Member, and (5) any other relevant information available to us.

Our decision of an appeal will be sent to the Member in writing. The decision will identify the specific information considered in your appeal and an explanation of the basis for the decision with reference to the plan provisions on which the decision was based. If the decision is to deny coverage based on a Medical Necessity determination, the decision will include (1) the specific information upon which the decision was based, (2) the Member’s presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons this medical evidence fails to meet the relevant medical review criteria, (3) identification of any alternative treatment option covered by us, and (4) the applicable clinical practice and review criteria information relied on to make the decision. The decision will also include a description of other options available for further

review of the appeal. These options are described in section VI.F. *WHAT YOU MAY DO IF YOUR APPEAL IS DENIED*.

No one involved in the initial decision to deny a claim under appeal will be a decision-maker in any stage of the appeal process. Members have the right to receive, free of charge, all documents, records or other information relevant to the initial denial and appeal.

E. THE EXPEDITED APPEAL PROCESS

1. Expedited Appeals Process

Members may obtain expedited review of certain types of appeals. An expedited appeal may be requested if we deny coverage for health services involving (1) continued hospital care, (2) care that a physician certifies is required to prevent serious harm, or (3) a Member with a terminal illness. An expedited appeal will not be granted to review a termination or reduction in coverage resulting from (1) a benefit limit or cost sharing provision of this Handbook or (2) the termination of membership.

Members may request an expedited appeal – other than an appeal involving mental health and substance use disorder treatment– by contacting us orally or in writing at the following phone numbers or addresses:

**HPHC Appeals and Grievances Department
Harvard Pilgrim Health Care
1600 Crown Colony Drive
Quincy, MA 02169
1-888-333-4742
Fax: 1-617-509-3085**

Members may request orally or in writing an expedited appeal that involves mental health and substance use disorder treatment by contacting:

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

We will make a decision of an expedited appeal within 72 hours from receipt of the appeal unless a different time limit is specified below. If we do not act on an expedited appeal within the time limits stated below, including any extension of time mutually agreed upon in writing by the Member and us, the appeal will be deemed to be resolved in favor of the Member. Our decision will be sent to the Member in writing.

If you are filing an expedited appeal with HPHC, you may also file a request for expedited external review with the Massachusetts Office of Patient Protection 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.F. *WHAT YOU MAY DO IF YOUR APPEAL IS DENIED*, "External Review" for information on how to file for external review.

The circumstances and procedures under which Members may obtain an expedited appeal are as follows:

i. Hospital Discharge

A Member who is an inpatient in a hospital will be provided with an expedited review of any action by us to terminate or reduce coverage for continued hospital care based upon the medical necessity of the hospitalization or the services provided. Any such appeal will be decided prior to the termination or reduction of coverage for the Member's hospital stay. Coverage for services will be continued through the completion of the appeals process. We will provide the Member with written notification of the appeal decision prior to discharge from a hospital.

ii. Services or Durable Medical Equipment Required to Prevent Serious Harm

An expedited review will be provided for appeals for services or durable medical equipment that, if not immediately provided, could result in serious harm to the Member. "Serious harm" means circumstances that could (1) jeopardize the life or health of the Member, (2) jeopardize the ability of the Member to regain maximum function, or (3) result in severe pain that cannot be adequately managed without the care or treatment requested.

An expedited review will be provided in any case in which we have denied coverage for a service or durable medical equipment if the physician recommending the treatment or durable medical equipment provides us with a written certification stating that:

- a) The service or durable medical equipment is Medically Necessary;
- b) A denial of coverage for the service or durable medical equipment would create a substantial risk of serious harm to the Member; and
- c) The risk of serious harm is so immediate that the provision of the services or durable medical equipment should not await the outcome of the normal appeal process.

Any such certification must contain the name, address and telephone number of the certifying physician and his or her signature. Certifications may be delivered in person, by mail or by fax at the addresses and telephone numbers listed above in this subsection. Upon receipt of a proper certification, HPHC will review the denial of coverage and provide the Member with notice of the decision within 48 hours. A decision may take place earlier than 48 hours for durable medical equipment if (1) a request for the early reversal is included in the certification and (2) the physician's certification includes specific facts indicating that immediate and severe harm to the Member that will result from a 48-hour delay.

iii. Member with a Terminal Illness

If a Member with a terminal illness files an appeal of a denial of coverage, a decision will be made by us within 5 business days of receipt of the appeal. A terminal illness is an illness that is likely to cause death within 6 months.

If a decision is made on appeal to deny coverage to a Member with a terminal illness, we will provide the Member with a written decision within 5 business days of the decision. In the event a decision is made to deny the coverage requested, the decision will include:

- a) A statement of any medical and scientific reasons for the denial; and
- b) A description of any relevant alternative treatment, services, or supplies covered by us.

If a decision is made on appeal to deny coverage to a Member with a terminal illness, the Member may request a meeting with HPHC to reconsider the denial. The meeting will be held within 10 days of request, unless the treating physician requests that it be held earlier. In such event, the meeting will be held within 5 business days. At the meeting, the Member and the committee will review the information previously provided in response to the Member's appeal. HPHC will have authority to approve or deny the appeal. HPHC's decision will be our final decision.

2. Continuation of Services Pending Expedited Appeal

If an expedited appeal is filed concerning the termination or reduction of coverage for ongoing treatment, the coverage will be continued through the completion of our internal expedited appeal process if:

- a) The service was authorized by us at the time the services was initiated;

- b) The service was not terminated or reduced due to a benefit limit under this Handbook or Schedule of Benefits;
- c) The appellant is, and continues to be, a duly enrolled Member under this Handbook; and
- d) The appeal is filed on a timely basis, based on the course of treatment.

F. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED

If you disagree with the decision of your appeal, you may have a number of options for further review. These options may include (1) reconsideration of appeals that involve a Medical Necessity determination (as described in *VI.B. HOW TO FILE AN APPEAL*) by our review committee, (2) external review by an independent organization appointed by the Office of Patient Protection, or (3) legal action. Below is a summary of these options.

1. Reconsideration by the Plan

If a Member disagrees with a decision concerning an appeal that involves a Medical Necessity determination, the Member may request reconsideration of such appeal if there is additional clinical information that hasn't previously been reviewed by HPHC. The Member must request reconsideration within 15 days of the date of our letter denying the appeal.

Reconsideration is not available for the following types of appeals:

- Decisions involving a benefit limitation where the limit is stated in the Handbook or Schedule of Benefits
- Decisions involving excluded services, except Experimental, Unproven or Investigational services, and
- Decisions concerning Member Cost Sharing requirements

Our reconsideration process is voluntary and optional. A Member may request reconsideration before or after seeking any other dispute resolution process described below. The only exception involves appeals that have been accepted by the Office of Patient Protection for external review. For example, a Member may request reconsideration of an appeal before seeking external review from the Office of Patient Protection, or the Member may proceed directly to external review. A Member may also request reconsideration if the Office of Patient Protection has determined that an appeal is not eligible for external review. However, we will

not reconsider an appeal that has been accepted for external review by the Office of Patient Protection.

Reconsideration by HPHC will not affect the Member's rights to any other benefits. On reconsideration, HPHC will make an impartial evaluation of the Member's appeal based on the review criteria in "The Formal Appeal Process," above without deference to any prior decisions made on the claim. HPHC will provide the Member with a written decision of the review.

We will not assert that a Member has failed to exhaust administrative remedies because the Member has chosen not to seek reconsideration of an appeal that has been denied under the formal appeal process. We also agree that any statute of limitations or defense based on timeliness is tolled during the time period in which a request for reconsideration is pending. No fees or costs will be charged for reconsidering an appeal decision.

2. External Review

Any Member who wishes to contest a final appeal decision involving a medical necessity determination may request external review of the decision by an independent organization under contract with the Office of Patient Protection. To obtain external review, a written request for external review must be filed with the Office of Patient Protection within 4 months of receipt of the written notice of our appeal decision. A copy of the external review form will be enclosed with your notice from us of its decision to deny your appeal.

A request for an external review must meet the following requirements:

- 1) The request must be submitted on the Office of Patient Protection's application form called, "Request for Independent External Review of a Health Insurance Grievance." A copy of this form is included with the denial letter and may also be obtained by calling the Member Services Department at **1-888-333-4742**. It may also be obtained from the Office of Patient Protection by calling **1-800-436-7757**. In addition, copies of the form may be downloaded from the Department's website at **www.mass.gov/hpc/opp**.
- 2) The form must include the Member's signature or the signature of the Member's authorized representative, consenting to the release of medical information.
- 3) A copy of our final appeal decision must be enclosed.

- 4) A fee of \$25 must be paid. The Office of Patient Protection may waive this fee for extreme financial hardship.

The Office of Patient Protection will screen requests for external review to determine whether external review can be granted. If the Office of Patient Protection determines that a request is eligible for external review, the appeal will be assigned to an external review agency and the Member (or Member representative) and HPHC will be notified. The decision of the external review agency is binding, and we must comply with the decision.

If the Office of Patient Protection determines that a request is not eligible for external review, the Member (or Member representative) will be notified within 10 business days or, in the case of requests for expedited review, 72 hours.

The Office of Patient Protection may be reached at:

**Health Policy Commission
Office of Patient Protection
50 Milk Street, 8th Floor
Boston, MA 02109
1-800-436-7757
Fax: 1-617-624-5046
HPC-OPP@state.ma.us
<http://www.mass.gov/hpc/opp>**

The Office of Patient Protection may arrange for an expedited external review. If you are not receiving inpatient service, a request for expedited external review must include a written certification from a physician that a delay in providing or continuing the health services that are the subject of the appeal decision would pose a serious and immediate threat to the health of the insured.

If the subject of an external review involves the termination of ongoing services, the Member may ask the external review panel to continue coverage for the service while the review is pending. Any request for continuation of coverage must be made before the end of the second business day following receipt of the final adverse decision. The review panel may order the continuation of coverage if it finds that substantial harm to the Member's health may result from the termination of coverage. The panel may also order the continuation of coverage for good cause. Any such continuation of coverage shall be at our expense regardless of the final external review determination.

3. 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.A. *LIMITATION ON LEGAL ACTIONS*. Please note that government plans are not subject to ERISA.

G. THE FORMAL COMPLAINT PROCEDURE

A complaint may be filed when a Member seeks redress of any action taken by us or any aspect of our services, other than a denial of coverage for health services. All complaints will initially be considered through the informal inquiry process described above in “The Informal Inquiry Process.”

Complaints may be filed in person, by mail, by fax or by telephone at the addresses or telephone numbers listed below. An Appeals and Grievances Analyst will investigate each complaint and respond in writing.

For all complaints, except mental health and substance use disorder treatment, please call or write to us at:

HPHC Appeals and Grievances Department
1600 Crown Colony Drive.

Quincy, MA 02169

Telephone: 1-888-333-4742

Fax: 1-617-509-3085

www.harvardpilgrim.org

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

HPHC Behavioral Health Complaints
c/o Optum Behavioral Health Complaints

P.O. Box 30768

Salt Lake City, UT 84130-0768

Telephone: 1-888-777-4742

Fax: 1-248-524-7603

1. Documentation of Oral Complaints

If a complaint is filed by phone, a Member Services Representative will write a summary of the complaint and send it to the Appeals and Grievances Department. The Appeals and Grievances Analyst will send as acknowledgement letter to the Member within 48 hours of receipt. This time limit may be extended by mutual agreement between the Member and us. Any such agreement must be in writing.

2. Acknowledgment of Complaints

Written complaints will be acknowledged in writing within 15 days of receipt. This time limit may be extended by written mutual agreement between the Member and us. No acknowledgment of a complaint will be sent if a Member Services Representative has

previously sent a summary of a complaint submitted by phone.

3. Release of Medical Records

Any complaint that requires the review of medical information must include a signed authorization to release or obtain protected health information. This form must be signed and dated by the Member or the Member’s authorized representative (when signed by an authorized representative, appropriate proof of authorization to release or obtain protected health information must be provided). If an authorization to release or obtain protected health information form is not provided when the complaint is filed, a Member Services Representative will send a blank form to the Member or the Member’s representative. If a signed authorization to release or obtain protected health information is not received within 30 days of the date the complaint is received, we may respond to the complaint without the missing information.

4. Time Limit for Responding to Complaints

Members will be provided with a written response to a complaint within 30 days of the date the complaint was received. This time limit may be extended by mutual agreement between the Member and us. Any extension will not exceed 30 days from the date of the agreement. Any such agreement must be in writing.

If a complaint requires the review of medical records, the date of receipt will be the date we receive a signed authorization to release or obtain protected health information. If we do not respond to an informal inquiry within 3 business days, the date of receipt will be the fourth business day following the date we receive the informal inquiry. No complaint will be deemed received until actual receipt of the complaint at the appropriate address or phone number listed in the section VI.B. *HOW TO FILE AN APPEAL*.

If we do not act on a complaint concerning benefits under this contract within 30 days, plus any extension of time mutually agreed upon in writing by the Member and us, the complaint will be deemed to be resolved in favor of the Member.

5. Medical Records and Information

The Appeals and Grievances Analyst will try to obtain all information, including medical records, relevant to a complaint. Due to the limited time available for processing complaints, Members may be asked to assist the Appeals and Grievances Analyst in obtaining any missing information or to extend the time limit for response to the complaint until such information can be obtained. If information cannot be obtained by

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the 15th day following the receipt of the authorization to release or obtain protected health information and no agreement can be reached on extending the time limit for responding to the complaint, the Appeals and Grievances Analyst may respond to the complaint without the missing information.

VII. Eligibility

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

A. ELIGIBILITY

1. Subscriber Eligibility

To be a Subscriber under this Plan, you must:

- Be an employee of an Employer Group, in accordance with employee eligibility guidelines agreed to by the Employer Group and us; and
- Be enrolled through an Employer Group that is up-to-date in the payment of the applicable premium for coverage.

We have the right to examine an Employer Group's records, including payroll records, to verify eligibility and premium payments.

2. Dependent Eligibility

Unless an employer has elected different types of coverage for Dependents, a Dependent must meet one of the requirements for coverage listed below to be eligible for coverage under the Plan. Please note that employers may elect different coverage for Dependents and different ages for the termination of Dependents to the extent allowed by law. Please consult your Employer Group's Benefits Office to determine the specific Dependent eligibility requirements that apply to your Plan.

To be eligible as a Dependent, an individual must be one of the following:

- 1) The legal spouse of the Subscriber. A legal spouse means the same-sex or opposite-sex spouse of the Subscriber who has entered into a legally valid marriage or civil union in a jurisdiction where such marriage or civil union is legal. We recognize same-sex spouses and partners in a civil union subject to the Employer's eligibility policies.

- 2) The former spouse of the Subscriber, until either the Subscriber or the former spouse remarries or until the divorce judgment between them no longer requires the Subscriber to provide health coverage to the former spouse, whichever comes first.

Please Note: After the remarriage of the Subscriber, a former spouse may continue coverage through an individual contract, if the provision of such coverage is (1) required by the divorce judgment and (2) the applicable premium for such coverage is paid to us. There is no coverage for the former spouse after he or she remarries.

- 3) A child (including an adopted child) of the Subscriber or spouse of the Subscriber until the end of the month in which the child turns 26.
- 4) A child (including an adopted child) of the Subscriber or spouse of the Subscriber, age 26 years or older who meets each of the following requirements: (a) is currently Disabled; (b) was Disabled on his or her 26th birthday; (c) lives either with the Subscriber or spouse or in a licensed institution; and (d) remains financially dependent on the Subscriber. The term "Disabled" means unable to engage in any substantial gainful activity by reason of a specific medically determinable physical or mental impairment which can be expected to last, or has lasted, for at least 12 months or result in death.
- 5) A child under the age of 19* years for whom the Subscriber or Subscriber's spouse is the court appointed legal guardian. Proof of guardianship must be submitted to us prior to enrollment.
- 6) The child of an enrolled Dependent child of the Subscriber (or the Subscriber's enrolled spouse) until (1) the child's parent is no longer an eligible Dependent, or (2) the child reaches age 19*, whichever occurs first. There is no coverage under this paragraph unless the enrolled Dependent parent has legal custody of the child.

We may require reasonable evidence of eligibility from time to time.

B. EFFECTIVE DATE - NEW AND EXISTING DEPENDENTS

Please see your Employer Group's Benefit Administrator 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 Employer Group 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

To add a new Dependent to your Plan, please contact your Employer's human resources or benefits department. If you already have family coverage, you may also call our Member Services Department at **1-888-333-4742** to add a newborn or newly adopted child.

Dependents of eligible employees who meet the eligibility guidelines described in this Handbook and the Employer Agreement will be enrolled in the Plan using HPHC enrollment forms or in a manner otherwise agreed to in writing by us and the Member's Employer Group.

We must receive proper notice from the Employer Group of any Member enrollment in, or termination from, the Plan no more than 60 days after such change is to be effective unless otherwise required by law. Please see your Employer Group for information on Dependent eligibility and effective dates of coverage.

F. NEWBORN COVERAGE

A newborn infant of a Member or a newborn infant of a Dependent of a Member is eligible for coverage under the Plan from the moment of birth as required by Massachusetts law. 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. Please see your Employer Group's benefits administrator for information on enrollment and effective date of coverage. 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, enrollment must be requested 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, enrollment must be requested 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 within 60 days after Medicaid or CHIP coverage ends. An employee or Dependent

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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 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: We may not have current information concerning membership status. Employer Groups may notify us of enrollment changes retroactively. As a result, the information we have may not be current. Only your Employer Group can confirm membership status.

A. TERMINATION BY THE SUBSCRIBER

You may end your membership under this Plan with your Employer Group's approval. We must receive a completed Enrollment/Change form from the Employer Group within sixty (60) days of the date you want your membership to end.

B. TERMINATION FOR LOSS OF ELIGIBILITY

A Member's coverage will end under this Plan if the Employer Group contract through which the Member receives coverage is terminated. A Member's coverage may also end for failing to meet any of the specified eligibility requirements.

We will inform you in writing if coverage ends for loss of eligibility.

C. TERMINATION FOR NON-PAYMENT BY THE EMPLOYER GROUP

A Member's coverage will end under this Plan if the Employer Group contract through which the Member receives coverage is terminated for non-payment.

We will notify you in writing, if your coverage is terminated due to your Employer Group failing to pay its premium. We will elect to follow one of two options in this event: 1) continue your coverage up to the date you receive notice of termination, or 2) offer temporary continued coverage and individual coverage provided you satisfy the state mandated eligibility criteria.

You may be eligible for continued enrollment under federal or state law, if your membership is terminated. See "Continuation of Employer Group Coverage" in this Section for more information.

D. MEMBERSHIP TERMINATION FOR CAUSE

We 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, the Plan 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. Premium paid for periods after the effective date of termination will be refunded.

E. CONTINUATION OF EMPLOYER GROUP COVERAGE REQUIRED BY LAW

1. Massachusetts Law

If you lose Employer Group eligibility under a Massachusetts employer with 2 - 19 employees, you may be eligible for continuation of group coverage under the Massachusetts Small Group Continuation Coverage law. Under this law you have 60 days to elect coverage. You should contact the Employer Group or the Member Services Department for more information about coverage under this law. In addition to the Small Group Continuation Coverage law, there are other state laws which may apply. You should contact the Employer Group for more information if membership ends due to: 1) plant closing or partial closings; 2) loss of dependency status due to age or divorce or legal separation; 3) separation from employment or reduction of work hours.

Continuation of Employer Group coverage under the Plan may be available to a Member under one or more of the following provisions of Massachusetts Law:

i. Following Termination of Employment

Provided premium is received by HPHC, coverage shall continue for a Member for a period of thirty-one days following termination of employment unless, during such period, he or she shall otherwise be entitled to similar health coverage.

ii. Following Involuntary Layoff or Death of the Member

A Member may elect to continue Plan coverage in the event that coverage terminates due to involuntary layoff or death of the Member.

Such continued coverage shall be available only if the former Member elects continuation of coverage in writing and pays his or her Employer Group the required premium within thirty days from the date coverage would otherwise terminate. The required premium will be the whole premium for Plan coverage, including both the amounts normally paid by the Employer Group and the Member.

Continued coverage under the Plan will, in no event, continue beyond the earliest of:

- 1) thirty-nine weeks from the date the coverage would otherwise cease;
- 2) the amount of time for which the former Member was most recently covered under this Handbook, if less than thirty-nine weeks;
- 3) the last day for which HPHC has received the required premium from the Employer Group;
- 4) the date the Member becomes eligible for another group medical plan;
- 5) the date the Employer Group ceases to participate in the Plan;
- 6) the date a Dependent no longer qualifies as a Dependent.

iii. Following Plant Closing or Partial Closing

A Member may elect to continue Plan coverage for himself and his Dependents in the event that his or her coverage terminates due to plant closing or covered partial closing as defined by Chapter 151A, section 71A of Massachusetts law.

Such continued insurance shall be available only if the former Member elects continuation of coverage in writing and pays his or her Employer Group the required premium within thirty days from the date coverage would otherwise terminate. The required premium will include that amount normally paid by the Member for coverage through the Employer Group and that amount normally paid by the Employer Group for such coverage

The Employer Group is required to pay the full premium amount to HPHC.

Continued coverage will, in no event, continue beyond the earliest of:

- 1) ninety days from the date the coverage would otherwise cease;
- 2) the last day for which HPHC has received the required premium from the Employer Group;
- 3) the date the Member becomes eligible for another group medical plan;
- 4) the date the Employer Group ceases to participate in the Plan;
- 5) the date a Dependent no longer qualifies as a Dependent.

iv. Following Separation or Divorce

A Dependent spouse may elect to continue Plan coverage for himself or herself under this Handbook in the event that his or her coverage terminates due to divorce or legal separation from the Member unless the judgment of divorce or separation provides otherwise.

Coverage will, in no event, continue beyond the earliest of:

- 1) the remarriage of either the Member or the former Dependent spouse. However, upon remarriage of the Member, if provided in the judgment of divorce, the former Dependent spouse may elect to continue coverage at additional premium rates, as determined by HPHC;
- 2) the date that the Member's coverage terminates;
- 3) the period of time as determined in the judgment of divorce or separation;
- 4) the last day for which HPHC has received the required premium from the Employer Group;
- 5) the date the Employer Group ceases to participate in the Plan.

2. Federal Law

If you lose Employer Group eligibility and the Employer Group 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 Employer Group for more information if health coverage ends due to: 1) separation from employment; 2) reduction of work hours; or 3) loss of dependency status. Continuation of coverage may not be extended beyond the applicable time allowed under federal law. The size of your Employer Group will determine whether you select

your continuation of coverage rights under state or federal law.

A Member may elect between the continuation of benefits rights under state or federal law. Once an election is made, however, there may be no duplication of such continuation rights.

F. INDIVIDUAL COVERAGE

We offer individual health plans for Massachusetts, Maine and New Hampshire residents. Coverage purchased on an individual basis may differ from the coverage under your previous Plan. Individuals may enroll only in a plan offered in their state of residence and must satisfy all eligibility guidelines. Your state of residence will have specific rules about eligibility and coverage.

1. Massachusetts Residents:

For individual coverage questions please call us at **1-800-208-1221** - weekdays 8:30 a.m. -5 p.m.

2. Maine Residents:

For individual coverage questions please call us at **1-855-354-4742**- weekdays 8:30 a.m. - 5:00 p.m.

3. New Hampshire Residents:

For individual coverage questions please call us at **1-844-213-1591** - weekdays 8:30 a.m. -5:30 p.m.

G. MEMBERS ELIGIBLE FOR MEDICARE

If your membership ends because you are eligible for Medicare under circumstances in which federal law permits Medicare to be the primary payer for Medicare-covered services, you may apply for coverage under an HPHC plan for Medicare enrollees. You may contact HPHC's Member Services Department for more information.

IX. When You Have Other Coverage

This section explains how benefits under the Plan will be paid when another company or individual is also responsible for payment for health services a Member has received. This can happen when there is other insurance available to pay for health services, in addition to that provided by the Plan. It can also happen when a third party is legally responsible for an injury or illness suffered by a Member.

Nothing in this section should be interpreted as providing coverage for any service or supply that is not expressly covered under the Handbook, Schedule of Benefits and Prescription Drug Brochure (if applicable) or to increase the level of coverage provided.

A. BENEFITS IN THE EVENT OF OTHER INSURANCE

Benefits under this Handbook, Schedule of Benefits, and Prescription Drug Brochure (if applicable) will be coordinated to the extent permitted by law with other plans covering health benefits, including: motor vehicle insurance, medical payment policies, governmental benefits (including Medicare), and all Health Benefit Plans. The term "Health Benefit Plan" means all group HMO and other group 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 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 will determine 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 other plan 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. PAYMENT WHEN HPHC COVERAGE IS PRIMARY OR SECONDARY

When HPHC is primary, HPHC is responsible for processing and paying claims for Covered Benefits first. Coverage will be provided to the full extent of benefits available under this Handbook, Schedule of Benefits and Prescription Drug Brochure (if applicable).

When HPHC is secondary, HPHC is responsible for processing claims for Covered Benefits after the primary plan has issued a benefit determination. HPHC will first review the primary plan's benefit determination. HPHC will then pay or provide Covered Benefits as the secondary payor. HPHC's benefits will be reduced so that the total amount paid by all plans for a Covered Benefit will not exceed the amount payable under this Handbook. HPHC may recover any payments made for services in excess of HPHC's liability as the secondary plan, either before or after payment by the primary plan.

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, HPHC may suspend payment for such services until a determination is made whether payment will be made by such program. If HPHC

provides or pays for services for an illness or injury covered under Workers' Compensation, Employer's liability or other program of similar purpose, or by a federal, state or other government agency, HPHC will be entitled to recovery of its expenses from the provider of services or the party or parties legally obligated to pay for such services.

D. SUBROGATION AND REIMBURSEMENT

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

If another person or entity is, or may be, liable to pay for services related to a Member's illness or injury which have been paid for or provided by HPHC, HPHC will be subrogated and succeed to all rights of the Member to recover against such person or entity 100% of the value of the services paid for or provided by the Plan. HPHC will have the right to seek such recovery from, among others, the person or entity that caused the injury or illness, his/her liability carrier or the Member's own auto insurance carrier, in cases of uninsured or underinsured motorist coverage. HPHC will also be entitled to recover from a Member 100% of the value of services provided or paid for by HPHC when a Member has been, or could be, reimbursed for the cost of care by another party. HPHC's recovery will be made from any recovery the Member receives from an insurance company or any third party.

HPHC's right to recover 100% of the value of services paid for or provided by HPHC is not subject to reduction for a pro rata share of any attorney's fees incurred by the Member in seeking recovery from other persons or organizations.

HPHC's right to 100% recovery shall apply even if a recovery the Member receives for the illness or injury is designated or described as being for injuries other than health care expenses. The subrogation and recovery provisions in this section apply whether or not the Member recovering money is a minor.

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

Nothing in this Handbook shall be construed to limit HPHC'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 the Member is 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 HPHC.

F. MEMBER COOPERATION

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

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

G. HPHC'S RIGHTS

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

H. MEMBERS ENROLLED IN 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 HPHC. HPHC will be liable for any amount eligible for coverage that is not paid by Medicare. The Member shall take such action as is required to assure payment by Medicare, including presenting his or her Medicare card at the time of service.

For a Member who is eligible for Medicare by reason of End Stage Renal Disease, HPHC will be the primary 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), HPHC will pay for services only to the extent payments would exceed what would be payable by Medicare.

X. Plan Provisions and Responsibilities

A. LIMITATION ON LEGAL ACTIONS

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

B. ACCESS TO INFORMATION

You agree that, except where restricted by law, we 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. We 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.

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

C. SAFEGUARDING CONFIDENTIALITY

We are 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 with us, you agreed to certain uses and disclosures of information which are necessary for us to provide and administer services and benefits, such as: 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.

We disclose our 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.

D. NOTICE

Any Member mailings, including but not limited to, notices, plan documents, invoices, and Activity Statements will be sent to the Member's last address on file with HPHC. It is the Member's responsibility to notify HPHC of an address change to ensure mailed materials are sent to the appropriate address. HPHC is not responsible for mailed materials being sent to the incorrect address if a Member has not updated his/her address with HPHC prior to the materials being mailed out. Notice to HPHC, other than a request for 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*.

E. MODIFICATION OF THIS HANDBOOK

This Benefit Handbook, Schedule of Benefits, Prescription Drug Brochure (if applicable) and applicable riders, may be amended by us upon thirty (30) days written notice to your Employer Group. Amendments do not require the consent of Members.

This Benefit Handbook, the Schedule of Benefits, Prescription Drug Brochure (if applicable), applicable riders and amendments comprise the entire contract between you and the Plan. The responsibilities of HPHC to the Member are only as stated in those documents. They can only be modified in writing by an authorized officer of the Plan. No other action by us, including the deliberate non-enforcement of any benefit limit shall be deemed to waive or alter any part of these documents.

F. OUR RELATIONSHIP WITH PLAN PROVIDERS

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

G. WELLNESS INCENTIVES

As a Member of the Plan, you may be able to receive incentives for participation in wellness and health improvement programs. HPHC may provide incentives, including reimbursement for certain fees that you pay for when participating in fitness or weight loss programs. The award of incentives is not contingent upon the outcome of the wellness or health improvement program. Please visit our website at www.harvardpilgrim.org for more information or see your Plan documents for the amount of incentives, if any, available under your Plan. For tax information, please consult with your employer or tax advisor.

H. IN THE EVENT OF A MAJOR DISASTER

We will try to provide or arrange for services in the case of a major disaster. This might include war, riot,

epidemic, public emergency, or natural disaster. Other causes include the partial or complete destruction of our facility(ies) or the disability of service providers. If we cannot provide or arrange services due to a major disaster, we are not responsible for the costs or outcome of this inability.

I. EVALUATION OF NEW TECHNOLOGY

We have a dedicated team of 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, Unproven or Investigational. The team researches the safety and effectiveness of these new technologies by reviewing published peer reviewed medical reports and literature, consulting with expert practitioners, and benchmarking. The team 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. GOVERNING LAW

This Evidence of Coverage is governed by Massachusetts law.

K. RESPONSIBILITIES OF HARVARD PILGRIM HEALTH CARE, INC.

The responsibilities of Harvard Pilgrim Health Care, Inc. to the Member are only as stated in this Handbook. They can only be modified in writing by a duly authorized officer of Harvard Pilgrim Health Care, Inc. No other action by Harvard Pilgrim Health Care, Inc. including the non-enforcement of any limitation on coverage, shall be deemed a waiver or alteration of any provision of this Handbook.

L. UTILIZATION REVIEW PROCEDURES

We use 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).** We review selected inpatient admissions, surgical day care, outpatient/ambulatory procedures, and Medical Drugs prior to the provision of such services 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. Prior Approval 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, we 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"), we 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: 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.** We review 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 an 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 us. 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.

M. 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.

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

We use 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.

O. PROCESS TO DEVELOP CLINICAL GUIDELINES AND UTILIZATION REVIEW CRITERIA

We use 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 clinical criteria for both physical and mental health services.

For example, we use 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.

P. 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.

Q. 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 and New Technology Assessment Committee or Pharmacy Services Department along with the Pharmacy and Therapeutics Committee 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: Not all Plans provide coverage for outpatient prescription drugs through Harvard Pilgrim. If your Plan does not provide coverage for outpatient prescription drugs through Harvard Pilgrim, coverage under this benefit handbook is limited to Medical Drugs. If your Plan provides coverage for outpatient prescription drugs through Harvard Pilgrim, please refer to your prescription drug brochure for additional information.

R. DETERMINATION OF COVERED BENEFITS

We have the discretionary authority to decide whether, and to what extent, you are eligible for Covered Benefits. We also have the discretionary authority to interpret the terms of your Evidence of Coverage. Our decisions and interpretations are final and binding.

S. PAYMENT RECOVERY

If we determine that benefit payments under the Plan were made erroneously, we reserve the right to (1) seek recovery of such payments from the Provider or Member to whom the payments were made, and (2) offset subsequent benefit payments to a Provider (regardless of payment source) or Member by the amount of any such overpayment.

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' rights 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.

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