Harvard Pilgrim Health Care

Commonwealth of Massachusetts
Group Insurance Commission

Benefit Handbook

THE HARVARD PILGRIM INDEPENDENCE PLAN℠ POS FOR GROUP INSURANCE COMMISSION MEMBERS

MASSACHUSETTS

This benefit Plan is provided to you by the Group Insurance Commission (GIC) on a self-insured basis. Harvard Pilgrim Health Care has arranged for the availability of a Network of health care Providers and will be performing various benefit and claim administration and case management services on behalf of the GIC. Although some materials may refer to you as a Member of one of Harvard Pilgrim Health Care's products, the GIC is the insurer of your coverage.

IMPORTANT NOTICE: This Plan includes a tiered Provider Network. In this Plan, Members pay different levels of Member Cost Sharing depending on the tier of the Provider delivering a Covered Benefit or supply. The Independence Plan Provider Directory includes Provider tiering information and is available online at **www.harvardpilgrim.org/GIC** or by calling Member Services at **1-888-333-4742**. For TTY service, please call **711**.

EFFECTIVE DATE: 07/01/2019
GIC_POS_04

INTRODUCTION

Welcome to Harvard Pilgrim Independence Plan℠ POS for Group Insurance Commission Members (the Plan). Thank you for choosing us to help you meet your health care needs.

The health care services under this Plan are administered by Harvard Pilgrim Health Care (HPHC) through its Provider Network. The Harvard Pilgrim Independence Plan POS is a self-insured health benefits plan for the Group Insurance Commission (GIC). The GIC is your Plan Sponsor and is financially responsible for this Plan's health care benefits. HPHC provides benefits and claims administration and case management services on behalf of the GIC as outlined in this Benefit Handbook and the Schedule of Benefits.

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

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

In-Network Benefits
Your "In-Network" benefits provide coverage at a lower out-of-pocket cost. With very limited exceptions, you must receive care from Plan Providers to obtain In-Network benefits. Plan Providers are medical Providers under contract to care for HPHC Members. They include Primary Care Providers (PCPs), specialists, hospitals and many other types of Providers. You can locate Plan Providers by calling the Member Services Department at **1-888-333-4742** or you may access the Independence Plan Provider Directory online at **www.harvardpilgrim.org/GIC**.

Out-of-Network Benefits
Your "Out-of-Network" benefits provide coverage at a higher out-of-pocket cost. However, your Out-of-Network benefits allow you to receive Covered Benefits from almost any medical Provider.

You must choose a PCP for yourself and each Member of your family when you enroll in the Plan. Most care must be provided or arranged by your PCP, except as described in section *I.E.2. Your PCP Manages Your Health Care*.

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.

Your benefits will also be covered at the Out-of-Network level if you receive services from Plan Providers in the Service Area without a Referral from your PCP, when a Referral is required.

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 Schedules of Benefits and Benefit Handbook, look up benefits, Copayments, claims history, and Deductible status,

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

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

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

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

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

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

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

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
Phone: 1-888-333-4742
www.harvardpilgrim.org

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

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

Prescription Drug Coverage

Your outpatient prescription drug coverage is not administered by HPHC. Please see your **Express Scripts Prescription Drug Plan brochure** or call **Express Scripts** at **1-855–283–7679** for information on coverage of outpatient prescription drugs. Regardless of whether the Express Scripts brochure is specifically noted in a handbook section, any reference to outpatient drugs found within this handbook is governed by the Express Scripts Prescription Drug Plan brochure .

Employee Assistance Program (EAP)

If you have a question about **Employee Assistance Program** benefits	
Optum (844) 263-1982 www.liveandworkwell.com *(Website Access Code: Mass4You)*	• What your Employee Assistance Program (EAP) benefits are • The status of (or a question about) an EAP claim

Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता 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, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-333-4742 (TTY: 711).

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

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

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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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TABLE OF CONTENTS

Benefit Handbook

I. How the Plan Works

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

A. HOW TO USE THIS BENEFIT HANDBOOK

1. Why This Benefit Handbook is Important

This Benefit Handbook and the Schedule of Benefits make up the agreement stating the terms of the Plan. The Benefit Handbook describes how your membership works. It explains what you must do to obtain coverage for services and what you can expect under the Plan. It is also your guide to the most important things you need to know, including:

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

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

2. Words With Special Meaning

Some words in this Benefit 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 also in your Schedule of Benefits. You must review section *III. Covered Benefits* and your Schedule of Benefits for a complete understanding of your benefits.

Your Express Scripts prescription drug coverage is not administered by HPHC. For details on your prescription drug benefit, please refer to your **Express Scripts Prescription Drug Plan brochure** or call **Express Scripts** at **1-855–283–7679** for information on coverage of outpatient prescription drugs.

B. HOW TO USE YOUR INDEPENDENCE PLAN PROVIDER DIRECTORY

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

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

The online Independence Plan 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 a paper directory.

You may also 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**. You can also get a paper copy of the Independence Plan Provider Directory, free of charge, by calling the Member Services Department at **1–888–333–4742**.

Please Note: Plan Providers participate through contractual arrangements that can be terminated either by a Provider or by HPHC. Under a tiered Network Plan, a Provider's tier level may also change. In addition, a Provider may leave the Network because of retirement, relocation or other reasons. This means that we cannot guarantee that the Plan Provider you choose will continue to be listed under the same tier or participate in the Network for the duration of your membership. If your PCP leaves the Network for any reason, we will make every effort to notify you at least 30 days in advance, and will help you find a new Plan Provider. Under certain circumstances, you may be eligible for transition services if your Provider leaves the Network (please see section *I.H. SERVICES PROVIDED BY A DISENROLLED NON-PLAN PROVIDER* for details).

C. INDEPENDENCE PLAN TIERED NETWORK

For In-Network services, this Plan has a Network of Providers in which hospitals and physicians have been placed into 3 benefit levels or "tiers." HPHC determined its tiers by using standard analytical techniques to evaluate Network PCPs, specialists and hospitals. Based on this evaluation, Providers are grouped into three levels, known as Tier 1, Tier 2 and Tier 3.

Plan Providers are under contract to provide Covered Benefits to Members of the Plan. Hospitals and physicians and their tier placements are listed in the Independence Plan Provider Directory at www.harvardpilgrim.org/GIC. You may also obtain a paper copy of the directory, free of charge, by calling HPHC's Member Services Department at **1-888-333-4742**.

Tiering of In-Network Providers is determined by cost efficiency standards and nationally recognized quality of care benchmarks. Cost efficiency is evaluated by comparing how much it costs doctors and hospitals to treat patients for similar conditions. Quality of care is evaluated based on standards derived from clinical guidelines for care. The tier associated with a hospital or physician determines your Member Cost Sharing for Covered Benefits. Tier 1 is the lowest cost tier. Tier 2 is the medium cost tier. Tier 3 is the highest cost tier.

HPHC evaluated PCPs and specialists based on the performance of the physician's medical group. Physicians are defaulted to Tier 2 if: (1) they are not affiliated with a medical group; (2) they are in HPHC's national network and not located in Massachusetts, Maine or New Hampshire; or (3) there was insufficient data to assign a tier.

Hospitals within the Independence Plan Network were evaluated based on the individual hospital's performance.

Providers are placed in In-Network tiers as follows:

- **Tier 1 Providers** – Includes PCPs, specialists and acute hospitals that met both HPHC's cost efficiency and quality benchmarks.
- **Tier 2 Providers** – Includes PCPs, specialists and acute hospitals that fall into one of these categories: (1) met the quality benchmark and have a moderate cost efficiency benchmark score; (2) met the cost efficiency benchmark but may not have met other benchmarks; (3) PCPs and specialists that are not affiliated with a medical group; (4) Providers in HPHC's national network; or (5) Providers for whom there was insufficient data available.
- **Tier 3 Providers** – Includes PCPs, specialists and acute hospitals with the lowest cost efficiency benchmark scores.

Because Member Cost Sharing is dependent upon the tier placement of a doctor or hospital, you will have lower out-of-pocket costs when you select Providers from the lower tiers. You should consider a Provider's tier and where the Provider has hospital admitting privileges before selecting a PCP or specialist. For example, if you require hospital care and your Tier 1 PCP refers you to a Tier 1 hospital, you would pay the lower out-of-pocket costs for both your physician and hospital care. However, if your Tier 1 PCP were to refer you to a Tier 3 hospital, you would pay the lowest out-of-pocket costs for physician services but the highest out-of-pocket costs for hospital care.

Only acute care hospitals, PCPs and medical specialists that are Plan Providers are assigned to one of three tiers. Certain Covered Benefits, including mental health and substance use disorder treatment, are not covered based on a Provider Tier. Please see your Schedule of Benefits for the specific Member Cost Sharing amounts that apply to all your Covered Benefits.

A Provider's tier level may be changed if there is change that impacts the criteria used to evaluate and determine tier placement as indicated above. Plan Providers and their tier placements are listed in the Independence Plan Provider Directory at www.harvardpilgrim.org/GIC. You may also call HPHC's Member Services Department at **1-888-333-4742** to check a Provider's status and tier placement.

IMPORTANT POINTS TO REMEMBER

Under the Plan, your out-of-pocket costs will vary depending on whom you see and where you go for care. Please review and consider the following when seeking coverage under the Plan:

- You can lower your out-of-pocket cost by selecting Plan Providers and hospitals in the lowest cost tier.
- When you choose a PCP, it is important to consider the tier of the hospital that your PCP uses. For example, a Tier 1 PCP may admit patients to a Tier 2 or Tier 3 hospital.
- A Plan Provider may practice at more than one location and may have a different tier assigned to each location. Different out-of-pocket costs may apply to the same Plan Provider based upon where you are treated by that Provider.
- Some Plan Providers have multiple offices and may be a Plan Provider at one location, and a Non-Plan Provider at another. For In-Network coverage, you must check with HPHC to make sure the services you seek are covered as In-Network for that specific Plan Provider at that specific location.
- For certain Covered Benefits Member Cost Sharing is not tiered. These Covered Benefits include services provided by Plan Providers in the following specialties: behavioral health; early intervention; physical, speech and occupational therapy; chiropractic; audiology; and optometry.

In summary, it is important to be aware that Providers are affiliated with many health insurers that offer different plan options with a variety of networks. In order to be certain that your Provider participates in the Harvard Pilgrim Independence Plan, you must check with HPHC itself, either on-line or by calling Member Services as noted, to confirm whether a particular Provider is included in the Network.

D. MEMBER OBLIGATIONS

1. Choose a Primary Care Provider (PCP)

To obtain In-Network coverage in the Service Area, you must choose a PCP for yourself and each of your family Members when you enroll in the Plan. If you do not choose a PCP when you first enroll, or if the PCP you select is not available, we will assign a PCP to you. The Plan Service Area is the states of Massachusetts, New Hampshire, Maine, Rhode Island, Connecticut and Vermont.

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

When you choose a PCP, it is important to consider the tier of the hospital that your PCP uses. For example, a Tier 1 PCP may admit patients to a Tier 2 or Tier 3 hospital. If your Tier 1 PCP were to refer you to a Tier 2 or Tier 3 hospital, you would pay the lowest out-of-pocket costs for physician services but the higher out-of-pocket costs for hospital care.

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

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

2. Obtaining Referrals to In-Network Specialists

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

If you need to see a specialist in the Service Area, you must contact your PCP for a Referral prior to the appointment For exceptions, see *I.E.8. Services That Do Not Require a Referral*. In most cases, a Referral will be given to a Plan Provider who is affiliated with the same hospital as your PCP or who has a working relationship with your PCP. Referrals to Plan Providers must be given in writing.

You do not need a Referral from your PCP when you receive care outside of the Service Area (the Service Area includes the states of Massachusetts, New

Hampshire, Maine, Rhode Island, Connecticut and Vermont). However, except in a Medical Emergency, you must obtain care from a Plan Provider to obtain In-Network coverage under this Benefit Handbook.

3. Show Your Identification Card

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

4. Share Costs

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

- Copayments
- Coinsurance
- Deductibles

For In-Network services, Member Cost Sharing amounts for Covered Benefits provided by PCPs, specialists or hospitals are dependent upon the tier placement of the Provider and where you receive services.

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

5. Obtain Prior Approval

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

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

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

E. HOW TO OBTAIN CARE

IMPORTANT POINTS TO REMEMBER

1) You and each enrolled Member of your family who lives in the Service Area must select a PCP.
2) The Service Area includes the states of Massachusetts, New Hampshire, Maine, Rhode Island, Connecticut and Vermont.
3) You have two types of Covered Benefits, known as "In-Network" and "Out-of-Network."
4) In order to receive In-Network Covered Benefits in the Service Area, your care must be provided or arranged by your PCP through Plan Providers, except as noted below.
5) Your Plan has a tiered Network comprised of Tier 1, Tier 2 and Tier 3 Providers.
6) Plan Providers that are PCPs, specialists and acute hospitals are placed into three tiers; Tier 1, Tier 2 and Tier 3.
7) For In-Network tiered services, Member Cost Sharing is lowest for Tier 1 Providers and highest for Tier 3 Providers.
8) Out-of-Network Covered Benefits are available when received from Non-Plan Providers.
9) Some services require Prior Approval by the Plan.
10) In the event of a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. You do not need a Referral for services in a Medical Emergency.

In-Network and Out-of-Network

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

To receive In-Network coverage you must use Plan Providers. Plan Providers have agreed to participate in the Plan and accept the Plan payment minus Member Cost Sharing as payment in full. Since we pay Plan Providers directly, if you show your Member ID card you should not have to file a claim when you use your In-Network coverage.

You receive Out-of-Network coverage when Covered Benefits are provided from Non-Plan Providers or Plan Provider without a Referral when one is required.

Although your Member Cost Sharing is generally higher for Out-of-Network benefits, you may obtain Covered Benefits from the Provider of your choice.

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

Your coverage is described further below.

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

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

1. How Your In-Network Benefits Work

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

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

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

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

2. Your PCP Manages Your Health Care

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

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

- Care in a Medical Emergency.
- Mental health and substance use disorder treatment. For mental health and substance use disorder treatment you should call the Behavioral Health Access Center at **1-888-777-4742**. The telephone number for the Behavioral Health Access Center is also listed on your ID card. Please see section *III. Covered Benefits*, *Mental Health and Substance Use Disorder Treatment* for information on this benefit.
- Special services that do not require a Referral that are listed in section *I.E.8. Services That Do Not Require a Referral*.

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

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

3. Referrals for Hospital and Specialty Care

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

When you need specialty care, your PCP will refer you to a Plan Provider who is affiliated with the hospital your PCP uses. This helps your PCP coordinate and

maintain the quality of your care. Please ask your PCP about the Referral Network that he or she uses.

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

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

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

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

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

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

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

4. Using Plan Providers

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

1) The service was received in a Medical Emergency from an emergency room or for ambulance transport. (Please see section *I.E.6. Medical Emergency Services* for information on your coverage in a Medical Emergency.)
2) No Plan Provider has the professional expertise needed to provide the required service. In this case, services by a Non-Plan Provider must be authorized in advance by us, unless one of the exceptions above applies.
3) Your physician is disenrolled as a Plan Provider or you are a new Member of the Plan, and one of the exceptions stated in section *I.H. SERVICES PROVIDED BY A DISENROLLED NON-PLAN PROVIDER* applies. Please refer to that section for the details of these exceptions.

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

5. Centers of Excellence

Plan Providers with special training, experience, facilities or protocols for certain specialized services are designated as "Centers of Excellence." Centers of Excellence are selected by us based on the findings of recognized specialty organizations or government agencies such as Medicare. Centers of Excellence are located in Massachusetts, Maine, New Hampshire, Connecticut and Rhode Island. In order to receive In-Network coverage, the following specialized service should be obtained through a designated Center of Excellence:

- Weight loss surgery (bariatric surgery)

A list of Centers of Excellence may be found in the Independence Plan Provider Directory. The Independence Plan Provider Directory is available online at **www.harvardpilgrim.org/GIC** 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 HPHC

determines 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 service at a facility other than a contracted Center of Excellence, coverage will be at the Out-of-Network benefit level.

To receive In-Network benefits for the 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 Independence Plan 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. 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 HPHC at **1-888-333-4742** within 48 hours or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to the Plan by an attending emergency physician no further notice is required.

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

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

In-Network Coverage

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

If you need Mental health or substance use disorder treatment outside of the Service Area, simply contact the Plan's Behavioral Health Access Center at **1-888-777-4742**.

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

Out-of-Network Coverage

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

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

8. Services That Do Not Require a Referral

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

i. Family Planning Services:

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

ii. Outpatient Maternity Services

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

iii. Gynecological Services

- Annual gynecological exam, including routine pelvic and clinical breast exam
- Cervical cryosurgery
- Colposcopy with biopsy

- Excision of labial lesions
- Medically Necessary evaluations for acute or emergency gynecological conditions
- Follow-up care provided by an obstetrician or gynecologist for obstetrical or gynecological conditions identified during maternity care, annual gynecological visit or an evaluation for acute or emergency gynecological conditions
- Laser cone vaporization of the cervix
- Loop electrosurgical excisions of the cervix (LEEP)
- Treatment of amenorrhea
- Treatment of condyloma

iv. Other Services:

- Chiropractic care
- Routine eye examination
- Urgent Care services

9. How Your Out-of-Network Coverage Works

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

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

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

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

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

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.

F. MEMBER COST SHARING

You are required to share the cost of Covered Benefits provided under the Plan. Your Member Cost Sharing may include Copayments, Coinsurance and Deductibles when using Plan Providers or Non-Plan Providers. The In-Network and Out-of-Network Member Cost Sharing is listed in your Schedule of Benefits.

1. In-Network Member Cost Sharing

You are required to share the cost of Covered Benefits provided under your Plan. Your In-Network Member Cost Sharing for medical coverage and mental health and substance use disorder treatment.

Please Note: There are certain specialized services that must be received at designated Plan Providers, called "Centers of Excellence" to receive In-Network coverage. Please see section *I.E.5. Centers of Excellence* for further information.

i. Copayments

A Copayment is a fixed dollar amount that you must pay for certain Covered Benefits. Copayments are due at the time of service or when billed by the Provider. The Copayment amounts that apply to your Plan are listed in your Schedule of Benefits.

Your Plan has three levels of Copayments that apply to office visits and hospitals (Tier 1, Tier 2, and Tier 3). Your Copayment will vary depending upon which Plan Provider you see.

a. Inpatient Hospital Copayment

There is a maximum of one Inpatient Hospital Copayment per Member during each Quarter in a Plan Year, waived if you are readmitted within 30 days in the same Plan Year. The Inpatient Hospital Copayment amounts that apply to your Plan are listed in your Schedule of Benefits.

b. Surgical Day Care Copayment

The Surgical Day Care Copayment amount that applies to your Plan is listed in your Schedule of Benefits. There is a maximum of one Copayment per visit up to a maximum of four Copayments per Member per Plan Year.

c. Emergency Room Copayment
The emergency room Copayment amount that applies to your Plan is stated in your Schedule of Benefits. The Copayment is waived if you are admitted directly to the Hospital from the emergency room, in which case you are responsible for the Inpatient Hospital Copayment. Please see Inpatient Hospital Copayment above for more information.

d. Advanced Radiology Copayment
The advanced radiology Copayment amount that applies to your Plan is stated in your Schedule of Benefits. These services include, CT Scans, MRAs, MRIs, PET Scans and nuclear medicine services. There is a maximum of one Copayment per Member per day.

ii. In-Network Deductible
A Deductible is a specific dollar amount that is payable by the Member for Covered Benefits each Plan Year before certain Covered Benefits are available under this Plan. Your Deductible limits, and the services to which they apply, are listed in your Schedule of Benefits.

When you use a Plan Provider, you must first satisfy the Deductible before the Plan begins paying Covered Benefits for certain In-Network services. Each Member enrolled in Individual Coverage must satisfy the per-Member annual In-Network Deductible amount each Plan Year. When Members are enrolled in Family Coverage, the Family Deductible is met once any combination of Members has paid the total Family Deductible amount; no family Member will pay more than the per-Member annual Deductible.

iii. Coinsurance
Coinsurance is a percentage of the Allowed Amount for certain Covered Benefits that must be paid by the Member. Coinsurance amounts, and the services to which they apply, are listed in the Schedule of Benefits.

iv. In-Network Out-of-Pocket Maximum
The In-Network Out-of-Pocket Maximum is the total amount of In-Network Copayments, Coinsurance and Deductibles a Member or family pays in a year. Your In-Network Out-of-Pocket Maximum limits are listed in your Schedule of Benefits.

2. Out-of-Network Member Cost Sharing

i. Deductibles
Your Out-of-Network Deductible limits, and the services to which they apply, are listed in your Schedule of Benefits.

The Out-of-Network Deductible for medical and mental health and substance use disorder treatment accumulates separately from the In-Network Deductible for medical care.

ii. Copayments
The emergency room Copayment amount that applies to your Plan is stated in your Schedule of Benefits. The emergency room Copayment is waived, but the Member owes the Inpatient Hospital Copayment in the event of an emergency admission, unless the Member has already had an inpatient admission in the same Quarter of a given Plan Year or has been admitted within the last 30 days in the same Plan Year.

iii. Coinsurance
Coinsurance is a percentage of the Allowed Amount for certain Covered Benefits that must be paid by the Member. Coinsurance amounts, and the services to which they apply, are listed in the Schedule of Benefits.

iv. Penalty
A Penalty is applied to any Covered Benefit that requires Prior Approval and is not received, as described in section *I.G. PRIOR APPROVAL*.

v. Out-of-Pocket Maximum
Your Out-of-Network Out-of-Pocket Maximum limits, and the services to which they apply, are listed in your Schedule of Benefits.

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

3. Combined Payment Levels
Under some circumstances, you may receive services from both a Plan Provider and a Non-Plan Provider when receiving care. When this occurs, your entitlement to In-Network or Out-of-Network coverage always depends upon the participation status of the individual 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.

G. 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 *J. 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 services 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:

- **Some elective 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 (fixed wing and ground)**
  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 and the extraction of teeth impacted in bone. (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 any questions regarding services that require Prior Approval, please contact Member Services 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 will be requested:

- The Member's name
- The Member's ID number
- The treating Provider'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 admissions 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 Provider'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 only receive coverage for services later determined to be Medically Necessary and be responsible for any applicable Member Cost Sharing. For services received from a Non-Plan Provider, you will 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 benefits not otherwise payable under this Benefit Handbook or the Schedule of Benefits.

Please see section *J. UTILIZATION REVIEW PROCEDURES* for information on the time limits for Prior Approval decisions and reconsideration procedures for Providers if coverage is denied. Please see Section *VII. 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 services 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.

H. SERVICES PROVIDED BY A DISENROLLED NON-PLAN PROVIDER

1. Disenrollment of Primary Care Provider (PCP)

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

2. Pregnancy

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

3. Terminal Illness

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

4. New Membership

If you are a new Member, the Plan will provide In-Network coverage for services delivered by a

physician who is not a Plan Provider, under the terms of this Benefit 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 is a Non-Plan Provider, and
- The physician is providing you with an ongoing course of treatment or is your PCP.

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

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

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

- Accept reimbursement from the Plan at the rates applicable prior to notice of disenrollment as payment in full and not to impose Member Cost Sharing with respect to the Member in an amount that would exceed the Member Cost Sharing that could have been imposed if the Provider had not been disenrolled;
- Adhere to the quality assurance standards of HPHC and to provide the Plan with necessary medical information related to the care provided; and
- Adhere to our policies and procedures, obtaining Prior Plan Approval and providing Covered Benefits pursuant to a treatment plan, if any, approved by us.

I. 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**.

J. 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 listed as a Covered Benefit in 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 PCPs to provide both an answering service that can be contacted 24-hours a day and prompt appointments when Medically Necessary.

II. Glossary

This section lists words with special meaning within the Handbook.

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

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

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

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

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

a. If you receive Out-of-Network services in the states of Massachusetts, New Hampshire, Maine, Rhode Island, 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:

   The Allowed Amount is an amount that is consistent, in the judgment of the Plan, with the normal range of charges by health care Providers for the same, or similar, products or services provided to a Member. If the Plan has appropriate data for the area, the Plan will determine the normal range of charges in the geographic area where the product or services were provided to the Member. If the Plan does not have data to reasonably determine the normal range of charges where the products or services were provided, the Plan will utilize the normal range of charges in Boston, Massachusetts. Where services are provided by non-physicians but the data on 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 from a Provider located outside of the Service Area (the states 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 and substance use disorder treatment 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 the GIC upon which the yearly benefit changes normally become effective. This Benefit Handbook and Schedule of Benefits will terminate unless renewed on the Anniversary Date.

Behavioral Health Access Center The organization designated by HPHC that is responsible for arranging for the provision of services for Members in need of mental health and substance use disorders treatment. You may call 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, which 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 for physical therapy services, once you reach your 30 visit limit for that Plan Year, no additional benefits for that service will be covered by the Plan.

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 applicable to your Plan are stated in the Schedule of Benefits.

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

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

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

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

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

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

Deductible A specific dollar amount that is payable by the Member for Covered Benefits received each Plan Year before any benefits subject to the Deductible are payable by the Plan. When 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 in a Plan Year. Deductible amounts are incurred on the date of service. The Deductible amounts that apply to your Plan are 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.

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 (other than the Subscriber) covered under the Subscriber's Family Coverage who meets the eligibility requirements for coverage through a Subscriber as determined by the GIC.

Experimental, Unproven, or Investigational Any product 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 and Schedule of Benefits, for use in the diagnosis or treatment of a particular medical condition if any of 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 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 establish 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 Subscriber and one or more Dependents.

(The) Group Insurance Commission or GIC The state agency that has contracted with HPHC to provide health care services and supplies for the employees, retirees and their Dependents it covers under the Plan. The GIC is the Plan Sponsor and insures the health care coverage.

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

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

Health Benefit Plans A group HMO and other group prepaid health plan, medical or hospital service corporation plan, commercial health insurance and self-insured health plan, which is separate from this Plan.

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

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.

Inpatient Hospital Copayment A Copayment payable for inpatient care. Please refer to the Schedule of Benefits to determine what Covered Benefits are subject to the Inpatient Hospital Copayment.

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

Medical Drugs A prescription drug that is administered to you either (1) in a doctor's office or other outpatient medical facility, or (2) at home while you are receiving home health care services or receiving drugs administered by home infusion services. Medical Drugs cannot be self-administered. The words "cannot be self-administered" mean that the active participation of skilled medical personnel is always required to take the drug. When a Member is receiving drugs in the home, the words "cannot be self-administered" will also include circumstances in which a family member or friend is trained to administer the drug and ongoing supervision by skilled medical personnel is required.

Medical Emergency A medical condition, whether physical or mental(including a condition resulting from a substance use disorder), manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the Member or another person in serious jeopardy, serious impairment to body function, or 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.

Examples of mental health emergencies are: suicidal or homicidal or intention, and the inability to care for oneself because of intoxication or psychotic ideas.

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

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

Member Any Subscriber or Dependent covered under the Plan.

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

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

Non-Plan Provider Providers who do not have an agreement to render services to Members. Your Out-of-Pocket costs are generally higher when you use Non-Plan Providers. In addition, the Plan's coverage for services by Non-Plan Providers is limited to the Allowed Amount.

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

✔ FOR EXAMPLE: If a Non-Participating Provider charges $1,000 for an office visit and the Allowed Amount is $800, your cost sharing will be calculated as follows: you will first be responsible for paying your $400 Out- of- Network Deductible. You will then be responsible for paying $80, which is 20% Coinsurance on the remaining Allowed Amount. HPHC will pay the remaining $320 of the Allowed Amount. Please note: You may be billed the difference between the Provider's charged amount and the amount HPHC allows for the service (in this example, an additional $200).

Out-of-Pocket Maximum An Out-of-Pocket Maximum is a limit on the amount of Member Cost Sharing (Copayments, Coinsurance and Deductibles) that a Member must pay for certain Covered Benefits in a Plan Year. Member Cost Sharing for some services may be excluded from the Out-of-Pocket Maximum. In addition, Penalty amounts and charges above the Allowed Amount never apply to the Out-of-Pocket Maximum. Your Schedule of Benefits will list the services that do not apply to the Out-of-Pocket Maximum. In some instances, a family Out-of-Pocket Maximum applies. Once a family Out-of-Pocket Maximum has been met in a year, the Out-of-Pocket Maximum is deemed to have been met by all Members in a family for the remainder of the year.

✔ FOR EXAMPLE: If your Plan has an individual Out-of-Pocket Maximum of $1,000, this is the most Member Cost Sharing you would pay in a Plan Year for services to which the Out-of-Pocket Maximum applies. For example, as long as the services you received are not excluded from the Out-of-Pocket Maximum, you could combine $500 in Deductible expenses, $100 in Copayments, and $400 in Coinsurance payments to reach the $1,000 Out-of-Pocket Maximum.

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

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 (Independence Plan) This package of health care benefits known as The Harvard Pilgrim Independence Plan, that is administered by HPHC on behalf of the GIC. For In-Network coverage under this Plan, Covered Benefits must be obtained from Plan Providers.

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 Independence Plan Provider Directory.

Plan Sponsor The GIC is the Plan Sponsor of this Plan. The GIC has contracted with HPHC to provide health care services and supplies for its employees and their Dependents under the Plan. The GIC pays for the health care coverage provided under the Plan.

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. The Plan Year begins on the Plan's Anniversary Date. Benefits under your Plan are administered on a Plan Year basis.

Primary Care Provider (PCP) A Plan Provider designated to help you maintain your health and to provide and authorize your medical care under the Plan. A PCP may be a physician, a physician assistant or a nurse practitioner specializing in one or more of the following specialties: internal medicine, adult medicine, adolescent medicine, geriatric medicine, pediatrics or family practice. A PCP may designate other Plan Providers to provide or authorize a Member's care.

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

Please see section*I.G. 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 care), nurse midwives, nurse anesthetists, chiropractors, 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. Plan Providers are listed in the Independence Plan Provider Directory.

Quarter One fourth of a Plan Year; the three consecutive months beginning July 1st, October 1st, January 1st, and April 1st.

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.

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

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

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

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

Skilled Nursing Facility An inpatient extended care facility, or part of one, that is operating pursuant to law and provides skilled nursing services.

Subscriber The person who meets the Subscriber eligibility requirements described in this Benefit Handbook as define by the GIC.

Surgical Day Care Copayment A Copayment that is applicable to Surgical Day Care services. The Surgical Day Care Copayment is indicated in the Schedule of Benefits.

Surgical Day Care 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.

Tier 1 Copayment (Tier 1) A lower Copayment amount that applies to certain services and Plan Providers.

Please see the Schedule of Benefits for detailed information on when a Tier 1 Copayment applies.

Tier 2 Copayment (Tier 2) A mid-range Copayment amount that applies to certain services and Plan Providers. Please see the Schedule of Benefits for detailed information on when a Tier 2 Copayment applies.

Tier 3 Copayment (Tier 3) The highest Copayment amount that applies to certain Plan Providers. Please see the Schedule of Benefits for detailed information on when a Tier 3 Copayment applies.

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

III. Covered Benefits

This section contains detailed information on the benefits covered under your Plan. Member Cost Sharing information and any applicable Benefit Limits that apply to your Plan are listed in your Schedule of Benefits.

You have one set of Covered Benefits per Plan Year. If the Covered Benefit has limits, you are restricted to those limits regardless of whether you receive care In-Network, Out-of-Network or both. For example, if the Covered Benefit is limited to ten visits and you receive nine visits In-Network and one visit Out-of-Network, then you will have reached your Benefit Limit and will no longer have coverage for that benefit for the remainder of that Plan Year.

Basic Requirements for Coverage

All Services

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

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

In-Network Coverage

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

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

Out-of-Network Coverage

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

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

Benefit	Description
1 . Ambulance Transport	
	Emergency Ambulance Transport If you have a Medical Emergency, (including an emergency related to a substance use disorder or mental health condition), your Plan covers ambulance transport, including ground and/or air transportation, to the nearest hospital that can provide you with Medically Necessary care. **Non-Emergency Ambulance Transport** You are also covered for non-emergency ambulance ground transport between hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary. For In-Network coverage, services must be arranged by Plan Provider.

Benefit	Description
Ambulance Transport (Continued)	
	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.G. PRIOR APPROVAL* for more information.
2 . Autism Spectrum Disorders Treatment	
	Coverage is provided for the diagnosis and treatment of Autism Spectrum Disorders, as defined below. Covered Benefits include the following: • Diagnosis of Autism Spectrum Disorders. This includes Medically Necessary assessments, evaluations, including neuropsychological evaluations, genetic testing or other tests to diagnose whether an individual has one of the Autism Spectrum Disorders. • Professional services by 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. Autism Spectrum Disorders include any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. These include Autistic Disorder; Asperger's Disorder; and Pervasive Developmental Disorders Not Otherwise Specified. Applied behavior analysis is defined as the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior. It includes the use of direct observation, measurement and functional analysis of the relationship between environment and behavior. There is no coverage for services related to autism spectrum disorders provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor.
3 . Cardiac Rehabilitation Therapy	
	The Plan covers cardiac rehabilitation. Coverage includes only Medically Necessary services for Members with established coronary artery disease or unusual and serious risk factors for such disease.
4 . Chemotherapy and Radiation Therapy	
	The Plan covers outpatient chemotherapy administration and radiation therapy at a hospital or other outpatient medical facility. Covered Benefits include the facility charge, the charge for related supplies and equipment, and physician services for anesthesiologists, pathologists and radiologists. **Prior Approval Required:** You must obtain Prior Approval for radiation oncology. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section for more information.
5 . Chiropractic Care	
	The Plan covers musculoskeletal adjustment or manipulation up to the Benefit Limit listed in the Schedule of Benefits.

Benefit	Description
6 . Clinical Trials for the Treatment of Cancer or Other Life-Threatening Diseases	
	The Plan covers services for Members enrolled in a qualified clinical trial studying potential treatment(s) for any form of cancer or other life-threatening disease under the terms and conditions provided for under federal law. Covered Benefits include items and services provided when you are enrolled in a qualified clinical trial consistent with your diagnosis and the study protocol. Coverage is subject to all of the requirements of the Plan, including Medical Necessity review, use of participating Providers, Prior Approval requirements, and Provider payment methods. 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 qualified clinical trial to the extent it is not paid for by its manufacturer, distributor, or Provider.
7 . Dental Services	
	Important Note: The Plan does not provide dental insurance. It covers only the limited dental services described below. No other Dental Care is covered. The benefits described in sections a – d below are provided only when the Member has a serious medical condition, including but not limited to, hemophilia or heart disease, that makes it essential that he or she be admitted to a general Hospital as an inpatient or to a Surgical Day Care unit or ambulatory surgical facility as an outpatient in order for the Dental Care to be performed safely. **a. Extraction of Impacted Teeth** The Plan covers the extraction of teeth impacted in bone. Only the following services are covered: • Pre-operative and post-operative care, immediately following the procedure • Anesthesia • X-rays **b. Extraction of Seven or More Teeth** The Plan covers the extraction of seven or more sound natural teeth. **c. Removal of Tumors or Cysts** The Plan covers the excision of radicular cysts involving the roots of three or more teeth. **d. Gingivectomies of Two or More Gum Quadrants** The Plan covers gingivectomies (including osseous surgery) of two or more gum quadrants.

Benefit	Description
Dental Services (Continued)	
	e. Emergency Dental Care The Plan covers emergency Dental Care needed due to an injury to sound, natural teeth. All services, except for suture removal, must be received within three days of injury. Only the following services are covered: • Initial first aid (trauma care) • Reduction of swelling • Pain relief • Covered non-dental surgery • Non-dental diagnostic x-rays • Extraction of the teeth damaged in the injury when needed to avoid infection • Suturing and suture removal • Reimplantion and stabilization of dislodged teeth • Repositioning and stabilization of partly dislodged teeth • Medication received from the Provider **f. Oral Surgery Procedures** The Plan covers oral surgical procedures for non-dental medical treatment, such as the reduction of a dislocated or fractured jaw or facial bone, and removal of benign or malignant tumors, to the same extent as other surgical procedures described in this Benefit Handbook. **g. Cleft Lip or Cleft Palate Care for Children** 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 the section titled *Reconstructive Surgery*. **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 for more information.
8 . Diabetes Services and Supplies	
	Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care: The Plan covers outpatient self-management education and training for the treatment of diabetes, including medical nutrition therapy services, used to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes. Services must be provided on an individual basis. Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care. The following items are also covered: **Diabetes Equipment:** • Blood glucose monitors

Benefit	Description
Diabetes Services and Supplies (Continued)	
	• Continuous glucose monitoring systems • Dosage gauges • Injectors • Insulin pumps (including supplies) and infusion devices • Lancet devices • Therapeutic molded shoes and inserts • Visual magnifying aids • Voice synthesizers Diabetes equipment including needles and syringes for the administration of insulin are covered by this Plan. Insulin (other than insulin administered with an insulin pump) and other pharmacy supplies are covered under your outpatient prescription drug coverage, which is not administered by HPHC. Please see your **Express Scripts Prescription Drug Plan brochure** or call **Express Scripts** at **1-855–283–7679** for information on coverage of outpatient prescription drugs. **Prior Approval Required:** You must obtain Prior Approval for insulin pumps and continuous glucose monitoring systems. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.G. PRIOR APPROVAL* for more information.
9 . Dialysis	
	The Plan covers dialysis on an inpatient, outpatient or at home basis. When federal law permits Medicare to be the primary payer, you must apply for Medicare and also pay any Medicare premium. When Medicare is primary (or would be primary if the Member were timely enrolled), the Plan will only cover those costs that exceed what would be payable by Medicare. Coverage for dialysis in the home includes non-durable medical supplies and drugs and equipment necessary for dialysis. **Prior Approval Required:** You must notify HPHC in advance of any planned inpatient admission to a Non-Plan Medical Facility. Also, Prior Approval is required for any services provided in the home. If you use a Plan Provider located within the Service Area, he/she will notify HPHC of your inpatient admission or seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414.** Please see section *I.G. PRIOR APPROVAL* for more information.
10 . Drug Coverage	
	You have limited coverage for drugs received during inpatient and outpatient treatmentunder this Benefit Handbook. This coverage is described in Subsection 1, below. **1) Your Coverage under this Benefit Handbook** This Benefit Handbook covers the following: 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. b. Drugs Received During Outpatient or Home Care. These drugs are known as "Medical Drugs." A Medical Drug is administered to you either (1) in a doctor's office or other outpatient medical facility, or (2) at home while

Benefit	Description
Drug Coverage (Continued)	
	you are receiving home 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. 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. c. Drugs and Supplies. Coverage is provided for certain diabetes equipment and supplies. Please see the benefits for "Diabetes Services and Supplies" for the details of those benefits. No coverage is provided under this Benefit Handbook for: (1) drugs that have not been approved by the United States Food and Drug Administration; (2) drugs the Plan excludes or limits, including, but not limited to, drugs for cosmetic purposes or weight loss; and (3) any drug that is obtained at an outpatient pharmacy except covered diabetes equipment and supplies, as explained above. **Prior Approval Required:** You must obtain Prior Approval for select Medical Drugs. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-844-387-1435**. Please see section *I.G. PRIOR APPROVAL* for more information. **2) Express Scripts Prescription Drug Coverage** In addition to the coverage provided under this Benefit Handbook, you also have outpatient prescription drug coverage. Your outpatient prescription drug coverage is not administered by HPHC. Please see your **Express Scripts Prescription Drug Plan brochure** or call **Express Scripts** at **1-855–283–7679** for information on coverage of outpatient prescription drugs. Regardless of whether the Express Scripts brochure is specifically noted in a handbook section, any reference to outpatient drugs found within this handbook is governed by the Express Scripts Prescription Drug Plan brochure.
11 . Durable Medical Equipment (DME)	
	The Plan covers DME when Medically Necessary and ordered by a Provider. The Plan will rent or buy all equipment. The cost of the repair and maintenance of covered equipment is also covered. In order to be covered, all equipment must be: • Able to withstand repeated use • Not generally useful in the absence of disease or injury • Normally used in the treatment of an illness or injury or for the rehabilitation of an abnormal body part • Suitable for home use Coverage is only available for: • The least costly equipment adequate to allow you to perform Activities of Daily Living;

Benefit	Description
Durable Medical Equipment (DME) (Continued)	
	• One item of each type of equipment. No back-up items or items that serve duplicate purposes are covered. For example, the Plan covers a manual or an electric wheelchair, not both. Covered equipment and supplies includes: • Canes • Certain types of braces • Crutches • Hospital beds • Oxygen and oxygen equipment • Respiratory equipment • Walkers • Wheelchairs Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan.
12 . Early Intervention Services	
	The Plan covers early intervention services provided for Members until three years of age. Covered Benefits include: • Nursing care • Physical, speech, and occupational therapy • Psychological counseling • Screening and assessment of the need for services
13 . Emergency Room Care	
	If you have Medical Emergency, you are covered for care in a Hospital emergency room. Please remember the following: • If you need follow-up care after you are treated in an emergency room, you should call your PCP. To be eligible for In-Network coverage, you must obtain Covered Benefits from a Plan Provider. • If you are hospitalized, you must call HPHC at **1-888-333-4742** within 48 hours or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to HPHC by an attending emergency physician, no further notice is required.
14 . Family Planning Services	
	The Plan covers family planning services, including the following: • Annual gynecological examination • Contraceptive monitoring • Family planning consultation • FDA approved birth control implants. devices or Medical Drugs. • Genetic counseling • Pregnancy testing • Professional services relating to the injection of birth control drugs and the insertion or removal of birth control implants or devices. However, birth control drugs, implants or devices that must be obtained at an outpatient pharmacy are covered under your Express Scripts prescription drug coverage.

Benefit	Description
15 . Hearing Aids	
	The Plan covers hearing aids up to the limit listed in your Schedule of Benefits. A hearing aid is defined as any instrument or device, excluding a surgical implant, designed, intended or offered for the purpose of improving a person's hearing. The Plan will pay the cost of each Medically Necessary hearing aid up to the limit listed in your Schedule of Benefits, minus any applicable cost sharing. If you purchase a hearing aid that is more expensive than the limit listed in your Schedule of Benefits, you will be responsible for the additional cost. No back-up hearing aids that serve a duplicate purpose are covered. Covered services and supplies related to your hearing aid are not subject to the dollar limit listed in your Schedule of Benefits. Covered Benefits include the following: • One hearing aid per hearing impaired ear; • Except for batteries, any necessary parts, attachments or accessories, including ear moldings; and • Services provided by a licensed audiologist, hearing instrument specialist or licensed physician that are necessary to assess, select, fit, adjust or service the hearing aid. **Prior Approval Required:** You must obtain Prior Approval for cochlear implants. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section for more information.
16 . Home Health Care	
	If you are homebound for medical reasons, you are covered for the home health care services listed below. To be eligible for home health care, your Provider must determine that skilled nursing care or physical therapy is an essential part of active treatment. There must also be a defined medical goal that your Provider expects you will meet in a reasonable period of time. When you qualify for home health care services as stated above, the Plan covers the following services when Medically Necessary: • Durable medical equipment and supplies (must be a component of the home health care being provided) • Medical and surgical supplies • Medical social services • Nutritional counseling • Physical therapy • Occupational therapy • Services of a home health aide • Skilled nursing care • Speech therapy **Prior Approval Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414.** Please see section *I.G. PRIOR APPROVAL* for more information.

Benefit	Description
17 . Hospice Services	
	The Plan covers hospice services for a terminally ill Member who needs 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. Inpatient care is only covered when Medically Necessary to control pain and manage acute and severe clinical problems which cannot be managed in a home setting. Covered Benefits include: • Care to relieve pain • Counseling • Drugs that cannot be self-administered • Durable medical equipment appliances • Home health aide services • Medical supplies • Nursing care • Physician services • Occupational therapy • Physical therapy • Speech therapy • Respiratory therapy • Respite care • Social services **Prior Approval Required:** You must obtain Prior Approval for home hospice care. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414.** Please see section *I.G. PRIOR APPROVAL* for more information.
18 . Hospital — Inpatient Care	
	The Plan covers acute hospital care including, but not limited to, the following inpatient services: • Semi-private room and board • Doctor visits, including consultation with specialists • Medications • Laboratory, radiology and other diagnostic services • Intensive care • Surgery, including related services • Anesthesia, including the services of a nurse-anesthetist • Radiation therapy • Physical therapy • Occupational therapy • Speech therapy There are certain specialized services for which you will be directed to a Center of Excellence for care. See section *I.E.5. Centers of Excellence* for more information. **Prior Approval Required:** You must obtain Prior Approval for any planned inpatient admission. If you use a Plan Provider located within the Service Area,

Benefit	Description
Hospital — Inpatient Care (Continued)	
	he/she will notify HPHC for you. The notification process is initiated by calling: **1-800-708-4414**. Please see section *I.G. PRIOR APPROVAL* more information.
19 . House Calls	
	The Plan covers house calls from a licensed physician to the extent they are Medically Necessary.
20 . Human Organ Transplant Services	
	The Plan covers human organ transplants, including bone marrow transplants for a Member with metastasized breast cancer in accordance with the criteria of the Massachusetts Department of Public Health. The Plan covers human organ transplants, including bone marrow transplants for a Member with metastasized breast cancer in accordance with the criteria of the Massachusetts Department of Public Health. The Plan covers the following services when the recipient is a Member of the Plan: • Care for the recipient • Donor search costs through established organ donor registries • Donor costs that are not covered by the donor's health plan If a Member is a donor for a recipient who is not a Member, then the Plan will cover the donor costs for the Member, when they are not covered by the recipient's health plan.
21 . Infertility Services and Treatment	

	Infertility is defined as the inability of a woman age 35 or younger to conceive or produce conception during a period of one year. In the case of a woman over age 35, the time period is reduced to 6 months. If a woman conceives but is unable to carry the pregnancy to live birth, the time she attempted to conceive prior to that pregnancy is included in the one year or 6 month period, as applicable.
	The Plan covers the following diagnostic services for infertility:
	• Consultation
	• Evaluation
	• Laboratory tests
	When a Member meets Medical Necessity criteria, the Plan covers the following infertility treatment:
	• Therapeutic donor insemination, including related sperm procurement and banking
	• Advanced reproductive technologies:
	  • Donor egg procedures, including related egg and inseminated egg procurement, processing and banking
	  • Assisted hatching
	  • Gamete intrafallopian transfer (GIFT)
	  • Intra-cytoplasmic sperm injection (ICSI)
	  • Intra-uterine insemination (IUI)
	  • In-vitro fertilization (IVF)
	  • Zygote intrafallopian transfer (ZIFT)

Benefit	Description
Infertility Services and Treatment (Continued)	
	• Preimplantation genetic diagnosis (PGD) • Miscrosurgical epididiymal sperm aspiration (MESA) • Testicular sperm extraction (TESE) • Sperm collection, freezing and up to one year of storage is also covered for male Members in active infertility treatment. **Important Note:** 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.** **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.G. PRIOR APPROVAL* for more information.
22 . Laboratory, Radiology and Other Diagnostic Services	
	The Plan covers laboratory, 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: • The facility charge and the charge for supplies and equipment • The charges of anesthesiologists, pathologists and radiologists In addition, the Plan covers the following: • Human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish bone marrow transplant donor suitability (including testing for A, B, or DR antigens, or any combination, consistent with rules, regulations and criteria established by the Massachusetts Department of Public Health). • Diagnostic screenings and tests including: hereditary and metabolic screening at birth; tuberculin tests; lead screenings; hematocrit, hemoglobin or other appropriate blood tests, and urinalysis. • Screening and diagnostic mammograms. **Please Note:** No In-Network Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice at: **www.harvardpilgrim.org/GIC**. **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.G. PRIOR APPROVAL* for more information.
23 . Low Protein Foods	
	The Plan covers food products modified to be low-protein ordered for the treatment of inherited diseases of amino acids and organic acid up to the limit stated in your Schedule of Benefits.

Benefit	Description
24 . Maternity Care	

	The Plan covers the following maternity services:
	• Routine outpatient prenatal care, including evaluation and progress screening, physical exams, recording of weight and blood pressure monitoring
	• Prenatal genetic testing
	• 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 *VIII. Eligibility* for more enrollment information.
	• Routine outpatient postpartum care for the mother, up to six weeks after delivery
	• Non-routine prenatal and post-partum care, including, but not limited to:
	  • Administration and supply of immune globulin, RhoGAM
	  • Amniocentesis
	  • Nuchal translucency ultrasound when performed separately from a standard obstetrical ultrasound
	• Non-routine nursery charges for a newborn (covered as a separate inpatient stay)
	Please Note: No In-Network Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice at: **www.harvardpilgrim.org/GIC**.
	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. Please see section *I.G. PRIOR APPROVAL* for more information.

25 . Medical Formulas	
	The Plan covers the following up to the limit stated in your Schedule of Benefits: • Non-prescription enteral formulas for home use for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction and inherited diseases of amino acids and organic acids. • Prescription formulas for the treatment of phenylketonuria, tyrosinemia, homocystrinuria, maple syrup urine disease, propionic acidemia or methylmalonic acidemia in infants and children or to protect the unborn fetuses of pregnant women with phenylketonuria. **Prior Approval Required:** You must obtain Prior Approval for outpatient formulas and enteral nutrition. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.G. PRIOR APPROVAL* for more information.

Benefit	Description
26 . Mental Health and Substance Use Disorder Treatment	
	For In-Network coverage of mental health and substance use disorder treatment, you should obtain care from a Plan Provider. The exceptions to this rule are listed in Section *I.E.4. Using Plan Providers*. To locate a Plan Provider, you may call the Behavioral Health Access Center at **1-888-777-4742**. The Behavioral Health Access Center phone line is staffed by licensed mental health clinicians. A clinician will assist you in finding an appropriate Plan Provider and arranging the services you require. You must obtain Prior Approval for Out-of-Network coverage of certain mental health treatment, and substance use disorder treatment (except Acute Treatment Services and Clinical Stabilization Services) from a Provider not certified or licensed by the Massachusetts Department of Public Health. To obtain Prior Approval you should call the Behavioral Health Access Center at **1-888-777-4742**. **Please Note:** Prior Approval is not required to obtain Acute Treatment Services or Clinical Stabilization Services from either a Plan Provider or a Non-Plan Provider. For more information on utilizing Non-Plan Providers, please refer to your Out-of-Network benefits. The terms "Acute Treatment Services" and "Clinical Stabilization Services" are defined in the Glossary at Section II of this Benefit Handbook. Services beyond the 14 day period may be subject to concurrent review as described in section *J. UTILIZATION REVIEW PROCEDURES*. of this Handbook. The following is a list of the mental health services that 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 –** Outpatient visits of more than 50 minutes duration with or without medication management. Also included is any treatment routinely involving more than one outpatient visit in a day. • **Applied Behavioral Analysis (ABA) for the treatment of Autism** 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 staffed by licensed mental health clinicians. A clinician will assist you in finding an appropriate Provider and arranging the services you require. In a Medical Emergency you should go to the nearest emergency facility or call 911 or your local emergency number. You do not need to use a Plan Provider or call the Behavioral Health Access Center. 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

Benefit	Description
Mental Health and Substance Use Disorder Treatment (Continued)	
	Necessity for mental health care will be made in consultation with a Licensed Mental Health Professional. **Minimum Requirements for Covered Providers** To be eligible for coverage under this benefit, all services must be provided either (1) at the office of a Licensed Mental Health Professional, or (2) at a facility licensed or approved by the health department or mental health department of the state in which the service is provided. (In Massachusetts, those departments are the Department of Public Health and the Department of Mental Health, respectively.) To qualify, a facility must be both licensed as, and function primarily as, a health or mental health care facility. A facility that is also licensed as an educational or recreational institution will not meet this requirement unless the predominate purpose of the facility is the provision of mental health care services. To qualify for coverage, all services rendered outside of a state licensed or approved facility must be provided by an independently Licensed Mental Health Professional. For services provided in Massachusetts, a Licensed Mental Health Professional must be one of the following types of Providers: a licensed physician who specializes in the practice of psychiatry; a licensed psychologist; a licensed independent clinical social worker; a licensed nurse mental health clinical specialist; a licensed marriage and family therapist; a licensed mental health counselor or a level I licensed alcohol and drug counselor. For services provided outside of Massachusetts, a Licensed Mental Health Professional is an independently licensed clinician with at least a Masters degree in a clinical mental health discipline from an accredited educational institution and at least two years of clinical experience. The term "clinical mental health discipline" includes the following: psychiatry; psychology; clinical social work; marriage and family therapy; clinical counseling; developmental psychology; pastoral counseling; psychiatric nursing; developmental or educational psychology; counselor education; or any other discipline deemed acceptable by the Plan. **Benefits** The Plan will provide coverage for the care of all conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. (The only exception is conditions for which only a "Z Code" designation applies, which means that the condition is not attributable to a mental disorder.) Please refer to your Schedule of Benefits as it lists the Member Cost Sharing that applies to the coverage of these services. Covered mental health and substance use disorder treatment services include the following: a) **Mental Health and Substance Use Disorder Treatment** Subject to the Member cost sharing stated in your Schedule of Benefits, the Plan provides coverage for the following Medically Necessary mental health care services: 1) **Inpatient Services** • Hospitalization, including detoxification 2) **Intermediate Care Services** • Acute residential treatment, including detoxification (long-term residential treatment is not covered), crisis stabilization, and in-home family stabilization • Intensive outpatient programs, partial hospitalization and day treatment programs for mental health and substance use disorder

Benefit	Description
Mental Health and Substance Use Disorder Treatment (Continued)	
	treatment, 24-hour intermediate care facilities, and therapeutic foster care 3) **Outpatient Services** • Care by a Licensed Mental Health Professional • Detoxification • Medication management • Methadone maintenance • Psychological testing and neuropsychological assessment.
27 . Observation Services	
	The Plan covers observation services including short term treatment, assessment and reassessment for up to 48 hours in a 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.
28 . Ostomy Supplies	
	The Plan covers ostomy supplies up to the Benefit Limit listed in the Schedule of Benefits. Only the following supplies are covered: • Irrigation sleeves, bags and catheters • Pouches, face plates and belts • Skin barriers
29 . Physician and Other Professional Office Visits	

	Physician services, including services of all covered medical professionals, can be obtained on an outpatient basis in a physician's office or a hospital. These services may include:
	• Routine physical examinations, including routine gynecological examination and annual cytological screenings
	• Follow-up care provided by an obstetrician or gynecologist for obstetrical or gynecological conditions identified during maternity care or an annual gynecological visit
	• Immunizations, including childhood immunizations as recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention and the American Academy of Pediatrics
	• Well baby and well child care, including physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and developmental screening, and assessment at the following intervals:
	  • At least six visits per Plan Year are covered for a child from birth to age one.
	  • At least three visits per Plan Year are covered for a child from age one to age two.
	  • At least one visit per Plan Year is covered for a child from age two to age six
	• School, camp, sports and premarital examinations
	• Health education and nutritional counseling
	• Sickness and injury care
	• Allergy testing, antigens and treatments
	• Vision and Hearing screenings

Benefit	Description
Physician and Other Professional Office Visits (Continued)	
	• Medication management • Consultations concerning contraception and hormone replacement therapy • Chemotherapy • Radiation therapy • Diagnostic screenings and tests (including EKGs) **Please Note:** No In-Network Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice at: **www.harvardpilgrim.org/GIC**.
30 . Prosthetic Devices	
	The Plan covers prosthetic devices as described below. In order to be covered, all devices must be able to withstand repeated use. Coverage is only available for: • The least costly prosthetic device adequate to allow you to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports. and; • One item of each type of prosthetic device. No back-up items or items that serve a duplicate purpose are covered. Covered prostheses include: • Breast prostheses, including replacements and mastectomy bras • Prosthetic arms and legs (including myoelectric and bionic arms and legs) • Prosthetic eyes Any Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan. **Prior Approval Required:** You must obtain Prior Approval for 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.G. PRIOR APPROVAL*for more information.
31 . Reconstructive Surgery	
	The Plan covers reconstructive and restorative surgical procedures as follows: • Reconstructive surgery is covered when the surgery can reasonably be expected to improve or correct a Physical Functional Impairment resulting from an accidental injury, illness, congenital anomaly, birth injury or prior surgical procedure. If reconstructive surgery is performed to improve or correct a Physical Functional Impairment, as stated above, Cosmetic Services that are incidental to that surgery are also covered. After a Physical Functional Impairment is corrected, no further Cosmetic Services are covered by the Plan. • Restorative surgery is covered to repair or restore appearance damaged by an accidental injury. (For example, this benefit would cover repair of a facial deformity following an automobile accident.) Benefits are also provided for the following: • Post mastectomy care, including coverage for:

Benefit	Description
Reconstructive Surgery (Continued)	
	– Prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient; – Reconstruction of the breast on which the mastectomy was performed; and – Surgery and reconstruction of the other breast to produce a symmetrical appearance. • Treatment of cleft lip and cleft palate for children under the age of 18, including coverage for: – Medical, dental, oral, and facial surgery, including surgery performed by oral and plastic surgeons, and surgical management and follow-up care related to such surgery; – Orthodontic treatment; – Preventative and restorative dentistry to ensure good health and adequate dental structures to support orthodontic treatment or prosthetic management therapy; – Speech therapy; – Audiology services; and – Nutrition services. • Treatment to correct or repair disturbances of body composition caused by HIV-associated lipodystrophy syndrome, including but not limited to coverage for: – Reconstructive surgery; – Restorative procedures; and – Dermal injections or fillers to treat facial lipoatrophy associated with HIV. Benefits include coverage for procedures that must be done in stages, as long as you are an active Member. Membership must be effective on all dates on which services are provided. There is no coverage for Cosmetic Services or surgery except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care as described above. **Important Note:** We use clinical guidelines to evaluate whether different types of reconstructive and restorative procedures are Medically Necessary. If you are planning to receive such treatment, you may review the current guidelines. To obtain a copy, please call **1-888-888-4742 ext. 38732.** **Prior Approval Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.G. PRIOR APPROVAL* for more information.

Benefit	Description
32 . Rehabilitation Hospital Care	
	The Plan covers care in a facility licensed to provide rehabilitative care on an inpatient basis. Coverage is provided when you need daily Rehabilitation Services that must be provided in an inpatient setting. Rehabilitation Services include cardiac rehabilitation therapy, physical therapy, pulmonary rehabilitation therapy, occupational therapy and speech therapy. The Benefit Limit is listed in the Schedule of Benefits. **Prior Approval or Notification Required:** You must obtain Prior Approval for rehabilitation hospital care. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.G. PRIOR APPROVAL* for more information.
33 . Rehabilitation and Habilitation Services – Outpatient	
	The Plan covers the following outpatient Rehabilitation and Habilitation Services: • Occupational therapy • Physical therapy • Pulmonary rehabilitation therapy Outpatient Rehabilitation and Habilitation Services are covered up to the Benefit Limit listed in the Schedule of Benefits. Services are covered only: • If, in the opinion of your Provider, there is likely to be significant improvement in your condition within the period of time benefits are covered; and • When needed to improve your ability to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports. Rehabilitation and Habilitation Services are also covered under your inpatient hospital and home health benefits. **Prior Approval Required:** You must obtain Prior Approval for coverage of outpatient physical, occupational, pulmonary rehabilitation and speech 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.G. PRIOR APPROVAL* for more information. **Please Note:** Outpatient physical and occupational therapies for children under the age of 3 are covered to the extent Medically Necessary. The Benefit Limit stated in the Schedule of Benefits does not apply.
34 . Scopic Procedures – Outpatient Diagnostic	
	The Plan covers diagnostic scopic procedures and related services received on an outpatient basis. Diagnostic scopic procedures are those for visualization, biopsy and/or polyp removal. Scopic procedures are: • Colonoscopy • Endoscopy • Sigmoidoscopy **Please Note:** No In-Network Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice at: **www.harvardpilgrim.org/GIC**.

Benefit	Description
35 . Skilled Nursing Facility Care	
	The Plan covers care in a health care facility licensed to provide skilled nursing care on an inpatient basis. Coverage is provided only when you need daily skilled nursing care that must be provided in an inpatient setting. The Benefit Limit is listed in the Schedule of Benefits. **Prior Approval Required:** You must obtain Prior Approval for Skilled Nursing Facility care. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.G. PRIOR APPROVAL* for more information.
36 . Smoking Cessation	
	The Plan covers treatment for tobacco dependence/smoking cessation. The following services are covered: • Telephonic or face-to-face counseling. Face-to-face counseling may be completed in either individual or group sessions. Outpatient prescription drugs are covered under your outpatient prescription drug coverage, which is not administered by HPHC. Please see your **Express Scripts Prescription Drug Plan brochure** or call **Express Scripts** at **1-855–283–7679** for information on coverage of outpatient prescription drugs for smoking cessation.
37 . Speech-Language and Hearing Services	
	The Plan covers diagnosis and treatment of speech, hearing and language disorders to the extent Medically Necessary when provided by speech-language pathologists and audiologists. **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.G. PRIOR APPROVAL* for more information.
38 . Surgical Day Care	
	The Plan covers outpatient surgery, including related services. Outpatient surgery is defined as any surgery or procedure in a day surgery department, ambulatory surgery department or outpatient surgery center. There are certain specialized services for which you will be directed to a Center of Excellence for care. See section *I.E.5. Centers of Excellence* for more information. **Prior Approval Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414.** Please see section *I.G. PRIOR APPROVAL* for more information.
39 . Telemedicine Virtual Visit Services	
	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. Member Cost Sharing for telemedicine virtual visit services is usually the same as or less than 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.

Benefit	Description
40 . Temporomandibular Joint Dysfunction Services	
	The Plan covers medical treatment of Temporomandibular Joint Dysfunction (TMD). Only the following services are covered: • Initial consultation with a physician • Physical therapy, (subject to the visit limit for outpatient physical therapy listed in the Schedule of Benefits) • Surgery • X-rays **Important Notice:** No Dental Care is covered for the treatment of Temporomandibular Joint Dysfunction (TMD). **Prior Approval Required:** You must obtain Prior Approval for 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.G. PRIOR APPROVAL* for more information.
41 . Transgender Health Services	

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

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

Benefit	Description
42 . Urgent Care Services	
	The Plan covers Urgent Care you receive at (1) a convenience care clinic or (2) an urgent care center. Convenience care clinics provide treatment for minor illnesses and injuries. They are usually staffed by non-physician Providers, such as nurse practitioners, and are located in stores, supermarkets or pharmacies. To see a list of convenience care clinics covered by the Plan, please refer to your Independence Plan Provider Directory and search under "convenience care." Urgent care centers provide treatment for illnesses and injuries that require urgent attention but are not life threatening. Urgent care centers are independent 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 Independence Plan Provider Directory and search under "urgent care." Some hospitals provide Urgent Care services as part of the hospital's outpatient services. Because the services provided are considered outpatient hospital services, only the hospitals are listed in the Independence Plan Provider Directory. 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: • Care for minor cuts, burns, rashes or abrasions, including suturing • Treatment for minor illnesses and infections, including ear aches • Treatment for minor sprains or strains You do not need to obtain a Referral from your PCP to be covered for Urgent Care services at an urgent care center or convenience clinic. Whenever possible, you should contact your PCP prior to obtaining care at either a convenience care clinic or an urgent care center. Your PCP may be able to provide the services you require at a lower out-of-pocket cost. In addition, your PCP is responsible for coordinating your health care services and should know about the services you receive. **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. This includes heart attack or suspected heart attack, shock, major blood loss, or loss of consciousness. Please see section *I.E.6. Medical Emergency Services* for more information.
43 . Vision Services	
	Routine Eye: The Plan covers routine eye examinations. The Benefit Limit is listed in the Schedule of Benefits. **Vision Hardware for Special Conditions:** The Plan provides coverage for contact lenses or eyeglasses needed for the following conditions. • Keratoconus. One pair of contact lenses is covered per Plan Year. The replacement of lenses, due to a change in the Member's condition, is limited to 3 per affected eye per Plan Year.

Benefit	Description
Vision Services (Continued)	
	• 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 0.50 diopters or more within 90 days of the surgery is covered up to a Benefit Limit of $140. • Post-cataract surgery without lens implant (aphakes). One pair of eyeglass lenses or contact lenses is covered per Plan Year. Coverage of up to $50 per Plan 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. • 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 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.
44 . Voluntary Sterilization	
	The Plan covers voluntary sterilization, including tubal ligation and vasectomy.
45 . Voluntary Termination of Pregnancy	
	The Plan covers voluntary termination of pregnancy.
46 . Wigs and Scalp Hair Prostheses	
	The Plan covers wigs and hair prostheses when needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis, or permanent hair loss due to injury.

IV. Exclusions

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

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

Exclusion	Description
1 . Alternative Treatments	
	1. Acupuncture services. 2. Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments. 3. Aromatherapy, treatment with crystals and alternative medicine. 4. Any of the following types of programs: health resorts, spas, recreational programs, camps, outdoor skills programs, 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). 5. Massage therapy. 6. Myotherapy.
2 . Dental Services	
	1. Dental Care, except the specific dental services listed as Covered Benefits in this Benefit Handbook and your Schedule of Benefits. 2. All services of a dentist for Temporomandibular Joint Dysfunction (TMD). 3. Preventive Dental Care.
3 . Durable Medical Equipment and Prosthetic Devices	
	1. Any devices or special equipment needed for sports or occupational purposes. 2. Any home adaptations, including, but not limited to home improvements and home adaptation equipment. 3. Devices and procedures intended to reduce snoring including, but not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards 4. Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. 5. Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.
4 . Experimental, Unproven or Investigational Services	
	1. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.
5 . Foot Care	
	1. Foot orthotics, except for the treatment of severe diabetic foot disease. 2. Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members with diabetes.
6 . Maternity Services	
	1. Childbirth classes. 2. Planned home births.

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

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

Exclusion	Description
11 . Reproduction	
	1. 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 treatment for Members who are not medically infertile. 4. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). 5. Sperm collection, freezing and storage except as described in section *III. Covered Benefits*, *Infertility Services and Treatment*. 6. Sperm identification when not Medically Necessary (e.g., gender identification). 7. The following fees: wait list fees, non-medical costs, shipping and handling charges etc.
12 . Services Provided Under Another Plan	
	1. Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. 2. Costs for services for which payment is required to be made by Workers' Compensation plan or an employer under state or federal law.
13 . Telemedicine Services	
	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 . Transgender Health Services	
	1. Abdominoplasty. 2. Chemical peels. 3. Collagen injections. 4. Dermabrasion 5. Electrolysis or laser hair removal (for all indications, except when required pre-operatively for genital surgery). 6. Reversal of transgender health services and all related drugs and procedures. 7. Hair transplantation. 8. Implantations (e.g. cheek, calf, pectoral, gluteal) 9. Liposuction. 10. Lip reduction/enhancement. 11. Panniculectomy 12. Removal of redundant skin. 13. Silicone injections (e.g. for breast enlargement). 14. Voice modification therapy/surgery 15. Reimbursement for travel expenses

Exclusion	Description
15 . Types of Care	
	1. Custodial Care. 2. Recovery programs including rest or domiciliary care, sober houses, transitional support services, and therapeutic communities. 3. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. 4. Pain management programs or clinics. 5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. 6. Private duty nursing. 7. Sports medicine clinics. 8. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
16 . Vision and Hearing	
	1. Eyeglasses, contact lenses and fittings, except as listed in this Benefit Handbook. 2. Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD. 3. Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism.
17 . All Other Exclusions	
	1. All food or nutritional supplements except those covered under the benefits for (1) low protein foods and (2) medical formulas. 2. Any drug or other product obtained at an outpatient pharmacy, except when specifically listed as a Covered Benefit under this Benefit Handbook and your Schedule of Benefits. Please see section *III. Covered Benefits*, *Diabetes Services and Supplies* for information on coverage of diabetes equipment and supplies. 3. Any service or supply furnished in connection with a non-Covered Benefit. 4. Any service or supply purchased from the internet, except for contact lenses covered under the benefit for Vision Hardware for Special Conditions. 5. Beauty or barber service. 6. Diabetes equipment replacements when solely due to manufacturer warranty expiration. 7. Donated or banked breast milk 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 by the Plan. 13. Services that are not Medically Necessary.

Exclusion	Description
All Other Exclusions (Continued)	
	14. Taxes or governmental assessments on services or supplies. 15. Transportation other than by ambulance. 16. The following products and services: • Air conditioners, air purifiers and filters, dehumidifiers and humidifiers. • Car seats • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners • Electric scooters • Exercise equipment • Home modifications including but not limited to elevators, handrails and ramps • Hot tubs, jacuzzis, saunas or whirlpools • Mattresses • Medical alert systems • Motorized beds • Pillows • Power-operated vehicles • Stair lifts and stair glides • Strollers • Safety equipment • Vehicle modifications including but not limited to van lifts • Telephone • Television

V. STUDENT DEPENDENT COVERAGE

When your eligible Dependent child goes to school away from home, he or she is still covered by the Plan. The Plan coverage works one of two ways for student Dependents, depending on where they get care while they go to school.

A. STUDENTS INSIDE THE SERVICE AREA

If your child goes to school and receives Covered Benefits inside the Service Area, he or she can obtain In-Network level of benefits when care is provided or arranged by the PCP (unless it is one of the services in section *I.E.8. Services That Do Not Require a Referral*) and is obtained from a Plan Providers.

B. STUDENTS OUTSIDE THE SERVICE AREA

If your child goes to school and receives Covered Benefits outside the Service Area, the Plan provides coverage for Non-Plan Providers at the Out-of-Network level, except as stated in the following paragraphs.

Out-of-Network level cost sharing does not apply in a Medical Emergency, see section services *I.E.6. Medical Emergency Services* for details.

In-Network level of benefits can also be provided outside the Service Area when services are provided from a Plan Provider in the Plan's national Provider Network. See section *I.E.1. How Your In-Network Benefits Work* for more details. When you receive care outside of the Service Area, you do not need a Referral from your PCP.

All the rules and limits on coverage listed in this Benefit Handbook for Out-of-Network coverage apply to these benefits.

VI. Reimbursement and Claims Procedures

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

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

A. BILLING BY PROVIDERS

If you get a bill for a Covered Benefits you may ask the Provider to:

1) Bill us on standard health care claim forms (such as the CMS 1500 or the UB04 form); and
2) Send it to us at the address listed on the back of your Plan ID card.

B. REIMBURSEMENT FOR BILLS YOU PAY

If you pay a Provider who is not a Plan Provider for a Covered Benefit, we will reimburse you less your applicable Member Cost Sharing.

Claims for Mental Health and Substance Use Disorder Treatment:

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

Claims for Pharmacy Services:

Contact Express Scripts at **1-855-283-7679**.

All Other Claims:

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

To obtain reimbursement for a bill you have paid, other than for pharmacy items, you must submit an HPHC 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:

1) The Member's full name and address
2) The Member's date of birth
3) The patient's Plan ID number (on the front of the Member's Plan ID card)
4) 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
5) The Member's diagnosis or ICD 10 code
6) The date the service was rendered
7) The CPT code (or a brief description of the illness or injury) for which payment is sought
8) The amount of the Provider's charge
9) Proof that you have paid the bill

Important Notice: We may need more information for some claims. If you have any questions about claims, please call our Member Services Department 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 International Claim Form. The form can be found online at **www.harvardpilgrim.org** or by calling the Member Services Department. In addition to the International Claim Form, you will need to submit an itemized bill and proof of payment. We may also require you to provide additional documentation, including, but not limited to: (1) records from financial institutions clearly demonstrating that you have paid for the services that are the subject of the claim; and (2) the source of the funds used for payment.

2. Pharmacy Claims

Your outpatient prescription drug coverage is not administered by HPHC. Please see your **Express Scripts Prescription Drug Plan brochure** or call **Express Scripts** at **1-855–283–7679** for information on coverage of outpatient prescription drugs.

C. THE LIMITS ON FILING CLAIMS

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

D. TIME LIMITS FOR THE REVIEW OF CLAIMS

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

- Pre-service claims. A pre-Service claim is one in which coverage is requested for a health care service that the Member has not yet received. Pre-service claims will generally be processed within 72 hours of receipt of the claim by HPHC.
- Post-service claims. A post-service claim requests coverage of a health care service that the Member has already received. Post-service claims will generally be processed within 30 days after receipt of the claim by HPHC.
- Urgent Care claims. Urgent Care claims will generally be processed within 72 hours of receipt of the claim by HPHC. An Urgent Care claim is one which the use of the standard time period for processing pre-service claims:
    1. Could seriously jeopardize a Member's life or health or ability to regain maximum function; or
    2. Would result in severe pain that cannot be adequately managed without care or treatment requested.

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

E. PAYMENT LIMIT

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

VII. Appeals and Complaints

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

A. BEFORE YOU FILE AN APPEAL

Claim denials may result from a misunderstanding with a Provider or a claim processing error. Since these problems can be easy to resolve, we recommend that Members contact an HPHC Member Services Associate prior to filing an appeal. (A Member Services Associate can be reached toll free at **1-888-333-4742** or **711** for TTY service.) The Member Services Associate will investigate the claim and either resolve the problem or explain why the claim is being denied. If you are dissatisfied with the response of the Member Services Associate, you may file an appeal using the procedures outlined below.

B. MEMBER APPEAL PROCEDURES

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

A Member may also appeal a rescission of coverage. A rescission of coverage is defined in section *VII.C. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED*.

HPHC staff is available to assist you with the filing of an appeal. If you wish such assistance, please call **1-888-333-4742**.

1. Initiating Your Appeal

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

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

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

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

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

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

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

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

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

This Plan does not provide coverage for outpatient prescription drugs through HPHC. Please see your **Express Scripts Prescription Drug Plan brochure** or call **Express Scripts** at **1-855–283–7679** for

information on the outpatient prescription drug appeal process.

2. The Standard Appeal Process

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

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

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

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

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

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

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

3. The Expedited Appeal Process

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

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

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

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

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

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

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

Important Notice: If you are filing an expedited appeal with HPHC, you may also file a request for expedited external review at the same time. You do not have to wait until HPHC completes your expedited appeal to file for expedited external review. Please see the section *VII.C. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED*, for information on how to file for external review.

C. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED

If you disagree with with the denial of your appeal you may be entitled to seek external review through an Independent Review Organization (IRO). **You must request external review within four (4) calendar months of the date you receive notice that your appeal has been denied**. If we send a notice of the denial of an appeal by First Class Mail, we will assume receipt of that notice five (5) days after the date of mailing.

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

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

HPHC Appeals and Grievances Department
1600 Crown Colony Drive
Quincy, MA 02169
Telephone: 1-888-333-4742
Fax: 1–617–509–3085

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

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

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

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

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

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

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

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

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

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

   Rescission of Coverage. A "rescission of coverage" means a retroactive termination of

a Member's coverage. However, a termination of coverage is not a rescission if it is based on a failure to pay required premiums or contributions for coverage in a timely manner.

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

You will be allowed to submit additional information in writing to the IRO which the IRO must consider. The IRO will give you at least five business days to submit such information.

D. THE FORMAL COMPLAINT PROCESS

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

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

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

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

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

VIII. Eligibility

This section describes requirements concerning eligibility under the Plan. The eligibility of Members and their Dependents and the effective dates of coverage are determined by the GIC.

A. MEMBER ELIGIBILITY

Eligible employees and retirees of the Commonwealth of Massachusetts, certain municipalities, and other entities may join this Plan as Subscribers.

1. Residence Requirement

To be eligible for coverage under this Plan, all people covered by this Plan must live and maintain a permanent residence within the Service Area at least nine months of a year. Adult children age 19 – 26 may reside outside of the service area but will be subject to the Plan's coverage rules.

If you have any questions about this requirement, you may call the Member Services Department for a current list of the cities and towns in the Service Area.

2. Who is Covered

Individual Coverage covers the Subscriber only (except for routine nursery care services if the mother only has Individual Coverage and the newborn is not being added to the policy). Family Coverage covers the Subscriber and the following enrolled Dependents:

1. The employee's or retiree's spouse or a divorced spouse who is eligible for Dependent coverage pursuant to Massachusetts General Laws Chapter 32A as amended; or
2. The child, stepchild, adoptive child, or eligible foster child of the Subscriber or the employee's or the retiree's spouse until the end of the month following the child's 26th birthday; or
3. A physically or mentally disabled child age 26 and older who was incapable of self-support before their 19th birthday may obtain handicapped Dependent coverage. Application must be made to the GIC to obtain this coverage. Coverage is subject to GIC approval and the insured parent's continued coverage with the GIC. If approved, disabled children receive their own identification numbers but are part of the family; or
4. A full-time student at an accredited educational institution at age 26 or over may continue to be covered as a Dependent family member, but must pay 100% of the required monthly individual premium. That student must file an application with the GIC within 30 days of their 26th birthday and that application must be approved by the GIC. If this application is submitted late, your dependent may apply during the GIC's annual enrollment period. Full-time students age 26 and over are not eligible for continued coverage if there has been a two-year break in their GIC coverage.

Surviving spouses of covered employees or retirees and/or their eligible Dependent children may be able to continue coverage under this health care program. Surviving spouse coverage ends upon remarriage. Orphan coverage is also available for some surviving Dependents. For more information on eligibility for survivors or orphans, contact the GIC at **(617)727-2310**.

If you have questions about coverage for someone whose relationship to you is not listed above, contact the GIC at **(617)727-2310**.

Under the federal law known as COBRA, coverage for subscribers and Dependents may also be extended after termination at 102% of the premium (no premium contribution by the Commonwealth) for up to 36 months as noted in the section on Termination, which follows. Please see Appendix A at the back of this Benefit Handbook, "Group Health Continuation Coverage Under COBRA" for more information

3. Changes in Status

It is the responsibility of the Subscriber to inform the GIC of all changes that affect Member eligibility, including but not limited to, divorce, remarriage of either spouse, marriage of a Dependent, Medicare eligibility as a result of disability, death, address changes, and when a Dependent previously eligible as a student is no longer enrolled in an accredited school on a full-time basis. Members must inform the GIC of these changes by contacting the GIC.

4. Adding, Removing or Updating the Status of a Subscriber or a Dependent

Members must notify the GIC of any change in the status of a Dependent. Eligible Dependents may only be added or removed within 60 days of a qualifying status change event, or during GIC's annual enrollment. To add, remove, or update eligibility, active employees must contact their GIC coordinator at their worksite. Retirees and surviving spouses should contact the GIC in writing at:

Group Insurance Commission
P.O. Box 8747
Boston, MA 02114-0998

For questions about Dependent eligibility, contact the GIC at **(617) 727-2310**

5. Divorced Spouses
Spouses who are divorced from employees who are enrolled in this Plan are eligible to continue group coverage unless such coverage is precluded by the divorce agreement or unless the divorce preceded Massachusetts divorced spouse laws (Chapter 32A, § 11A, or, for municipal employees, Chapter 32B, §9H). This coverage continues until either the former spouse or the employee remarries. After remarriage of the employee, the former spouse may be eligible for continued coverage upon the payment of an additional premium, if the GIC determines that the divorce agreement allows it. Terminated former spouses may be eligible for other coverage:

i. Federal law
The federal law known as COBRA provides eligibility for divorced spouses for a maximum of 36 months of continued group coverage from the date coverage is lost at 102% premium (no contribution from the Commonwealth).

ii. Individual Coverage
A divorced spouse who is no longer eligible for the continuation coverage described above may be eligible to enroll in individual coverage. Individual coverage varies from group coverage both in cost and the level of benefits. To limit a break in coverage, you should apply for individual coverage within 63 days of termination of your group coverage. To be eligible you must satisfy applicable state law requirements. Eligible Massachusetts residents may enroll, on a direct pay basis, in any individual plan offered in Massachusetts by HPHC.

6. Retired Employees
Retirees are eligible to participate in the Plan if they are not eligible for Medicare.

All retirees, their spouses, and others eligible for, or enrolled in, Medicare Parts A and B must join a separate GIC plan that covers people who are Medicare-eligible. To determine eligibility for Medicare, you should contact your local Social Security Administration office

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

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

For In-Network coverage, you must be hospitalized in an In-Network hospital. If you are hospitalized at an Out-of-Network hospital, you must notify HPHC by calling **1-800-708-4414** for medical services. For all mental health and substance use disorder treatment please call **1-888-777-4742**. Please see section *I.G. PRIOR APPROVAL* for more information.

IX. About Enrollment and Membership

A. ABOUT ENROLLMENT AND MEMBERSHIP

1. APPLICATION FOR COVERAGE

You must apply to the GIC for enrollment in the Plan. To obtain the appropriate forms, active employees should contact their GIC Coordinator, and retirees should contact the GIC.

You must enroll dependents when they become eligible. Newborns (including grandchildren, if they are eligible dependents of your covered dependents) must be enrolled within 60 days of birth, and adopted children within 60 days of placement in the home. Spouses must be enrolled within 60 days of the marriage. You must complete an enrollment form to enroll or add dependents. Additional documentation may be required, as follows:

- **Newborns:** copy of hospital announcement letter or the child's certified birth certificate
- **Adopted children:** photocopy of proof of placement letter or adoption
- **Foster children ages 19-26:** photocopy of proof of placement letter or court order
- **Spouses:** copy of certified marriage certificate

2. WHEN COVERAGE BEGINS

HPHC will issue identification cards for each enrolled Member within two weeks of receipt of enrollment information from the GIC. The identification card should be presented whenever a Member receives Covered Benefits.

Coverage under this Plan will begin as follows:

i. New employees

Coverage will begin on the first day of the month following 60 calendar days from the first date of employment, or two calendar months, whichever comes first.

In general, employees and retirees who choose not to join a health plan when first eligible must wait until the next annual enrollment period to join. Please see the section titled, "Special Enrollment Rights" below for more details.

ii. Persons applying during an annual enrollment period

Coverage begins each year on July 1.

iii. Spouses and dependents

Coverage begins on the later of: 1. The date your own coverage begins, or 2. The date that the GIC has determined your spouse or dependent is eligible .

iv. Surviving spouses

Upon application, you will be notified by the GIC of the date your coverage begins.

To obtain GIC enrollment and change forms, active employees should contact the GIC Coordinator at their workplace, and retirees should contact the GIC. Enrollment and change forms are also available at mass.gov/gic.

3. SPECIAL ENROLLMENT RIGHTS

If you declined to enroll your spouse or dependents as a new hire, your spouse or dependents may only be enrolled within 60 days of a qualifying status change event or during the GIC's annual enrollment period. To obtain GIC enrollment and change forms, active employees should contact the GIC Coordinator at their workplace, and retirees should contact the GIC. Enrollment and change forms are also available at **mass.gov/gic**.

4. When coverage ends for enrollees

Your coverage ends on the earliest of:

- The end of the month covered by your last contribution toward the cost of coverage.
- The end of the month in which you cease to be eligible for coverage.
- The date of death.
- The date the surviving spouse remarries.
- The date the Plan terminates.

5. WHEN COVERAGE ENDS FOR DEPENDENTS

A dependent's coverage ends on the earliest of:

- The date your coverage under the Plan ends.
- The end of the month covered by your last contribution toward the cost of coverage.
- The date you become ineligible to have a spouse or dependents covered.
- The end of the month in which the dependent ceases to qualify as a dependent.
- The date the dependent child, who was permanently and totally disabled by age 19, marries.

- The date the covered divorced spouse remarries (or the date the enrollee marries).
- The date of the spouse or dependent's death.
- The date the Plan terminates.

6. DUPLICATE COVERAGE

No person can be covered (1) as both an employee, retiree or surviving spouse, and a dependent, or (2) as a dependent of more than one covered person (employee, retiree, spouse or surviving spouse).

X. Termination and Transfer to Other Coverage

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

A. TERMINATION BY THE SUBSCRIBER

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

B. TERMINATION FOR LOSS OF ELIGIBILITY

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

You may be eligible for continued enrollment under federal law, if your membership is terminated. Please see section *X.G. CONTINUATION OF COVERAGE REQUIRED BY LAW* for more information.

C. MEMBERSHIP TERMINATION FOR CAUSE

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

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

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

D. CONTINUATION OF COVERAGE FOR SURVIVORS

Surviving spouses of covered employees or retirees, and/or their eligible dependent children, may be able to continue coverage. Surviving spouse coverage ends upon remarriage. Orphan coverage is also available for some surviving dependents. For more information on eligibility for survivors and orphans, contact the GIC. To continue coverage, you must submit an enrollment form to the GIC to continue coverage within 30 days of the covered employee or retiree's death. You must also make the required contribution toward the cost of the coverage. Coverage will end on the earliest of:

- The end of the month in which the survivor dies.
- The end of the month covered by your last contribution payment for coverage.
- The date the coverage ends.
- The date the Plan terminates.
- For dependents: the end of the month in which the dependent would otherwise cease to qualify as a dependent.
- The date the survivor remarries.

E. CONTINUATION OF COVERAGE FOR DEPENDENTS AGE 26 AND OVER

A dependent child who reaches age 26 is no longer eligible for coverage under this Plan. Dependents age 26 or over who are full-time students at accredited educational institutions may continue to be covered. However, you must pay 100% of the individual premium. The student must also submit an application to the GIC no later than 30 days after his or her 26th birthday. If this application is submitted late, your dependent may apply during the GIC's annual enrollment period. Full-time students age 26 and over are not eligible for continued coverage if there has been a two-year break in their GIC coverage.

F. CONTINUATION OF COVERAGE AFTER A CHANGE IN MARITAL STATUS

Your former spouse will not cease to qualify as a dependent under the Plan solely because a judgment of divorce or separate support is granted. (For the purposes of this provision, "judgment" means only a

judgment of absolute divorce or of separate support.) Massachusetts law presumes that he or she continues to qualify as a dependent, unless the divorce judgment states otherwise. If you get divorced, you must notify the GIC within 60 days and send the GIC a copy of the following sections of your divorce decree: Divorce Absolute Date, Signature Page, and Health Insurance Provisions. If you or your former spouse remarries, you must also notify the GIC. If you fail to report a divorce or remarriage, the Plan and the GIC have the right to seek recovery of health claims paid or premiums owed for your former spouse. Under M.G.L. Ch. 32A as amended and the GIC's regulations, your former spouse will no longer qualify as a dependent after the earliest of these dates:

- The end of the period in which the judgment states he or she must remain eligible for coverage.
- The end of the month covered by the last contribution toward the cost of the coverage.
- The date he or she remarries.
- The date you remarry. If your former spouse is covered as a dependent on your remarriage date, and the divorce judgment gives him or her the right to continue coverage, coverage will be available at full premium cost (as determined by the GIC) under a divorced spouse rider. Alternatively, your former spouse may enroll in COBRA coverage.

G. CONTINUATION OF COVERAGE REQUIRED BY LAW

Under Federal law, if you lose GIC eligibility, 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 GIC for more information if health coverage ends due to: 1) separation from employment; 2) reduction of work hours; or 3) loss of dependency status.

H. CONTINUATION OF DEPENDENT COVERAGE UNDER HPHC

Dependent coverage under this Plan will cease on the last day of the month when a family member no longer qualifies as a Dependent under the rules and regulations of the GIC. In addition to COBRA coverage, your Dependent may be eligible to enroll in individual coverage on a direct pay basis if he or she resides in the Service Area and if he or she is eligible under the law of his or her state of residence. To limit a break in coverage, the Dependent should apply for subsequent individual coverage within 63 days of termination of this Plan. Evidence of good health is not required for individual coverage. The benefits of the individual plan are different from those under this Plan. Eligible Massachusetts residents may enroll, on a direct pay basis, in any individual health plan offered in Massachusetts by HPHC.

XI. 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 this Handbook and Schedule of Benefits or to increase the level of coverage provided.

A. BENEFITS IN THE EVENT OF OTHER INSURANCE

Benefits under this handbook and Schedule of Benefits 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. Members who are eligible for Medicare as a result of disability, age, or end stage renal disease must notify the GIC.

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 shall occur among plans.

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

In the case of Health Benefit Plans that contain provisions for the coordination of benefits, the following rules shall decide which Health Benefit Plans are primary or secondary:

1. Employee/Dependent

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

2. Dependent Children

The order of benefits is determined as follows:

i. Dependent Child Whose Parents Are Not Separated or Divorced

The order of benefits is determined as follows:

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

ii. Dependent Child Whose Parents Are Separated or Divorced

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

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

3. Active Employee or Retired or Laid-Off Employee

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

or laid off or as a dependent of an individual who is retired or laid off.

4. COBRA or State Continuation
The benefits of a plan that covers the person as an employee, member, subscriber or retiree, or as a dependent thereof, are determined before those of the plan that covers the person as an individual under COBRA or other right to continuation of coverage under state or federal law.

5. Longer/Shorter Length of Coverage
If none of the above rules determines the order of benefits, the benefits of the plan that covered the employee, Member or Subscriber longer are determined before those of the plan that covered that person for the shorter time.

If you are covered by a Health Benefit Plan that does not have provisions governing the coordination of benefits between plans, that plan will be the primary plan.

B. PROVIDER PAYMENT WHEN PLAN COVERAGE IS SECONDARY

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

C. WORKERS' COMPENSATION/GOVERNMENT PROGRAMS

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

D. SUBROGATION AND REIMBURSEMENT

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

If another person or entity is, or alleged to be, liable to pay for services related to a Member's illness or injury which have been paid for or provided by the Plan, the Plan will be subrogated and succeed to all rights to recover against such person or entity up to the value of the services paid for or provided by the Plan. The Plan shall also have the right to be reimbursed from any recovery a Member obtains from such person or entity for the value of the services paid for or provided by the Plan. The Plan will have the right to seek such recovery from, among others, the person or entity that caused or allegedly caused the injury or illness, his/her liability carrier or your own auto insurance carrier, in cases of uninsured or underinsured motorist coverage. The Plan's right to reimbursement from any recovery shall apply even if the recovery the Member receives for the illness or injury is designated or described as being for injuries other than health care expenses or does not fully compensate the Member for his or her damages, fees or costs. Neither the "make whole rule" nor the "common fund doctrine" apply to the Plan's rights of subrogation and/or reimbursement from recovery.

The Plan's reimbursement will be made from any recovery the Member receives from any insurance company or any third party and the Plan's reimbursement from any such recovery will not be reduced by any attorney's fees, costs or expenses of any nature incurred by, or for, the Member in connection with the Member's receiving such recovery, and the Plan will have no liability for any such attorney's fees, costs or expenses.

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

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

F. MEMBER COOPERATION

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

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

G. THE PLAN'S RIGHTS

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

H. MEMBERS ELIGIBLE FOR MEDICARE

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

For a Member who is enrolled in Medicare by reason of End Stage Renal Disease, the Plan will be the primary payer for Covered Benefits during the "coordination period" specified by federal regulations at 42 CFR Section 411.62. Thereafter, Medicare will be the primary payer. When Medicare is primary (or would be primary if the Member were timely enrolled) the Plan will pay for services only to the extent payments would exceed what would be payable by Medicare.

XII. Plan Provisions and Responsibilities

A. IF YOU DISAGREE WITH RECOMMENDED TREATMENT

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

B. LIMITATION OF LEGAL ACTIONS

Any legal action against the Plan for failing to provide Covered Benefits, must be brought within two (2) years of the initial denial of any benefit.

C. 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 mental health and substance use disorder treatment records.

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

D. 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: coordination of care, including referrals and authorizations; conducting quality activities, including Member satisfaction surveys and disease management programs; verifying eligibility; fraud detection and certain oversight reviews, such as accreditation and regulatory audits. When we disclose Member information, we do so using the minimum amount of information necessary to accomplish the specific activity.

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 HPHC website, **www.harvardpilgrim.org**.

E. NOTICE

Any notice to a Member may be sent to the last address of the Member on file with HPHC. Notice to HPHC, other than a request for 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 *VII. Appeals and Complaints*.

F. MODIFICATION OF THIS BENEFIT HANDBOOK

This Benefit Handbook and the Schedule of Benefits may be amended by the Plan and the GIC. Amendments do not require the consent of Members.

This Benefit Handbook and the Schedule of Benefits, comprise the entire contract between you and the Plan.

G. 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 Benefit Handbook and Schedule of Benefits, or any applicable riders or create any obligation for HPHC. We are not liable for statements about this Benefit Handbook by them, their employees or agents. We may change our arrangements with Providers, including the addition or removal of Providers, without notice to Members.

H. IN THE EVENT OF A MAJOR DISASTER

We will try to provide or arrange for services in the case of major disasters. This might include war, riot, epidemic, public emergency, or natural disaster. Other causes include the partial or complete destruction of our facilities or the disability of service Providers. If we cannot provide or arrange such services due to a major disaster, we are not responsible for the costs or outcome of its 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, Investigational or Unproven. The team researches the safety and effectiveness of these new technologies by reviewing published peer reviewed medical reports and literature, consulting with expert practitioners, and benchmarking. The team presents its recommendations to internal policy committees responsible for making decisions regarding coverage of the new technology under the Plan. The evaluation process includes:

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

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

J. UTILIZATION REVIEW PROCEDURES

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 elective 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. 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 a Plan Provider. The terms "Acute Treatment Services" and "Clinical Stabilization Services" are defined in the *Glossary* 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 *VII. Appeals and Complaints*. Your right to appeal does not depend on whether or not your Provider sought reconsideration.

K. QUALITY ASSURANCE PROGRAMS

The goal of our quality program is to ensure the provision of consistently excellent health care, health information and service to our Members, enabling them to maintain and improve their physical and behavioral health and well-being. Some components of the quality program are directed to all Members and others address specific medical issues and Providers.

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

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

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

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

M. PROCESS TO DEVELOP CLINICAL GUIDELINES AND UTILIZATION REVIEW CRITERIA

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.

N. NON-ASSIGNMENT OF BENEFITS

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

O. NEW TO MARKET DRUGS

Your coverage under this Benefit Handbook is limited to Medical Drugs. New Medical 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 HPHC'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.

This Plan does not provide coverage for outpatient prescription drugs through HPHC. Please see your **Express Scripts Prescription Drug Plan brochure** or call **Express Scripts** at **1-855–283–7679** for information on coverage of outpatient prescription drugs.

P. 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.

XIII. 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.

XIV. INDEX

This Index provides the location of Covered Benefits within the Benefit Handbook. For services not listed below and for detailed information regarding Covered Benefits, please see section *III. Covered Benefits*

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Appendix A: Group Health Continuation Coverage Under COBRA General Notice

The Commonwealth of Massachusetts
Group Insurance Commission

P.O. Box 8747
Boston, Massachusetts 02114

(617) 727-2310
Fax (617) 227-2681
TTY (617) 227-8583
www.mass.gov/gic

GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

GENERAL NOTICE

This notice explains your COBRA rights and what you need to do to protect your right to receive it. You will receive a COBRA notice and application if the Group Insurance Commission (GIC) is informed that your current GIC coverage is ending due either to (1) end of employment, (2) reduction in hours of employment; (3) death of employee/retiree; (4) divorce or legal separation; or (5) loss of dependent child status. This COBRA notice contains important information about your right to temporarily continue your health care coverage in the Group Insurance Commission's (GIC's) health plan through a federal law known as COBRA. If you elect to continue your coverage, COBRA coverage will begin on the first day of the month immediately after your current GIC coverage ends.

You must complete the GIC COBRA Election Form and return it to the GIC by no later than 60 days after your group coverage ends by sending it by mail to the Public Information Unit at the GIC at P.O. Box 8747, Boston, MA 02114 or by hand delivery to the GIC, 19 Staniford Street, 4th floor, Boston, MA 02114. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage.

WHAT IS COBRA COVERAGE? The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called 'Qualifying Events.' If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

WHO IS ELIGIBLE FOR COBRA COVERAGE? Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an *independent right* to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts or municipality covered by the GIC's health benefits program, you have the right to choose COBRA coverage if

- You lose your group health coverage because your hours of employment are reduced; or
- Your employment ends for reasons other than gross misconduct.

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies;
- Your spouse's employment with the Commonwealth or participating municipality ends for any reason other than gross misconduct or his/her hours of employment are reduced; or
- You and your spouse legally separate or divorce.

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies;
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours or employment are reduced;
- The parents legally separate or divorce; or
- The dependent ceases to be a dependent child under GIC eligibility rules

HOW LONG DOES COBRA COVERAGE LAST? By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a *total* of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce - occurs during the 18 months of COBRA coverage. **You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage**. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18 month COBRA period ends in order to extend the coverage**.

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid ***in full*** when due (see section on paying for COBRA);
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);
- The Commonwealth of Massachusetts or your municipal employer no longer provides group health coverage to any of its employees; or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud).

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

HOW AND WHEN DO I ELECT COBRA COVERAGE? Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60–day election period, you will lose all rights to COBRA coverage**.

In considering whether to elect COBRA coverage you should take into account that you have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your GIC coverage ends due to a qualifying event. You will also have the same special enrollment right at the end of COBRA coverage if you get continuation coverage for the maximum time available to you.

HOW MUCH DOES COBRA COVERAGE COST? Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically; current COBRA rates are included with this notice.

HOW AND WHEN DO I PAY FOR COBRA COVERAGE? If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period**. After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement**. Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

CAN I ELECT OTHER HEALTH COVERAGE BESIDES COBRA? Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance 'conversion' policy with your current health plan without providing proof of insurability. Alternately, if you are a Massachusetts resident, you may purchase health insurance through the Commonwealth's Health Connector Authority, or for employees in other states, through a Health Insurance Marketplace where available. The GIC has no involvement in conversion programs, and only very limited involvement in Health Connector programs. You pay the premium to the plan sponsor for the coverage. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

YOUR COBRA COVERAGE RESPONSIBILITIES

- **You must inform the GIC of any address changes to preserve your COBRA rights;**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above**. If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill**. If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
- The employee's job terminates or his/her hours are reduced;
- The insured dies;
- The insured becomes legally separated or divorced;
- The insured or insured's former spouse remarries;
- A covered child ceases to be a dependent under GIC eligibility rules;
- The Social Security Administration determines that the employee or a covered family member is disabled; or
- The Social Security Administration determines that the employee or a covered family member is no longer disabled.

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. ***To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114.***

If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617/727-2310, ext. 1 or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at **www.dol.gov/ebsa** or call their toll free number at 866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit **www.healthcare.gov** or, in Massachusetts visit, **www.mahealthconnector.org**.

Appendix B: Important Notice About Your Prescription Drug Coverage and Medicare

Important Notice from the Group Insurance Commission (GIC) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Plan and your options under Medicare's prescription drug coverage. This information can help you decide whether or not to join a non-GIC Medicare drug plan. If you are considering joining a non-GIC plan, you should compare your current coverage – particularly which drugs are covered, and at what cost – with that of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage can be found at the end of this notice.

FOR MOST PEOPLE, THE DRUG COVERAGE THAT YOU CURRENTLY HAVE THROUGH YOUR GIC HEALTH PLAN IS A BETTER VALUE THAN THE NON-GIC MEDICARE PART D DRUG PLANS.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available to everyone with Medicare in 2006. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The GIC has determined that the prescription drug coverage offered by your plan is, on average for all participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Part D drug plan.

When Can You Join A Medicare Part D Drug Plan?

You can join a non-GIC Medicare drug plan when you first become eligible for Medicare and each subsequent year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period to join a non-GIC Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join A Non-GIC Medicare Drug Plan?

- If you enroll in another Medicare prescription drug plan or a Medicare Advantage plan with or without prescription drug coverage, you will be disenrolled from the GIC-sponsored Prescription Drug plan. If you are disenrolled from Harvard Pilgrim, you will lose your GIC medical, prescription drug, and behavioral health coverage.

- If you are the insured and decide to join a non-GIC Medicare drug plan, both you and your covered spouse/dependents will lose your GIC medical, prescription drug, and behavioral health coverage.
- If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available online at **www.socialsecurity.gov** or by phone at 1-800-772-1213 (TTY 1-800-325-0778).

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with a GIC plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage….

Contact the GIC at (617) 727-2310, extension 1. **NOTE:** You will receive this notice each year and if this coverage through the Group Insurance Commission changes. You may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for the telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227); TTY users should call 1-877-486-2048.

If you have limited income and assets, extra help paying for Medicare prescription drug coverage is available. For information about the Extra Help program, visit Social Security online at **www.socialsecurity.gov** or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Updated: November 2015

Appendix C: Notice of Group Insurance Commission Privacy Practices

NOTICE OF GROUP INSURANCE COMMISSION PRIVACY PRACTICES

NOTICE OF GROUP INSURANCE COMMISSION PRIVACY PRACTICES

Effective September 3, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the GIC must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as "protected health information" or "PHI") includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at www.mass.gov/gic.

REQUIRED AND PERMITTED USES AND DISCLOSURES

We use and disclose protected health information ("PHI") in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make *without* your authorization:

Payment Activities: The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

Health Care Operations: The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

To Provide You Information on Health-Related Programs or Products: Such information may include alternative medical treatments or programs or about health-related products and services, subject to limits imposed by law as of September 23, 2013

OTHER PERMITTED USES AND DISCLOSURES: The GIC may use and share PHI as follows:

- to resolve complaints or inquiries made by you or on your behalf (such as appeals);
- to enable business associates that perform functions on our behalf or provide services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. Our business associates are also directly subject to federal privacy laws;
- for data breach notification purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access or disclosure of your health information;
- to verify agency and plan performance (such as audits);
- to communicate with you about your GIC-sponsored benefits (such as your annual benefits statement);
- for judicial and administrative proceedings (such as in response to a court order);

- for research studies that meet all privacy requirements; and
- to tell you about new or changed benefits and services or health care choices.

Required Disclosures: The GIC **must** use and share your PHI when requested by you or someone who has the legal right to make such a request on your behalf (your Personal representative), when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

Organizations That Assist Us: In connection with payment and health care operations, we may share your PHI with our third party "Business Associates" that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI and also have direct responsibility to protect your PHI imposed by federal law.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based on your permission.

Your rights

You have the right to:

- Ask to see and get a copy of your PHI that the GIC maintains. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.
- Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. You must ask for this by in writing, along with a reason for your request. If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.
- Get a listing of those with whom the GIC shares your PHI. You must ask for this in writing. The list will not include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research;
- Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. You must ask for this in writing. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.
- Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. You must tell us in writing that you are in danger, and where to send communications.
- Receive notification of any breach of your unsecured PHI.
- Receive a separate paper copy of this notice upon request. (An electronic version of this notice is on our website at www.mass.gov/gic.)

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call (617) 727-2310, extension 1 or TTY for the deaf and hard of hearing at (617)-227-8583.

Appendix D: The Uniformed Services Employment and Reemployment Rights Act (USERRA)

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The GIC has more generous guidelines for benefit coverage that apply to persons subject to USERRA, as set forth below:

> If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents while in the military.
>
> Service members who elect to continue their GIC health coverage are required to pay the employee's share for such coverage.
>
> Even if you don't elect to continue coverage during your military service, you have the right to be reinstated to GIC health coverage when you are reemployed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information about your GIC coverage, please contact the Group Insurance Commission at (617) 727-2310, ext. 1.

Appendix E: Medicaid and the Children's Health Insurance Program Notice (CHIP)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507

ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 12/31/2019)

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