

HPHC Insurance Company, Inc.

Benefit Handbook

Medicare Enhance Plan

(A Medicare Plan for Retirees)

Medicare Enhance is a product of HPHC Insurance Company, Inc.,
a wholly owned subsidiary of Harvard Pilgrim Health Care, Inc.

NOTICE CONCERNING MASSACHUSETTS MINIMUM CREDITABLE COVERAGE REQUIREMENTS

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This Plan is designed to provide benefits that complement the benefits provided by Medicare Parts A and B. It does not, by itself, provide comprehensive health coverage and does not meet Massachusetts Minimum Creditable Coverage standards. However, in order to be enrolled in this Plan, all Subscribers must be enrolled in both Medicare Parts A and B. **Under Massachusetts law, any individual enrolled in either Medicare Part A or Part B automatically qualifies as having health coverage that meets Minimum Creditable Coverage standards.**

In summary, Medicare beneficiaries do not need to be enrolled in this Plan, or any other Medicare complement plan, to have health coverage that meets Massachusetts Minimum Creditable Coverage requirements. Enrollment in Medicare Parts A or B is all that is required.

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).

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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).

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

ខ្មែរ (Cambodian) ជូនដំណឹង: បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនសេវាកម្មដោយឥតគិតថ្លៃ។ ជូន 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).

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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).

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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. ໂທ 1-888-333-4742 (TTY: 711).

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



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

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General Notice About Nondiscrimination and Accessibility Requirements

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

HPHC:

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

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

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

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

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



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I. INTRODUCTION

Medicare Enhance (the “Plan”) is a product of HPHC Insurance Company, Inc. (“HPIC”), a subsidiary of Harvard Pilgrim Health Care, Inc. (“Harvard Pilgrim”).

This *Benefit Handbook* describes the benefits and the terms and conditions of coverage under the Plan. The Plan is designed to complement a Subscriber's Medicare coverage by:

1. Paying most Medicare Deductible and Coinsurance amounts for services covered by Medicare Parts A and B;
2. Covering certain services that Medicare does not cover at all; and
3. Paying for some Medicare covered services after your Medicare benefits have been exhausted.

To use Plan benefits, simply obtain services from any health care Provider eligible for payment by Medicare. (A few cases in which you do not need to use a Provider eligible for payment by Medicare are described in Section III.C, below.) Please see Section II of this Handbook for further information on how to use the Plan.

To understand your Medicare Enhance benefits fully, you should read the Medicare program handbook *Medicare and You*. *Medicare and You* describes your Medicare benefits in detail.

To learn more about health coverage for people with Medicare you may want to review the *Guide to Health Insurance for People with Medicare*. You may obtain Medicare publications at most Social Security Offices and by calling Medicare at **1-800-633-4227**. (TTY service is available at **1-877-486-2048**.) A number of publications explaining Medicare benefits may be obtained on the Internet at the following web address: <http://www.medicare.gov/publications/home.asp>

Changes in Medicare benefits or the Medicare program itself may result in changes to this *Benefit Handbook*. HPIC is not responsible for notifying Employer Groups or Subscribers for changes in Medicare benefits or in the Medicare program. In the event such changes affect the terms and conditions of this *Benefit Handbook* or Plan benefits, Employer Groups will be notified and Subscribers will be sent any necessary amendment(s) to this *Benefit Handbook*.

PLEASE NOTE THAT MEDICARE ENHANCE IS ONLY AVAILABLE TO SUBSCRIBERS ENROLLED THROUGH EMPLOYER GROUPS. IF A SUBSCRIBER'S ELIGIBILITY FOR EMPLOYER GROUP COVERAGE ENDS, ENROLLMENT IN THE PLAN MUST ALSO END.

The Massachusetts Managed Care Reform Law requires disclosure of premium information and information concerning HPIC's voluntary and involuntary disenrollment rate. This information including the specific premium amount paid on your behalf by your Employer Group will be sent to you in a separate letter. Please keep that letter with this *Benefit Handbook* for your records.

Contacting Member Services

You may contact a Plan Member Services representative by calling **1-888-333-4742**. Deaf and hard-of-hearing Subscribers who have access to a Teletypewriter (“TTY”) may communicate directly with the Member Services Department by calling our TTY machine at **1-800-637-8257**.

Non-English speaking Subscribers may also call our Member Services Department at **1-888-333-4742** to have their questions answered. Harvard Pilgrim offers free language interpretation services in more than 120 languages.

The Office of Patient Protection.

The Office of Patient Protection of the Health Policy Commission is the agency responsible for enforcing the Massachusetts laws concerning managed care grievance rights and for administering appeals to external review organizations. The Office of Patient Protection can be reached at:

**Health Policy Commission
Office of Patient Protection
Two Boylston Street, 6th Floor
Boston, MA 02116**

**Telephone: 1-800-436-7757
Fax: 1-617-624-5046**

Web Site: <http://www.mass.gov/hpc/opp>

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

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

Physician Profiling Information

The Commonwealth of Massachusetts Board of Registration in Medicine maintains Internet websites with physician profiling information at **www.massmedboard.org**.

You can also write the Board of Registration in Medicine at the following address:

**Board of Registration in Medicine
560 Harrison Avenue
Suite G4
Boston, MA 02118**

(617) 654-9800

Preexisting Conditions

The Plan does not impose any restrictions, limitations, or exclusions on your benefits that are related to preexisting conditions.

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II. ABOUT THE PLAN

A. HOW TO USE THIS BENEFIT HANDBOOK

1. THE DOCUMENTS THAT EXPLAIN YOUR COVERAGE

This *Benefit Handbook*, the *Schedule of Benefits* and the *Prescription Drug Brochure* (if your employer provides the Plan's prescription drug coverage) make up the legal agreement stating the terms and conditions of the Plan. This *Benefit Handbook* incorporates by reference the *Employer Agreement* with your Employer Group.

The *Benefit Handbook* contains most of the details of your coverage. The *Schedule of Benefits* states the Copayments and any other charges that apply to your Employer's plan. It also may be used as a brief summary of your benefits.

If your Employer provides the Plan's coverage for prescription drugs, it is described in your *Prescription Drug Brochure*. It is important that you read that document to understand how to obtain medications at the lowest out-of-pocket cost to you.

In writing these documents, we have tried to provide you with all of the information you need to make full use of your benefits under the Plan. You may use these documents to learn:

- What is covered;
- What is not covered;
- Any limits or special rules for coverage;
- Any Copayments or other charges you have to pay for Covered Services; and
- Procedures for filing claims and obtaining reimbursement for services.

2. WORDS WITH SPECIAL MEANING

Some words in this *Benefit Handbook* have special meanings. When we use one of these words, we capitalize it. We list such words and what they mean in the Glossary at the end of this Handbook

3. HOW TO FIND WHAT YOU NEED TO KNOW

The *Benefit Handbook* begins with a table of contents that will help you find what you need to know.

We have also organized this *Benefit Handbook* with the most important things first. For example, the Plan's benefits are described in the next section. The list of services that are not covered, known as "exclusions," follow the description of the Plan's Benefits. Procedures for obtaining reimbursement follow the list

of exclusions. As noted above, Copayments and other charges you need to pay are stated in the *Schedule of Benefits*.

4. INFORMATION ABOUT YOUR MEDICARE BENEFITS

Medicare Enhance complements the coverage you receive from the Medicare program. The information on Medicare benefits contained in this Handbook is only designed to help you make use of your benefits under the Plan. You should read the Medicare program handbook, *Medicare and You* for information on your Medicare benefits. You may obtain a copy of *Medicare and You* at most Social Security Offices and by calling Medicare at **1-800-633-4227**. (TTY service is available at **1-877-486-2048**.) A number of publications explaining Medicare benefits may be obtained on the Internet at the following web address: <http://www.medicare.gov/publications/home.asp>

5. YOUR IDENTIFICATION CARD

Each Subscriber receives an identification card. The card contains important information about your coverage. It must be presented along with your Medicare card whenever you receive health care services.

B. HOW MEDICARE ENHANCE WORKS

Medicare Enhance (the "Plan") provides Employer sponsored health coverage for persons enrolled in Medicare Parts A and B. A Medicare eligible Spouse of an eligible Subscriber may also be enrolled under a separate contract if he or she meets the eligibility requirements of the Plan and the Employer Group. The Plan complements Medicare coverage by:

- Paying most Medicare Deductible and Coinsurance amounts for services covered by Medicare; and
- Covering a number of Special Services that are required to be provided under State law.

The benefits of the Plan are explained in detail in Section III, below.

To use Plan benefits, simply obtain services from any health care Provider eligible for payment by Medicare. (A few cases in which you do not need to use a Provider eligible for payment by Medicare are described in Section III.C, below.) In the case of Medicare covered services, your health care Provider will first bill Medicare for services you receive. You or your Provider may then submit a Medicare Summary Notice (MSN) to the Plan for payment of the Medicare

Deductible and Coinsurance amount. In the case of services that are not covered by Medicare, the Plan may be billed directly by either you or your Provider. Please see Section V (“Reimbursement and Claims Procedures”), below, for a detailed explanation of the Plan’s claim filing procedures.

C. COVERAGE IN A MEDICAL EMERGENCY

You are always covered for care you need in a Medical Emergency within the United States. In a Medical Emergency you may obtain services from a physician, a Hospital, or a Hospital emergency room. Within the United States, you are also covered for ambulance transportation to the nearest Hospital that can provide the care you need. Please see your *Schedule of Benefits* for information on the Copayments that apply to the different types of emergency care.

In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number.

Some Employer Group Plans provide special benefits for emergency care outside of the United States (With very limited exceptions, Medicare does not cover any services received outside of the United States.) Please see your *Schedule of Benefits* to determine whether your Plan includes coverage for services received outside of the United States.

A Medical Emergency is a medical condition, whether physical or mental, 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 Subscriber or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part. With respect to a pregnant woman who is having contractions, Medical Emergency also means that there is inadequate time to effect a safe transfer to another Hospital before delivery or that transfer may pose a threat to the health or safety of the woman or the unborn child.

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

D. SUBSCRIBER COST SHARING AND PLAN PAYMENT LIMITS

Subscribers are required to share the cost of the benefits provided under the Plan. In some cases there may also be limits on the Plans payments for certain services. General information about cost sharing and payment limits is set forth below. The specific cost sharing and payment limits that apply to your Plan are explained in your *Schedule of Benefits*.

a. Plan Copayments

Most cost sharing under the Plan is in the form of Copayments. Copayments are fixed dollar fees that Subscribers must pay for certain services covered by the Plan. Copayments are generally payable at the time of service.

The Copayments that apply to your Plan, are listed in your *Schedule of Benefits*.

b. Plan Deductible

Some plans may have a Plan Deductible in addition to Copayments. A Plan Deductible is a dollar amount that is payable by the Subscriber for specific Covered Services received each calendar year before those services are covered by the Plan. Deductible amounts are incurred on the date of service.

Different Plans may have different Plan Deductibles, depending on the benefits purchased by your Employer Group. It is important that you review your *Schedule of Benefits* to understand the Deductible that applies to the specific Plan in which you are enrolled.

c. Limits on Payments by the Plan

The Plan has established a maximum amount it will pay for different types of Covered Services. This is called the “Payment Maximum.” For services covered by Medicare, the Payment Maximum is the Medicare approved (or “allowable”) amount for the service. However, Medicare Providers who do not “accept assignment” may charge somewhat more than the Medicare allowable amount. This is explained in Section V.D (“Claims for Services Covered By Medicare Part B”). The Payment Maximum may also apply to services that are not covered by Medicare. This is explained in Section V.J. (“The Payment Maximum”).

E. ACCESS TO INFORMATION AND CONFIDENTIALITY

The Subscriber agrees that, except where restricted by law, the Plan may have access to (1) all health records and medical data from health care Providers providing services covered under this *Benefit Handbook*, and (2) information concerning health coverage or claims from all Providers of motor vehicle insurance, medical payment policies, homeowners insurance and all types of health benefit plans.

The Plan is committed to ensuring and safeguarding the confidentiality of its Subscribers' information in all settings, including personal and medical information. The Plan staff access, use and disclose Subscriber information only in connection with providing services and benefits and in accordance with The Plan's confidentiality policies. The Plan permits only designated employees, who are trained in the proper handling of Subscriber information, to have access to and use of your information. The Plan sometimes contracts with other organizations or entities to assist with the delivery of care or administration of benefits. Any such entity must agree to adhere to the Plan's confidentiality and privacy standards.

When you enrolled in the Plan, you consented to certain uses and disclosures of information which are necessary for the provision and administration of services and benefits, such as: coordination of care; conducting quality activities, including Subscriber satisfaction surveys and disease management programs; verifying eligibility; fraud detection; and certain oversight reviews, such as accreditation and regulatory audits. When the Plan discloses Subscriber information, it does so using the minimum amount of information necessary to accomplish the specific activity.

The Plan discloses Subscribers' 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, the Plan discloses Subscriber information without individual identifiers and in all cases only discloses the amount of information necessary to achieve the purpose for which it was disclosed. The Plan will not disclose to other third parties, such as Employers, Subscriber-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, the Plan and all of its contracted health care Providers agree to provide Subscribers with access to, and a copy of, their medical records upon a Subscriber's request. In addition, your medical records cannot be released to a third party without your consent or unless permitted by law.

To review HPHC Insurance Company's Notice of Privacy Practices, visit www.harvardpilgrim.org (keyword: privacy) or call 888-333-4742 for a printed copy.

III. COVERED BENEFITS

A. INTRODUCTION

This section describes the products and services covered by the Plan.

The Plan covers services in conjunction with your benefits under Medicare Parts A and B. Medicare is the primary payer for Medicare covered services. The Plan will only provide coverage for such services after your Medicare benefits have been determined. The Plan also provides coverage for a number of benefits required by state law that may not be covered by Medicare. These benefits are described in Sections III.C (“State Mandated Benefits”) and III.D (“Additional Covered Services”), below.

Some Plans may include coverage for additional benefits not covered by Medicare. If your Plan includes such benefits you will find them described in Section III.D (“Additional Covered Services”) or your *Schedule of Benefits*.

To be covered by the plan, a product or service must meet each of the following basic requirements:

- It must be Medically Necessary;
- It must be received while enrolled as a Subscriber in the Plan;
- It must be either covered by Medicare or listed as a Covered Service in this *Benefit Handbook*, the *Schedule of Benefits* or the *Prescription Drug Brochure*; and
- It must not be listed as a product or service that excluded from coverage by the Plan.

All coverage is subject to the Subscriber cost sharing listed in the *Schedule of Benefits*. Payments by the Plan are limited to the Payment Maximum described in Section V (“Reimbursement and Claims Procedures”) and the Glossary. The Subscriber is responsible for any amount billed by a Provider that is in excess of the Payment Maximum.

B. SERVICES COVERED BY MEDICARE

This section describes your benefits for services that are covered by the Medicare program. The Plan covers the Medicare Deductible and Coinsurance amounts for all services covered by Medicare Parts A and B. All coverage is subject to the Subscriber cost sharing amounts (Copayments and Deductible, if applicable) stated in the *Schedule of Benefits*. In all cases, the decision of the Medicare program to provide coverage for a service must have been made before any Plan benefits will be payable under this section. No

coverage will be provided by the Plan for any service denied by Medicare unless the service is specifically listed in Sections III.C. or III. D., below.

The following is a summary of the services covered by Medicare Parts A and B. (Please see “*Medicare and You*” for additional information on Medicare coverage.) When Medicare Parts A or B covers a service but does not pay the full amount, the Plan covers the applicable Medicare Coinsurance and Deductible amounts up to the Payment Maximum. .

1. INPATIENT SERVICES

a. Hospital Care

Medicare coverage for Hospital inpatient care is determined by Benefit Periods. There is no limit to the number of Benefit Periods covered by Medicare during your lifetime. However, Medicare benefits for inpatient Hospital care are limited to 90 days during a Benefit Period. If you exhaust the 90-day limit, you can elect to use up to 60 additional days of inpatient Hospital care from your Medicare “lifetime reserve days.” These are non-renewable days of Hospital coverage that you may use only once in your life.

Most Hospital care covered by Medicare may be obtained at any Medicare certified Hospital, including a psychiatric Hospital. However, certain services, including liver, lung, heart, heart-lung, pancreas, and intestine transplants and bariatric surgery must be obtained at a Hospital that has been approved by Medicare for the specific type of surgery required. These Hospitals are required to meet strict quality standards. If Medicare requires that a service be provided at a Hospital specifically approved for the service, neither Medicare nor the Plan will provide any coverage if the service is obtained at an unapproved Hospital.

There is a 190-day Medicare lifetime limit on the coverage of services in a psychiatric Hospital. If the 190-day lifetime limit is reached, additional coverage for care in a psychiatric Hospital may be available under the Massachusetts mandated coverage for mental health and substance abuse rehabilitation described in Section III.C.1., below.

The Plan will provide the following coverage in connection with semi-private room and board and Special Services for Medicare covered inpatient Hospital services:

i. Deductible: The Plan will pay the Medicare Part A Deductible amount applicable to the 1st day of hospitalization through the 60th day of hospitalization in each Benefit Period.

ii. Coinsurance: The Plan will pay the Medicare Part A daily Coinsurance amount from the 61st day of hospitalization through the 90th day of hospitalization in each Benefit Period.

iii. Lifetime Reserve Days Coinsurance: The Plan will pay the Medicare lifetime reserve days daily Coinsurance amount from the 91st day of hospitalization in each Benefit Period for each of the 60 Medicare lifetime reserve days used.

Benefits for Non-Medicare Covered Hospital Services. Some Employers purchase coverage for Hospital care in excess of the Medicare limits described above. If your Plan includes such coverage, it will be listed in Section III.D (“Additional Covered Services”) and your *Schedule of Benefits*.

b. Care in a Skilled Nursing Facility (SNF)

The Plan covers the Medicare deductible and Coinsurance amounts for Medicare covered care in a Skilled Nursing Facility (SNF). Medicare covers up to 100 days per Benefit Period in a Medicare certified SNF. To be eligible for coverage, all rules applicable to Medicare coverage of SNF care must be met. These include the following:

- The Subscriber needs skilled nursing or rehabilitative care;
- The care is required on a daily basis;
- The care can, as a practical matter, only be provided in an inpatient setting; and
- The Subscriber must have been an inpatient in a Hospital for at least three days and enter the SNF within 30 days after Hospital discharge.

There is no coverage for care received in a SNF that does not meet Medicare coverage rules, including the requirements stated above.

The following is a description of the coverage provided by the Plan for care in a Medicare certified SNF:

i. First 20 Days: Medicare covers from the 1st day of inpatient services through the 20th day of inpatient services in each Benefit Period. No coverage is provided by the Plan.

ii. Coinsurance: The Plan will cover the Medicare Part A daily Coinsurance amount for a semi-private room and board and Special Services from the 21st day of inpatient services through the 100th day of inpatient services in each Benefit Period.

c. Care in a Religious Nonmedical Health Care Institution

The Plan will cover the Medicare Part A Coinsurance and Deductible amounts for inpatient care in a Religious Nonmedical Health Care Institution (RNHCI), such as a Christian Science Sanatorium. All Medicare conditions and limitations on the coverage of services in a RNHCI also apply to the coverage provided by the Plan. Religious aspects of care provided in RNHCIs are not covered.

2. OUTPATIENT SERVICES

a. Emergency Room Care

The Plan will pay the Medicare Coinsurance and Deductible amounts for Medicare covered services provided at a Hospital emergency room or other emergency facility.

b. Services of Physicians and Other Health Professionals

The Plan will pay the Medicare Coinsurance and Deductible amounts for Medicare covered services provided by physicians and other health professionals entitled to coverage by the Medicare program. Such health professionals include, but are not limited to, certified nurse-midwives, chiropractors, clinical social workers, clinical psychologists, dentists, nurse anesthetists, nurse practitioners, occupational therapists, physical therapists, physicians’ assistants, podiatrists, speech therapists, audiologists and registered dietitians. Please see Section III.B.2.k, below, for additional information on your coverage for physical, occupational and speech therapy.

Medicare coverage includes unlimited visits with mental health professionals eligible for payment by Medicare. These include physicians, clinical psychologists and clinical social workers.

Please note that very limited coverage is provided for the services of chiropractors and dentists. Medicare only covers the services of chiropractors for manual manipulation of the spine to correct a spinal subluxation. However, some Employers purchase coverage for chiropractic care in excess of the Medicare limits described above. If your Plan includes such coverage, it will be listed in your *Schedule of Benefits*. Please see Section III.B.2.m (“Dental Care and Oral Surgery”) for the circumstances under which the services of a dentist may be covered.

The services of podiatrists are covered by Medicare to treat injuries and diseases of the foot. Neither Medicare nor the Plan will cover most routine foot care, such as cutting of nails, the trimming of corns and bunions or the removal of calluses. However, Medicare does cover routine foot care that is Medically Necessary due to circulatory system disease, such as diabetes.

c. Preventive Care Services

Medicare covers a number of preventive care services at no cost to Members. The Plan will pay the Medicare Coinsurance and Deductible amounts for all Medicare covered preventive care services, if any.

Medicare coverage includes a one-time “Welcome to Medicare” physical examination received within the first 12 months a beneficiary is covered by Medicare Part B. HPHC recommends that Subscribers utilize this benefit if available. After being enrolled in Medicare Part B for one year, Medicare also covers a yearly physical exam, known as a “Wellness” visit. The first yearly physical exam must take place at least 12 months after the “Welcome to Medicare” physical examination, if a beneficiary has had one.

When specific Medicare coverage criteria are met, Medicare also provides coverage for preventive services including, but not limited to: (1) Pap tests, pelvic and breast exams; (2) Mammograms; (3) Prostate cancer screenings; (4) Diabetes screenings and (5) bone mass measurements; (6) glaucoma testing; (7) medical nutrition therapy; (8) counseling to stop smoking; (9) colorectal cancer screening, including fecal occult blood tests, flexible sigmoidoscopy, colonoscopy and barium enema examinations; and (10) immunizations for flu, pneumonia and hepatitis B. Coverage for mammograms includes a baseline mammogram for women between ages 35 and 39 and an annual mammogram for women 40 years of age and older.

In addition, your Plan covers a number of preventive care services not covered by Medicare. Please see Section III.D. 2. (“Preventive Care Services”) for the details of your coverage.

Please consult with your doctor and refer to *Medicare and You* for further information on Medicare covered preventive services that may benefit you.

d. Diagnostic Tests and Procedures

The Plan will pay the Medicare Coinsurance and Deductible amount for Medicare covered diagnostic laboratory tests, X-ray examinations and other diagnostic procedures.

e. Medical Therapies

The plan will pay the Medicare Coinsurance and Deductible amounts for Medicare covered therapeutic services. These include surgery, radiation therapy for cancer, and therapy for any condition for which isotopes, radium, or radon seeds are used. Also covered are chemotherapy and immunosuppressive drugs (and their administration) when such medications cannot be self-administered. (If your Employer Group has purchased the Plan’s prescription drug coverage, please see your *Prescription Drug Brochure* for information on your coverage of self-administered medications.)

Medicare covered services include post-mastectomy coverage for (1) surgical reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) physical complications for all stages of mastectomy, including lymphedemas, in a manner determined by the attending physician and the patient.

f. Durable Medical Equipment and Prosthetic Devices

The Plan will pay the Medicare Coinsurance and Deductible amounts for Medicare covered durable medical equipment and Prosthetic Devices. Medicare coverage is provided only for equipment or devices that are Medically Necessary for the treatment of illness or injury or to improve the functioning of a malformed body part.

Durable Medical Equipment is defined by Medicare as equipment which (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) generally is not useful in the absence of illness or injury and (4) is appropriate for use in the home. Examples of such equipment include oxygen and oxygen equipment, blood glucose monitors, hospital beds, crutches and canes.

Medicare defines prosthetic equipment as a device that replaces an internal body organ. Examples of such devices include cardiac pacemakers, prosthetic lenses, breast prostheses (including mastectomy bras) and eyeglasses or contact lenses after cataract surgery.

No coverage is provided for equipment that is not covered by Medicare, including, but not limited to, dentures or dental appliances. In addition, no coverage is provided for equipment provided by a company that is not enrolled in the Medicare program.

g. Home Health Care

Medicare provides coverage for Medically Necessary home health services if you are confined

to home. Services covered by Medicare may include intermittent skilled nursing care, physical therapy, occupational therapy, speech therapy, medical social services, nutritional counseling, the services of a home health aid, medical supplies and Durable Medical Equipment. A Medicare Participating Home Health Agency must provide Home Health Care Services.

Since no Medicare Deductible or Coinsurance amounts apply to home health care (other than Durable Medical Equipment), no additional coverage for home health care is provided by the Plan except that the Plan covers Medicare Coinsurance and Deductible amounts for Medicare covered Durable Medical Equipment furnished in connection with the Home Health Care Services. Please see Section III.B.2.f, above, for information on benefits for Durable Medical Equipment.

h. Ambulance Services

The Plan will pay the Medicare Part B Coinsurance and Deductible amount for Medicare covered ambulance transportation. Medicare covers ambulance services only if the ambulance Provider meets Medicare requirements and transportation by any other vehicle would endanger your health. In general, Medicare benefits are only provided for transportation between the following locations, (1) home and a Hospital, (2) home and a Skilled Nursing Facility (SNF) or (3) a Hospital and a Skilled Nursing Facility.

i. Hospice Care

Medicare covers Hospice services for a Subscriber with a Terminal Illness, when provided by a Medicare certified Hospice. The Plan will provide coverage for Medicare Deductible and Coinsurance amounts for Medicare covered Hospice care.

j. Kidney Dialysis

The Plan will pay the Medicare Coinsurance and Deductible amounts for Medicare covered kidney dialysis.

k. Physical, Occupational and Speech Therapy

The Plan will pay the Medicare Coinsurance and Deductible amounts for Medicare covered physical, occupational and speech therapy. In order to be covered by Medicare a physician must certify that: (1) the patient required the therapy; (2) a plan of care has been established; and (3) the services were provided while the patient was under the care of a physician. (Additional coverage for the diagnosis and treatment of speech, hearing and language disorders may be available for services not covered

by Medicare. Please Section III.C.7., below, for further information.)

l. Partial Hospitalization

The Plan will pay the Medicare Coinsurance and Deductible amounts for Medicare covered partial hospitalization for mental health and drug and alcohol abuse rehabilitation. Partial hospitalization services are an acute level of care that is more intensive than traditional outpatient services, but less intensive than 24-hour care. Medicare covers partial hospitalization when inpatient care would otherwise be required. Programs providing primarily social or recreational activities are not covered.

m. Dental Care and Oral Surgery

Medicare does not cover Dental Services. However, Medicare has determined that certain services provided by dentists or oral surgeons are primarily medical in nature and therefore eligible for Medicare coverage. The following are examples of services that are generally eligible for coverage by Medicare:

- The extraction of teeth to prepare the jaw for radiation treatment for neoplastic disease.
- Surgery of the jaw or related structures.
- Setting fractures of the jaw or facial bones.
- Services of a dentist that would be covered if provided by a physician, such as the treatment of oral infections and tumors.
- Dental examinations to diagnose an infection that would contraindicate surgery.

The Plan will pay the Medicare Coinsurance and Deductible amounts for the services of dentists and oral surgeons that have been covered by Medicare. No other Dental Services are covered unless your Employer Group has purchased additional coverage for such services. If additional coverage for Dental Services is available to you, it will be listed in your *Schedule of Benefits*.

n. Outpatient Prescription Drug Coverage

If your Employer Group has purchased Plan coverage for outpatient prescription drugs, that coverage is described in the *Prescription Drug Brochure* you received with this *Benefit Handbook*. It provides benefits for most prescription medications, subject to the Copayments listed on your Plan ID card. The Plan's drug coverage meets Medicare Part D creditable coverage requirements.

Please see the *Prescription Drug Brochure* for the details of the Plan's drug coverage.

If your Employer Group has not purchased outpatient drug coverage through the Plan, we recommend that you purchase a Prescription Drug Plan under Medicare Part D. If you delay getting drug coverage, a late enrollment penalty may apply. Please see the publication *Medicare and You* for information about Medicare Drug Plans.

Even if your Employer does not purchase the Plan's drug coverage, the Plan will pay the Medicare Coinsurance and Deductible amounts for any drug covered by Medicare Part B. **However, Medicare Part B drug coverage is very limited. Most standard outpatient drugs are not covered.**

When Medicare criteria are met, drugs covered by Medicare Part B may include: (1) injected drugs you get in a doctors office; (2) certain oral cancer drugs; (3) drugs used with some types of Durable Medical Equipment such as a nebulizer or infusion pump; (4) Hemophilia clotting factors; (5) antigens; (6) certain immunosuppressive drugs; and (7) Erythropoietin (EPO);.

This list is provided for informational purposes only and does not include all Medicare covered drugs. Specific information on the drugs covered by Medicare Part B and the criteria for coverage must be obtained from the Medicare program.

o. Coverage for Clinical Trials

The plan will pay the Medicare Coinsurance and Deductible amounts for Medicare covered services received during participation in a clinical trial. Please see the Medicare publication "Medicare & Clinical Trials," available from the Center for Medicare and Medicaid Services (CMS), for information on the Medicare coverage requirements for clinical trials.

p. Diabetes Screening and Treatment

The Plan will pay the Medicare Coinsurance and Deductible amounts for Medicare covered services for the screening and treatment of Diabetes. Subject to Medicare coverage criteria, these services include, but are not limited to, the following:

- Diabetes screening;
- Diabetes self-management training;
- Diabetic laboratory tests;
- Blood sugar self-testing equipment and supplies. These include blood glucose monitors and test strips, lancet devices and lancets and glucose control solutions;

- Insulin pumps and insulin used with an insulin pump;
- Therapeutic shoes or inserts for people with severe diabetic foot disease (if certified by a physician).

Insulin (other than insulin administered with an insulin pump) is covered under the Plan's coverage for outpatient prescription drug coverage (if available under your Employer Group's plan). Insulin is also covered under Medicare Part D drug plans. Needles and syringes for the administration of Insulin are covered by this Plan. Please refer to Section III.C.6 of this *Benefit Handbook*.

C. STATE MANDATED BENEFITS

This section lists additional Plan benefits that are required by Massachusetts law, which may not be covered by Medicare. If Medicare coverage is available for any service listed below, the coverage provided by the Plan is reduced by the Subscriber's Medicare benefits.

1. MENTAL HEALTH CARE AND SUBSTANCE ABUSE REHABILITATION SERVICES

The Plan provides coverage for Medicare Coinsurance and Deductible amounts for mental health and substance abuse rehabilitation services covered by Medicare. The Plan also covers additional benefits for such services that are mandated by Massachusetts law. Your Massachusetts mandated coverage is explained in this subsection.

When Medicare coverage is available for any of the services listed below, the Plan will cover only the applicable Medicare Coinsurance and Deductible amounts. When Medicare does not cover a service listed, payment for Medically Necessary Covered Services shall be made by the Plan up to the Payment Maximum, minus any applicable Copayment, as described below.

a. Covered Providers

The Medicare covered services described in Section III.B, above, are only available from Providers who are eligible to bill Medicare for Covered Services. The Massachusetts mandated mental health and substance abuse rehabilitation services may be obtained from any of the following types of Providers, some of whom may not be eligible for payment by Medicare.

Inpatient Care: In addition to Medicare certified institutions, the Plan will cover the Massachusetts mandated mental health and drug and alcohol abuse

rehabilitation services described in this section on an inpatient basis at any Inpatient Mental Health Facility in Massachusetts. An Inpatient Mental Health Facility is any one of the following types of institutions:

- A general Hospital licensed to provide such services;
- A facility under the direction and supervision of the Massachusetts Department of Mental Health;
- A private mental Hospital licensed by the Massachusetts Department of Mental Health; or
- A substance abuse facility licensed by the Massachusetts Department of Public Health.

Intermediate Care Services: In addition to care at Medicare Certified institutions, the Plan will cover Massachusetts mandated intermediate care services at any of the following types of facilities in Massachusetts that are licensed or approved by the Massachusetts Department of Public Health or the Massachusetts Department of Mental Health:

- A Level III Community Based Detoxification Facility;
- An Acute Residential Treatment Facility;
- A Partial Hospitalization Program;
- A Day Treatment Program; or
- A Crisis Stabilization Program.

Outpatient Care: The Plan will cover the Massachusetts mandated mental health and substance abuse rehabilitation services described in this section on an outpatient basis at any of the following:

- A licensed Hospital;
- A mental health or substance abuse clinic licensed by the Massachusetts Department of Public Health;
- A public community mental health center;
- A professional office; or
- Home-based services.

To be covered, a Licensed Mental Health Professional acting within the scope of his or her license must render such services. A “Licensed Mental Health Professional” is any 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; or a licensed mental health counselor.

b. Minimum Benefits for Mental Health Services

Massachusetts law provides minimum benefits for mental health services. Although Medicare provides extensive coverage for mental health services, there are circumstances in which no Medicare coverage is available. This might happen (1) where a Subscriber had used all of his or her Medicare covered inpatient days (described above in Section III.B.1.a, “Hospital Care”); or (2) where a Subscriber wanted to receive care from a Provider, such as a licensed Mental Health Counselor, who is not eligible for payment by Medicare. In such cases, the Plan will provide coverage, less any payments made by Medicare, for the diagnosis and treatment of all mental disorders, which are described in the most recent edition of the Diagnostic and Statistical Manual and the American Psychiatric Association (DSM), as follows:

- i. Inpatient Treatment:** The Plan will cover Medically Necessary inpatient mental health treatment for up to 60 days in a calendar year when provided at an Inpatient Mental Health Facility.
- ii. Outpatient Treatment:** The Plan will cover Medically Necessary outpatient mental health services for 24 outpatient visits per calendar year when services are rendered by a Licensed Mental Health Professional.

Please note that the benefit limits stated above do not apply to service provided for the mental health conditions described below in Subsection c (“Special Benefits for Certain Conditions”). Please see that subsection for additional benefits that may apply.

c. Special Benefits for Certain Conditions

Under the Massachusetts law special benefits are provided for the following specific mental health conditions:

- i. Biologically-Based Mental Disorders:** Biologically-based mental disorders are: (1) schizophrenia; (2) schizoaffective disorders; (3) major depressive disorder; (4) bipolar disorder; (5) paranoia and other psychotic disorders; (6) obsessive-compulsive disorder; (7) panic disorder; (8) delirium and dementia; (9) affective disorders; and (10) eating disorders; (11) post-traumatic stress disorders; (12) substance abuse disorders; and (13) autism.
- ii. Services Required As A Result Of Rape:** When services are required to diagnose and treat rape-related mental or emotional disorders for victims of rape or victims of an assault with the attempt to commit rape.

If you are diagnosed as having one of the specific mental conditions described above in this subsection, the Plan will cover Medically Necessary services, less any payments by Medicare, as follows:

- In the case of inpatient care, for the same number of days as the benefits available for Hospital care for a physical illness. This includes any coverage, in addition to Medicare benefits, provided by your Employer Group.
- In the case of intermediate care, to the extent Medically Necessary
- In the case of outpatient care, to the extent Medically Necessary.

d. Detoxification and Psychopharmacological Services

The Plan will provide coverage, less any payments made by Medicare, for detoxification and psychopharmacological services to the extent Medically Necessary.

e. Psychological Testing and Neuropsychological Assessment

The Plan will provide coverage, less any payments made by Medicare for psychological testing and neuropsychological assessment to the extent Medically Necessary.

2. SPECIAL FORMULAS FOR MALABSORPTION

The Plan will provide coverage, less any payments made by Medicare, for nutritional formulas for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, and chronic pseudo-obstruction. In order to be covered, formulas for these conditions must be ordered by a physician.

3. WIGS

The Plan will provide coverage of a scalp hair prosthesis (wig) up to the amount specified in the *Schedule of Benefits* when the treating physician provides the Plan with a written statement that the wig is Medically Necessary and needed as a result of treatment for any form of cancer or leukemia.

4. BONE MARROW TRANSPLANTS FOR BREAST CANCER

The Plan will provide coverage, less any payments made by Medicare, for autologous bone marrow transplants for metastasized breast cancer in accordance with the criteria established by the Massachusetts Department of Public Health.

5. LOW PROTEIN FOODS

The Plan covers low protein foods for inherited diseases of amino and organic acids up to the amount specified in the *Schedule of Benefits*.

6. HYPODERMIC SYRINGES AND NEEDLES

The Plan covers hypodermic syringes and needles to the extent Medically Necessary. If you use a non-Plan pharmacy or you do not have Harvard Pilgrim's Outpatient Prescription Drug Rider, you must file a claim as described in Section V.E ("Claims for Services Not Covered by Medicare"). If you have Harvard Pilgrim's Outpatient Prescription Drug Rider, you must get a prescription from your physician and present it at a pharmacy with your Plan ID card. Please see your Schedule of Benefits for the Copayments that apply.

7. SPEECH-LANGUAGE AND HEARING SERVICES

The Plan will provide coverage, less any payments made by Medicare, for diagnosis and treatment of speech, hearing and language disorders to the extent Medically Necessary. To be covered, services must be provided by a state licensed speech-language pathologist or audiologist.

8. CONTRACEPTIVE SERVICES AND HORMONE REPLACEMENT THERAPY

The Plan provides coverage, less any payments made by Medicare, for outpatient professional services for the prevention of pregnancy and in connection with the use of hormone replacement therapy for peri- and post-menopausal women. Such services include consultations, examinations, and procedures related to all methods of contraception that have been approved by the United States Food and Drug Administration. Please note that contraceptive drugs and devices and hormone replacement drugs are only covered if your Employer has selected the Plan's prescription drug coverage. If such coverage is available, please see your *Prescription Drug Brochure* for details.

9. MASSACHUSETTS MANDATED COVERAGE FOR HOSPICE CARE

In addition to the benefit for Medicare covered Hospice care described in Section III.B.2.i, above, the Plan will cover Hospice care provided by a Hospice licensed by the Massachusetts Department of Public Health that is not eligible for payment by Medicare. To qualify for coverage, a Subscriber must be terminally ill with a life expectancy of six months or less and receive authorization for Hospice care from a licensed physician.

10. ORAL MEDICATION FOR THE TREATMENT OF CANCER

The Plan provides coverage, less any payments made by Medicare, for certain prescribed orally administered medications for the treatment of cancer. Such medications are covered under your Benefit Handbook, whether or not you have the Plan's optional outpatient pharmacy benefit. The Member cost sharing that you must pay for such orally administered medications for the treatment of cancer shall not be higher than for drugs that cannot be self-administered, as described in your Benefit Handbook. Drugs that cannot be self-administered include intravenously administered or injected cancer medications.

11. CYTOLOGIC SCREENING (PAP SMEARS)

The Plan will provide coverage, less any payments made by Medicare, for an annual cytologic screening (Pap Smear) for women 18 years of age and older.

12. LYME DISEASE

The Plan will provide coverage for long-term antibiotic therapy for a Member diagnosed with Lyme disease as required by law. Please note: the plan will provide coverage for a long-term antibiotic drug, including an experimental drug, for an off-label use in the treatment of Lyme disease if the drug has been approved by the United States Food and Drug Administration.

13. LIPODYSTROPHY SYNDROME

The Plan will provide coverage for 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.

D. ADDITIONAL COVERED SERVICES

1. NON-MEDICARE COVERED HOSPITAL SERVICES

The Plan covers Hospital care in excess of the limits on Medicare coverage summarized on Section III.B.1.a, above. If all of the conditions outlined below are met, there is no limit to the number of days of Hospital care that may be covered by the Plan beyond the last day of Medicare Hospital coverage. Benefits for Hospital care in excess of Medicare limits will only be paid by the Plan only if all of the following conditions are met:

(1) the care is provided in a Medicare certified Hospital; (2) all 60 of the Subscriber's Medicare Lifetime Reserve Days have been used; (3) the Hospital services are Medically Necessary; and (4) Medicare coverage of Hospital care terminated because the Subscriber reached the day limits on Medicare covered Hospital services and not for any other reason.

2. PREVENTIVE CARE SERVICES

This section lists the preventive care services covered by either Medicare or the Plan. In some cases, Medicare coverage may be available for part of a service, the remainder of which is covered by the plan. If Medicare coverage is available for any service listed below, the Plan will pay the Medicare Coinsurance and Deductible amount. If Medicare coverage is not available, the Plan will cover the service up to the Payment Maximum.

a. Physician's Services

The Plan provides coverage, less any payments by Medicare, for the following preventive care services:

- i. An annual physical examination by a licensed physician, including education in self-care, blood pressure check, Pap Test and pelvic examination, clinical breast examination, fecal occult blood test, prostate cancer screening, nutritional counseling, and routine laboratory and blood tests.
- ii. The following preventive care services are covered to the extent Medically Necessary: immunizations, diabetes screenings, cholesterol measurements, glaucoma screening, prenatal and postpartum care and screenings for sexually transmitted diseases.

b. Diagnostic Tests and Procedures

The Plan or Medicare covers the following diagnostic tests, in addition to the preventive care services listed above, to the extent Medically Necessary:

- i. Colorectal cancer screening, including flexible sigmoidoscopy, colonoscopy, and barium enema;
- ii. Bone Mass Measurements;
- iii. An annual vision examination (including glaucoma screening); and
- iv. An annual hearing examination.

Coverage is also provided for a baseline mammogram for women between ages 35 and 39 and an annual mammogram for women 40 years of age and older.

3. SERVICES RECEIVED OUTSIDE OF THE UNITED STATES

This section describes the Plan's coverage for services received outside of the United States and its territories. (Generally, Medicare only covers services received within the United States.) Please note that the Plan's coverage is intended for persons living in the United States who travel to other countries. It is not intended for persons living outside the United States.

The Plan covers services received outside of the United States when needed to care for an unexpected Medical Emergency that takes place while traveling away from home. Covered Services include, but are not limited to, Medically Necessary emergency room care, physician services, and hospital care immediately following a Medical Emergency. Transportation by ambulance is covered only for a road ambulance from the place where a Medical Emergency takes place to the nearest hospital.

A Medical Emergency is a medical condition, whether physical or mental, 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 Subscriber or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part. With respect to a pregnant woman who is having contractions, Medical Emergency also means that there is inadequate time to effect a safe transfer to another hospital before delivery or that transfer may pose a threat to the health or safety of the woman or the unborn child.

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

No benefits will be provided for any service received outside of the United States that is: (1) a routine or preventive service of any kind; (2) a service that was, or could have been, scheduled before leaving the United States, even if such scheduling would have delayed travel plans; (3) a form of transportation, including transportation back to the United States, except road ambulance to the nearest hospital; or (4) a service that would not be covered by Medicare or the Plan in the United States.

4. HOME INFUSION THERAPY

Medicare does not cover most home infusion therapies. Infusion therapy involves the administration of drugs and nutritional products that must be administered intravenously or through a feeding tube. The Plan provides coverage, less any payments made by Medicare, for the following infusion therapies administered in the Subscriber's home: (1) parenteral nutrition, (2) enteral nutrition, (3) hydration, (4) pain management, and (5) antibiotic, antifungal and antiviral therapies. Coverage includes the drug or nutritional product being infused and Medically Necessary professional services, including mid-line and PICC line insertions.

In order to be covered under this benefit (1) all products and services must be Medically Necessary and (2) there must be a medical reason that appropriate drugs or nutritional products cannot be taken orally. Coverage by the Plan is only available for services that are not covered by Medicare. Please see Section III.B.2.g, above, for information on Medicare covered home health care.

5. HEARING AIDS

If your Employer Group has purchased Plan coverage for hearing aids, that coverage is described in the *Schedule of Benefits* you received with this *Benefit Handbook*.

6. EYEGLASSES

If your Employer Group has purchased Plan coverage for eyeglasses, that coverage is described in the *Schedule of Benefits* you received with this *Benefit Handbook*.

IV. EXCLUSIONS FROM COVERAGE

A. No benefits will be provided by the Plan for any of the following:

1. Any product or service that is not covered by Medicare unless specifically listed as a Covered Service in this *Benefit Handbook*, the *Schedule of Benefits* or the *Prescription Drug Brochure* (if applicable).
2. Any charges for products or services covered by a Medicare Advantage plan operated under Medicare Part C or a Prescription Drug Plan (PDP) under Medicare Part D.
3. Any product or service obtained at an unapproved hospital (or other facility) if Medicare requires that a service be provided at a Hospital (or other facility) specifically approved for that service. This exclusion applies to weight loss (bariatric) surgery; liver, lung, heart, heart-lung, pancreas, and intestine transplants; and any other services Medicare determines must be obtained at a Hospital (or other facility) that has been specifically approved for a specific service to be eligible for coverage by Medicare.
4. Any product or service that is provided to you after the date on which your enrollment in the plan has ended.
5. Any charges that exceed the Payment Maximum. (Please see the Glossary for the definition of "Payment Maximum.")
6. Any products or services received in a hospital not certified to provide services to Medicare beneficiaries, unless (1) the hospital is outside the United States, (2) the Subscriber's Plan includes benefits for services outside of the United States, and (3) coverage is available under that benefit.
7. Any product or service for which no charge would be made in the absence of insurance.

B. No Benefits will be provided by the Plan for any of the following unless covered by Medicare Parts A or B:

1. Any product or service that is not Medically Necessary.
2. Any product or service (1) for which you are legally entitled to treatment at government expense or (2) for which payment is required to be made by a Workers' Compensation plan or laws of similar purpose.
3. Any charges for inpatient care over the semi-private room rate, except when a private room is Medically Necessary.
4. Any product or service received outside of the United States that is: (1) related to the provision of routine or preventive care of any kind; (2) a service that was, or could have been, scheduled before leaving the United States, even if such scheduling would have delayed travel plans; (3) a form of transportation, including transportation back to the United States, except road ambulance to the nearest hospital; or (4) a service that would not be covered by Medicare or the Plan in the United States.
5. Any product or service that is Experimental or Unproven. (Please see the Glossary for the definition of "Experimental or Unproven.")
6. Private duty nursing unless specifically listed as a Covered Service in your *Schedule of Benefits*.
7. Cosmetic services or products, including, but not limited to, cosmetic surgery, except for services required to be covered under the Women's Health and Cancer Rights Act of 1998.
8. Rest or Custodial Care.
9. Eyeglasses and contact lenses, or examinations to prescribe, fit, or change eyeglasses or contact lenses unless specifically listed as a Covered Service in your *Schedule of Benefit*. (Note that Medicare provides limited benefits for eyeglasses or contact lenses after cataract surgery.)
10. Hearing aids unless specifically listed as a Covered Service in your *Schedule of Benefits*.
11. Biofeedback, massage therapy (including myotherapy), sports medicine clinics, treatment with crystals or routine foot care services such as the trimming of corns and bunions, removal of calluses, unless such care is Medically Necessary due to circulatory system disease such as diabetes.

12. Foot orthotics, except as required for the treatment of severe diabetic foot disease.
13. Any form of hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. (Please see Section III.C.3. for the coverage provided for wigs)
14. Dental Services, including, but not limited to, restorative, periodontal, orthodontic, endodontic, prosthodontic services (including any services related to dentures), or any Dental Services relative to the treatment of temporomandibular joint dysfunction (TMJ), except that (1) the Plan will cover the Medicare Coinsurance and Deductible amount for any Dental Service that has been covered by Medicare and (2) the Plan will cover additional Dental Services if such coverage is purchased by an Employer Group. If your Employer Group has purchased coverage for additional Dental Services, such coverage will be listed in your *Schedule of Benefits*. (Please see the Glossary for the definition of “Dental Services.”)
15. Infertility services or any related services supplies or drugs, including, but not limited to, in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intra-cytoplasmic sperm injection, donor egg procedures (including related egg and inseminated egg procurement), the preservation of eggs or sperm, voluntary sterilization or the reversal of voluntary sterilization, or any form of Surrogacy. (Please see the Glossary for the definition of “Surrogacy.”)
16. Ambulance services except as specified in this *Benefit Handbook* or the *Schedule of Benefits*. No benefits will be provided for transportation other than by ambulance.
17. Exercise equipment; or personal comfort or convenience items such as radios, telephone, television, or haircutting services.
18. Any product or service provided by (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
19. Refractive eye surgery, including laser surgery, orthokeratology or lens implantation for correction of myopia, hyperopia and astigmatism.
20. Any products or services related to diet plans or weight loss programs, including diet foods, drinks or drugs of any kind. (However, the Plan will cover Medicare Coinsurance and Deductible amounts for professional services or surgery covered by Medicare for the treatment of obesity.)
21. Drugs or medications that can be self-administered unless (1) the Employer Group has purchased prescription drug coverage on behalf of the Subscriber and coverage for such drug or medication is provided for in the *Prescription Drug Brochure*, (2) the drug or medication is covered by Medicare Parts A or B; or (3) coverage for the drug or medication is mandated by Massachusetts law.
22. Educational services or testing; services for problems of school performance; sensory integrative praxis tests, vocational rehabilitation, or vocational evaluations focused on job adaptability, job placement, or therapy to restore function for a specific occupation.
23. Planned home births.
24. Gender reassignment surgery or any related drugs and procedures.
25. Devices or special equipment needed for sports or occupational purposes.
26. 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 Service under this *Benefit Handbook*.
27. Acupuncture, aromatherapy, or alternative medicine unless specifically listed in the *Schedule of Benefits*
28. Mental health services that are (1) provided to Subscribers 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.

V. REIMBURSEMENT AND CLAIMS PROCEDURES

A. INTRODUCTION

This section explains how to obtain payments for Covered Services from the Plan. Because Plan benefits generally depend upon the coverage provided by Medicare, Providers must bill Medicare for services covered by Medicare before billing the Plan.

The Plan will usually cover benefits by making payments directly to service Providers. However, there are times when the Plan will pay you instead. This might occur, for example, when you have already paid the Provider for a Covered Service or when a Provider does not accept Medicare assignment. In such cases, the Plan may pay benefits directly to you.

Claims will be paid minus the Copayment, if applicable, that is listed in your *Schedule of Benefits*. All payments by the Plan are limited to the Payment Maximum described in the Subsection J, below. You are responsible for any amount billed by a Provider that is in excess of the Payment Maximum.

Claims will be reviewed within 45 days of receipt. If a claim cannot be paid within that time, the plan will either notify the Subscriber (1) that additional documentation is needed or (2) that the claim is denied, in whole or in part, and the reasons for denial. If the Plan does not provide such notice, interest will be payable to the Subscriber at the rate of 1.5% per month (not to exceed 18% per year) on the amount of benefits payable, beginning 45 days after receipt of the claim. No interest will be payable on any claim that the Plan is investigating because of suspected fraud.

B. THE ADDRESS FOR SUBMITTING CLAIMS

1. MEDICAL CLAIMS

All medical claims for benefits must be submitted to the Plan at the following address:

Medicare Enhance Claims
HPHC Insurance Company, Inc.
P.O. Box 699183
Quincy, MA 02269-9183

The Plan provides limited coverage for certain state mandated outpatient pharmacy products to Subscribers who do not have the Plan's outpatient prescription drug rider. Claims for these limited services should also be submitted to the address listed above.

2. MENTAL HEALTH OR DRUG AND ALCOHOL REHABILITATION CLAIMS

All claims for mental health or drug and alcohol rehabilitation should be mailed to:

HPIC - Behavioral Health Access Center
C/O United Behavioral Health
P.O. Box 31053
Laguna Hills, CA 92654-1053

3. PHARMACY CLAIMS

If your Employer Group has purchased Plan coverage for outpatient prescription drugs, requests for the reimbursement of pharmacy expenses must be sent to:

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

Please see Subsection G, below, for information on filing pharmacy claims.

C. CLAIMS FOR SERVICES COVERED BY MEDICARE PART A

This section explains the procedure to follow to obtain benefits for services covered by Medicare Part A, also known as Medicare Hospital Insurance. Medicare Part A services include inpatient care received in Hospitals, Skilled Nursing Facilities (SNFs) and Religious Nonmedical Health Care Institutions (RNHCIs). Medicare Part A also covers Hospice services and some home health care.

Use this procedure to file a claim for any inpatient service that is, or may be, eligible for coverage by Medicare Part A. See Subsections E (“Claims for Services Not Covered By Medicare”) and F (“Claims for Services Received in a Foreign Country”), below, for information on how to file a claim for an inpatient service that is not covered by Medicare. To obtain benefits for services under Medicare Part A, please follow these steps:

1. **Bill Medicare First.** Providers should first submit claims for Medicare Part A services to Medicare. Medicare will either pay the claim, in whole or in part, or deny coverage. You will be sent a Medicare Summary Notice (MSN). The MSN states the payment made by Medicare and explains any amount that was denied.
2. **Then Bill Medicare Enhance.** After the Medicare Summary Notice (MSN) is received from Medicare, the Subscriber or Provider must send each of the following items to the Plan to the address listed above:
 - i. A copy of the Medicare Summary Notice (MSN); and
 - ii. A standard UB 92 claim form completed by the Provider. (If a completed UB 92 claim form cannot be submitted, please see below.)

If a completed UB 92 claim form cannot be submitted, most claims can be processed using an itemized bill from the Provider in place of the claim form. Such an itemized bill must contain the following: The Provider’s name and address, the Provider’s Medicare identification number, the date the service was rendered, the diagnosis and procedure codes for the service, and the dollar amount of the claim.

The Plan may require the submission of additional information on some claims.

D. CLAIMS FOR SERVICES COVERED BY MEDICARE PART B

This section explains the procedure to follow to obtain benefits for services covered by Medicare Part B, also known as Medicare Supplemental Medical Insurance for the Aged and Disabled. Medicare Part B covers most outpatient services including most physician care, diagnostic tests, outpatient surgery, outpatient mental health care, physical, occupational and speech-language therapy and Durable Medical Equipment.

1. **PROVIDER BILLING FOR PART B SERVICES**

Health care professionals, such as physicians, and suppliers of health care equipment and supplies, may bill for Medicare covered services using one of two billing methods. These are that a Provider may either (1) “accept assignment” or (2) “not accept assignment” from Medicare. The following information on these billing methods is provided, for informational purposes only, to assist you in understanding your medical bills and the coverage available from the Plan. Please see the Medicare publication, *Medicare and You* for additional information on assignment and the limits that apply to Provider charges.

a. The Assignment Method Under Medicare

If a Provider accepts assignment from Medicare, the Provider agrees that he or she will accept Medicare’s approved (or “allowable”) amount as payment in full for the service rendered. When a physician accepts assignment the physician may not bill for more than the Medicare allowable amount and Medicare will pay the physician directly.

When a Provider accepts assignment, physician payment would generally work as follows:

The Provider would bill Medicare. Medicare would pay the Provider directly and send you a Medicare Summary Notice (MSN) explaining the payment. Then, either you or the Provider may file a claim with the Plan for the balance due the Provider. For most physician services the Plan will cover any unmet Medicare Deductible amount and the 20% Medicare Coinsurance amount, minus any Copayment you owe.

b. The Non-Assignment Method Under Medicare

If a Provider does not accept assignment from Medicare, the Provider may charge you more than the Medicare approved amount. If the Provider selects that option, Medicare will not pay the Provider directly. Medicare will pay benefits to the Subscriber and the Subscriber is responsible for paying the Provider.

When a Provider does not accept assignment, physician payment would generally work as follows:

The Provider would bill Medicare. Medicare would pay you and send you a Medicare Summary Notice (MSN) explaining the payment. In most cases, you would then file a claim with the Plan. For most physician services the Plan will cover any unmet Medicare Deductible amount and the 20% Medicare Coinsurance amount, minus any Copayment you owe. The 20% Coinsurance amount paid by the Plan is based on the Medicare approved amount, not the Provider's actual charge. If the Provider charged you an amount in excess of the Medicare approved amount, you are responsible for paying that excess. You must pay the physician directly.

2. BILLING THE PLAN

After Medicare has been billed and sent you a Medicare Summary Notice (MSN) for a Medicare Part B service, you or the Provider may file a claim with the Plan for any Copayment and Deductible amounts that have not been paid by Medicare. Since the Plan covers some services that are not covered by Medicare, you may also bill the Plan for services that Medicare has denied.

To file a claim with the Plan, the Subscriber or Provider must send each of the following items to the Plan to the address listed in Subsection B, above:

1. A copy of the Medicare Summary Notice (MSN); and
2. A standard CMS 1500 claim form completed by the Provider. (If a completed CMS 1500 claim form cannot be submitted, please see below.)

If a completed CMS 1500 claim form cannot be submitted, most claims can be processed using an itemized bill from the Provider in place of the claim form. Such an itemized bill must contain the following: The Provider's name and address, the Provider's tax identification number, the date the service was rendered, the diagnosis and procedure codes for the service, and the dollar amount of the claim

The Plan may require the submission of additional information on some claims.

E. CLAIMS FOR SERVICES NOT COVERED BY MEDICARE

The Plan covers a number of services that are not covered by Medicare. These services are described in Section III.C ("State Mandated Benefits") and, if included in your Plan, Section III.D ("Additional Covered Services"), above, or in your *Schedule of Benefits*. In addition, professionals or institutions that are not eligible to bill Medicare may provide certain Covered Services under Section III.C of this Handbook. This section describes how to file a claim for a service that is not covered by Medicare.

Whenever possible, your Providers should first bill Medicare for the services you receive. Submission of a Medicare Summary Notice (MSN), even if Medicare denies coverage, will prevent delays in the processing of claims that might be eligible for Medicare coverage. To bill the Plan for a service that is not covered by Medicare, please follow the procedure outlined below. If your Plan includes benefits for services rendered outside the United States, please follow the procedures outlined in the next section for such services.

To file a claim with the Plan for a service that is not covered by Medicare, the Subscriber or Provider must send each of the following items to the Plan to the address listed in Subsection B, above:

1. A copy of the Medicare Summary Notice (MSN), if one has been issued; and
2. A standard claim form, such as a CMS 1500 or UB 92 claim form, completed by the Provider. (If a completed CMS 1500 or UB 92 claim form cannot be submitted, please see below.)

If a standard claim form, such as a CMS 1500 or UB 92 claim form, cannot be submitted, most claims can be processed using an itemized bill from the Provider in place of the claim form. Such an itemized bill must contain the following: The Provider's name and address, the Provider's tax identification number, the date the service was rendered, the diagnosis and procedure codes for the service, and the dollar amount of the claim.

The Plan may require the submission of additional information on some claims.

F. CLAIMS FOR SERVICES RECEIVED IN A FOREIGN COUNTRY

If your Plan includes benefits for services received outside the United States, please file claims for such services as follows: Send the Plan an itemized bill for the service rendered to the address listed in Subsection B, above. The itemized bill must contain the following: The Provider's name and address, the date the service was rendered, a description of the service, and the amount of the claim.

The Plan may require the submission of additional information on some claims. The Plan may also require that the Subscriber provide an English translation of the itemized bill.

Payments for services provided outside the United States will be made only to the Subscriber. The Subscriber is responsible for paying the Provider.

G. PHARMACY CLAIMS

If your Employer Group provides the Plan's prescription drug coverage, please consult your *Prescription Drug Brochure* for the details of your coverage.

If you need to submit a claim for the reimbursement of covered pharmacy expenses, you will need to submit a drug store receipt with the following information: (1) the Subscriber's name, (2) the Subscriber's Plan ID number, (3) the name of the drug or medical supply, (4) the NDC number, (5) the quantity purchased, (6) the number of days supply, (7) the date the prescription was filled, (8) the prescribing physician's name, (9) the name and address of the pharmacy, and (10) the amount paid. The Plan may require the submission of additional information to process some claims.

Requests for pharmacy reimbursement must be sent to:

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

Subscribers may contact the Member Services Department at 1-888-333-4742 for assistance with pharmacy claims.

H. ASSIGNMENT OF BENEFITS

Subscribers may assign payments by the Plan to Providers by signing the appropriate section of the Provider's claim. The Plan will pay the Provider directly if benefits are assigned. If the Subscriber does not assign benefits to the Provider, the Plan will make payment for Covered Services to the Subscriber. The Subscriber will then be responsible for paying the Provider.

I. TIME LIMIT FOR FILING CLAIMS

All claims received from Providers or Subscribers for Covered Services must be submitted to the Plan at the address above within 365 days of the date of service, or the date of discharge if services were rendered on an inpatient basis. Whether the Subscriber or the Provider submits the claims, it is the Subscriber's responsibility to ensure that the claims are submitted within the above time frame.

J. THE PAYMENT MAXIMUM

The Plan limits the amount it will pay for any Covered Service to the "Payment Maximum." The Payment Maximum is as follows:

- a. For Medicare Covered Items. If Medicare Part A or B covers a product or service, the Payment Maximum is the Medicare Coinsurance amount plus any unmet Medicare Deductible amount. The Medicare Coinsurance amount is the portion or percentage of the Medicare-approved payment amount for a product or service that a beneficiary is responsible for paying. (Note that any Plan payment will be reduced by any applicable Copayment or unmet Deductible amount specified in the Subscriber's *Schedule of Benefits*.)

In some cases, Providers may bill Medicare patients for amounts that exceed the Medicare-approved payment amount. Any amount that exceeds the Medicare-approved amount is the Subscriber's responsibility and is not payable either by Medicare or the Plan. Please see the discussion of "assignment" in the Medicare publication *Medicare and You* for information on limits that apply to Provider charges.

- b. For Items Not Covered by Medicare. If Medicare Part A or B does not cover a product or service, the Payment Maximum depends upon whether the Provider is under contract to provide services to Subscribers of HPHC Insurance Company (HPIC). If a Provider is under contract to HPIC, the Payment Maximum is the contract rate for the service. If the Provider is not under contract to HPIC, the Payment Maximum is the amount, as determined by HPIC, that is within the normal range of charges made by health care Providers for the same, or similar, products or services in Boston, Massachusetts.

VI. APPEALS AND COMPLAINTS

This section explains the Plan's procedures for processing appeals and complaints concerning the benefits or services provided by the Plan. This section also explains the options available if an appeal is denied.

Please note that the appeal procedures stated below only apply to benefits of the Plan. If Medicare denies a claim, you must appeal to Medicare. Information on your Medicare appeal rights may be found on the Medicare Summary Notice, the document sent to you by Medicare that explains what action Medicare has taken on a claim.

A. HOW TO FILE AN APPEAL OR COMPLAINT

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

Appeals or complaints, other than those concerning mental health or drug and alcohol rehabilitation services, should be submitted to:

Member Services Department

HPHC Insurance Company
1600 Crown Colony Drive
Quincy, MA 02169.

Telephone: 1-888-333-4742

FAX: 1-617-509-3085

Appeals or complaints concerning mental health or drug and alcohol rehabilitation services should be submitted to:

Behavioral Health Access Center

C/O United Behavioral Health
Appeals Department
100 East Penn Square, Suite 400
Philadelphia, PA 19107

Telephone: 1-888-777-4742

FAX: 1-888-881-7453

B. ABOUT HPIC'S APPEAL AND COMPLAINT PROCEDURES

What are "Appeals" and "Complaints"? HPIC divides grievances into two types, "appeals" and "complaints" as follows:

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

Both appeals and complaints should be filed at the addresses or telephone numbers listed above in subsection 1.

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

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

Time Limit for Filing Appeals. A request for informal inquiry or appeal must be filed within 180 days of the date a service, or payment for a service, is denied by HPIC.

Appeals Involving Medical Necessity Determinations. Special rights apply to appeals involving medical necessity determinations. Such an appeal could involve a decision that a service (1) is not Medically Necessary, (2) is not being provided in an appropriate health care setting or level of care, (3) is not effective for treatment of the Subscriber's condition, or (4) is Experimental or Unproven. These include the right to appeal to an external review organization under contract with the Office of Patient Protection. The procedure for obtaining external review is summarized below in subsection 6.

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

practices. The Office of Patient Protection can be reached at:

Health Policy Commission
Office of Patient Protection
Two Boylston Street, 6th Floor
Boston, MA 02116

Telephone: 1-800-436-7757
Fax: 1-617-624-5046

Web Site: <http://www.mass.gov/hpc/opp>

HPIC Report on Appeals and Complaints. HPIC will file an annual report on appeals and complaints with the Office of Patient Protection. After filing, the report for the prior year will be available to Subscribers upon request. A copy may be requested from the Member Services Department at the address or telephone number listed above in subsection 1.

Membership Required for Coverage. To be eligible for coverage by HPIC, a Subscriber must be duly enrolled under this Handbook on the date a service is received. A response to an informal inquiry or an appeal decision approving coverage will not be valid for services received after the termination of membership. However, payment may be made after the termination of membership for services received while membership was effective.

C. THE INFORMAL INQUIRY PROCESS

Most appeals and complaints result from a misunderstanding with a Provider or a claim processing error. Since these problems can be easy to resolve, most appeals and complaints will first be considered in HPIC's informal inquiry process. However, the informal inquiry process will not be used to review a denial of coverage involving a medical necessity determination. Coverage decisions involving medical necessity determinations will be transferred directly to the formal appeal process described below in subsection 4.

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

If the Member Services representative responds to an inquiry within 3 business days of receipt but the inquiry is not resolved to the Subscriber's satisfaction, the Subscriber may either file a formal complaint or

appeal, as appropriate.

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

D. THE FORMAL APPEAL PROCESS

HPIC's internal appeal process is available whenever a Subscriber is denied coverage by HPIC. This includes either the denial of a health service sought by a Subscriber or the denial of payment for a health service that a Subscriber has received. If a denial involves a medical necessity determination, an appeal may be filed immediately. All other appeals will be considered in the informal inquiry process, described above in subsection 3, before an appeal is filed.

How to File an Appeal. Appeals may be filed in person, by mail, by FAX or by telephone at the addresses or telephone numbers listed in subsection 1, above. After an appeal is filed, HPIC will appoint an Appeal Coordinator who will be responsible for the appeal during the appeal process.

Documentation of Oral Appeals. If an appeal is filed by telephone, an Appeal Coordinator will write a summary of the appeal and send it to the Subscriber within 48 hours of receipt. This time limit may be extended by written mutual agreement between the Subscriber and HPIC.

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

Release of Medical Records. Any appeal that requires the review of medical information must include a signed "Authorization for Release of Medical Information." This form must be signed and dated by the Subscriber or the Subscriber's authorized representative. (When signed by an authorized representative, appropriate proof of authorization to release medical information must be provided.) If an Authorization for Release of Medical Information form is not provided when the appeal is filed, the Appeal Coordinator will promptly send a blank form to the Subscriber or the Subscriber's representative. If a signed Authorization for Release of Medical Information is not received by HPIC within 30 business days of the date the appeal is received, HPIC may issue a decision based on the information already in the file.

What are “Pre-Service” and “Post-Service” Appeals? HPIC divides 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 Subscriber has not yet received.
- A “Post-Service Appeal” requests coverage of a health care service that the Subscriber has already received.

Time Limit for Processing Appeals. For Pre-Service Appeals, Subscribers will be provided with a written appeal decision within 30 days of the date the appeal was received by HPIC. For Post-Service Appeals, Subscribers will be provided with a written appeal decision within 30 business days of the date the appeal was received by HPIC. These time limits may be extended by mutual agreement between the Subscriber and HPIC. (Any such agreement must be in writing.) Any extension will not exceed 30 business days from the date of the agreement. HPIC may decline to extend the review period for an appeal if a service has been continued pending an appeal.

If an appeal requires the review of medical information, the date of receipt will be the date HPIC receives a signed Authorization for Release of Medical Information. If HPIC does not respond to an informal inquiry within 3 business days, the date of receipt will be the 4th business day following the date HPIC received the inquiry or the date HPIC receives the signed Authorization for Release of Medical Information, whichever is later. No appeal shall be deemed received until actual receipt of the appeal by HPIC at the appropriate address or telephone number listed in subsection 1, above.

If HPIC does not act on an appeal within 30 business days plus any extension of time mutually agreed upon in writing by the Subscriber and HPIC, the appeal will be deemed to be resolved in favor of the Subscriber.

Medical Records and Information. The Appeal Coordinator will try to obtain all information, including medical records, relevant to the appeal. Due to the limited time available for the processing of appeals, Subscribers may be asked to assist the Appeal Coordinator in obtaining any missing information or to extend the appeal time limit until such information can be obtained. If information cannot be obtained by the 15th day following the receipt of the Authorization for Release of Medical Information and no agreement can be reached on extending the appeal time limit, the appeal may be decided without the missing information.

Continuation of Services Pending Appeal. If an appeal is filed concerning the termination or reduction of coverage for ongoing treatment, such coverage will be continued through the completion of HPIC’s internal appeal process if:

- a. The service was authorized by HPIC prior to a request for an informal inquiry or the filing of an appeal;
- b. The service was not terminated or reduced due to a benefit limit under this Handbook; and
- c. The appellant is, and continues to be, a duly enrolled Subscriber under this Handbook.

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

The Appeal Coordinator will investigate the appeal and determine if additional information is required from the Subscriber. Such information may include medical records, statements from doctors, and bills and receipts for services the Subscriber has received. The Subscriber may also provide HPIC with any written comments, documents, records or other information related to the claim. Should HPIC need additional information to decide an appeal, the Appeal Coordinator will contact the Subscriber and request the specific information needed.

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

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

HPIC’s decision of an appeal will be sent to the Subscriber in writing. The decision will identify the specific information considered in your appeal and an explanation of the basis for the decision with reference to the plan provisions on which the decision was based. If the decision is to deny coverage based on a Medical Necessity determination, the decision will include: (1) the specific information upon which the decision was

based; (2) the Subscriber's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria; (3) identification of any alternative treatment option covered by HPIC; and (4) the applicable clinical practice and review criteria information relied on to make the decision. The decision will also include a description of other options available for further review of the appeal. These options are described in Section 6, below.

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

E. THE EXPEDITED APPEAL PROCESS

Subscribers may obtain expedited review of certain types of appeals. An expedited appeal may be requested if HPIC denies coverage for health services involving: (1) continued Hospital care, (2) care that a physician certifies is required to prevent serious harm, or (3) a subscriber with a Terminal Illness. An expedited appeal will not be granted to review a termination or reduction in coverage resulting from (1) a benefit limit or cost sharing provision of this Handbook or (2) the termination of enrolment in the Plan.

Subscribers may request an expedited appeal – other than an appeal involving mental health or drug and alcohol rehabilitation services – by contacting HPIC orally or in writing at the following address or telephone numbers:

Member Appeals

HPHC Insurance Company
1600 Crown Colony Drive
Quincy, MA 02169

Telephone: 1-888-333-4742
FAX: 1-617-509-3085

Subscribers may request orally or in writing an expedited appeal that involves a mental health or drug and alcohol rehabilitation service by contacting:

Behavioral Health Access Center

C/O United Behavioral Health
Appeals Department
100 East Penn Square, Suite 400
Philadelphia, PA 19107

Telephone: 1-888-777-4742
FAX: 1-888-881-7453

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

If you are filing an expedited appeal with HPIC, you may also file a request for expedited external review with the Massachusetts Office of Patient Protection at the same time. You do not have to wait until HPIC completes your expedited appeal to file for expedited external review. Please see the Section VI.F.2., titled "External Review" for information on how to file for external review.

The circumstances and procedures under which Subscribers may obtain an expedited appeal by HPIC are as follows:

a. Hospital Discharge

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

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

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

An expedited review will be provided in any case in which HPIC has denied coverage for a service or Durable Medical Equipment if the physician recommending the treatment or Durable Medical Equipment provides HPIC with a written certification stating that:

- i. The service or Durable Medical Equipment is Medically Necessary;

- ii. A denial of coverage for the service or Durable Medical Equipment would create a substantial risk of serious harm to the Subscriber; and
- iii. The risk of serious harm is so immediate that the provision of the services or Durable Medical Equipment should not await the outcome of the normal appeal process.

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

c. Subscriber With a Terminal Illness

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

If a decision is made on appeal to deny coverage to a Subscriber with a Terminal Illness, HPIC will provide the Subscriber with a written decision within 5 business days of the decision. In the event a decision is made to deny the coverage requested, the decision will include:

1. A statement of any medical and scientific reasons for the denial; and
2. A description of any relevant alternative treatment, services, or supplies covered by HPIC.

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

F. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED

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

1. RECONSIDERATION BY HPIC

If a Subscriber disagrees with an appeal decision that involves a Medical Necessity determination, the Subscriber may request reconsideration of such appeal by the HPIC review committee. The Subscriber must request reconsideration within 15 days of the date of HPIC's letter denying the appeal. Reconsideration is not available for the following types of appeals:

- Decisions involving a benefit limitation where the limit is stated in the Handbook
- Decisions involving excluded services, except Experimental and Unproven services, and
- Decisions concerning Subscriber cost sharing requirements

The Subscriber may request that the committee review the appeal based upon the documents and records in the appeal file without participating in the meeting. Alternately, the Subscriber, or the Subscriber's representative, may participate in the committee's meeting via telephone conference call to discuss the appeal.

Subscribers are welcome to provide HPIC with any additional documents or records concerning the Subscriber's appeal prior to the meeting. The HPIC review committee will provide the Subscriber with a written decision of the review of the Subscriber's appeal.

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

Reconsideration by an HPIC review committee will not affect the Subscriber's rights to any other benefits. A Subscriber's authorized representatives may file a request for reconsideration and participate in the review committee meeting on a Subscriber's behalf. On reconsideration, the HPIC review committee will make an impartial evaluation of the Subscriber's appeal based on the review criteria in subsection 4 above without deference to any prior decisions made on the claim.

HPIC will not assert that a Subscriber has failed to exhaust administrative remedies because the Subscriber has chosen not to seek reconsideration of an appeal that has been denied under the formal appeal process. HPIC also agrees that any statute of limitations or defense based on timeliness is tolled during the time period in which a request for reconsideration is pending.

No fees or costs will be charged by HPIC for reconsidering an appeal decision.

2. EXTERNAL REVIEW

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

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

1. The request must be submitted on the Office of Patient Protection's application form called, "Request for Independent External Review of a Health Care Decision." A copy of this form may be obtained by calling the Member Services Department at 888-333-4742. It may also be obtained from the Office of Patient Protection by calling 1-800-436-7757. In addition, copies of the form may be downloaded from the Department's website at <http://www.mass.gov/hpc/opp>.
2. The form must include the Subscriber's signature, or the signature of the Subscriber's authorized representative, consenting to the release of medical information.
3. A copy of HPIC's final appeal decision must be enclosed.

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

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

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

The Office of Patient Protection may be reached at:

Health Policy Commission
Office of Patient Protection
Two Boylston Street, 6th Floor
Boston, MA 02116

Telephone: 1-800-436-7757
Fax: 1-617-624-5046

Web Site: <http://www.mass.gov/hpc/opp>

The Office of Patient Protection may arrange for an expedited external review. A request for expedited external review must include a written certification from a physician that a delay in providing or continuing the health services that are the subject of the appeal decision would pose a serious and immediate threat to the health of the insured.

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

3. LEGAL ACTION

A Subscriber enrolled through an Employer Group may be able to bring legal action under Section 502(a) of the Employee Retirement Income Security Act of 1974.

G. THE FORMAL COMPLAINT PROCEDURE

A complaint may be filed when a Subscriber seeks redress of any action taken by HPIC or any aspect of HPIC's services, other than a denial of coverage for health services. All complaints will initially be considered through the informal inquiry process described above in subsection 3.

Complaints may be filed in person, by mail, by FAX or by telephone at the addresses or telephone numbers listed in subsection 1, above. A Member Services Representative will investigate each complaint and respond in writing.

Documentation of Oral Complaints. If a complaint is filed by telephone, a Member Services Representative will write a summary of the complaint and send it to the Subscriber within 48 hours of receipt. This time limit may be extended by mutual agreement between the Subscriber and HPIC. Any such agreement must be in writing.

Acknowledgment of Complaints. Written complaints will be acknowledged in writing within 15 days of receipt by HPIC. This time limit may be extended by written mutual agreement between the Subscriber and HPIC. No acknowledgment of a complaint will be sent if a Member Services Representative has previously sent a summary of a complaint submitted by telephone.

Release of Medical Records. Any complaint that requires the review of medical information must include a signed "Authorization for Release of Medical Information." This form must be signed and dated by the Subscriber or the Subscriber's authorized representative. (When signed by an authorized representative, appropriate proof of authorization to release medical information must be provided.) If an Authorization for Release of Medical Information form is not provided when the complaint is filed, a Member Services Representative will send a blank form to the Subscriber or the Subscriber's representative. If a signed Authorization for Release of Medical Information is not received by HPIC within 30 business days of the date the complaint is received, HPIC may respond to the complaint without the missing information.

Time Limit for Responding to Complaints.

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

If a complaint requires the review of medical records, the date of receipt will be the date HPIC receives a signed Authorization for Release of Medical Information. If HPIC does not respond to an informal inquiry within 3 business days, the date of receipt will be the fourth business day following the date HPIC received the informal inquiry. No complaint shall be deemed received until actual receipt of the complaint by HPIC at the appropriate address or telephone number listed in subsection 1, above.

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

Medical Records and Information. The Member Services Representative will try to obtain all information, including medical records, relevant to a complaint. Due to the limited time available for processing complaints, Subscribers may be asked to assist the Member Services Representative in obtaining any missing information or to extend the time limit for response to the complaint until such information can be obtained. If information cannot be obtained by the 15th day following the receipt of the Authorization for Release of Medical Information and no agreement can be reached on extending the time limit for responding to the complaint, the Member Services Representative may respond to the complaint without the missing information.

VII. ELIGIBILITY AND ENROLLMENT

IMPORTANT NOTICE CONCERNING ENROLLMENT INFORMATION

PLEASE NOTE THAT THE PLAN MAY NOT HAVE CURRENT INFORMATION CONCERNING A SUBSCRIBER'S ENROLLMENT IN THE PLAN. EMPLOYER GROUPS MAY NOTIFY THE PLAN OF ENROLLMENT CHANGES RETROACTIVELY. AS A RESULT, THE PLAN'S ENROLLMENT INFORMATION MAY NOT BE UP TO DATE. ONLY YOUR EMPLOYER GROUP CAN ACCURATELY CONFIRM MEMBERSHIP STATUS.

A. ELIGIBILITY

To be eligible to enroll, or continue enrollment, in the Plan, an individual must meet all the following requirements at all times:

1. Be enrolled in Medicare Part A and Part B and pay any premium required for continued enrollment;
2. Be enrolled through an Employer Group that has entered into an agreement with HPHC Insurance Company (HPIC) for the enrollment of Subscribers in the Plan;
3. Be a resident of the United States or one of its territories; and
4. Be an individual for whom Medicare is primary to health benefits sponsored by the Employer Group. In general, these individuals are:
 - a. Retired employees of the Employer Group who are eligible for Medicare based on age;
 - b. Retired employees of the Employer Group who are eligible for Medicare based on disability; and
 - c. Active or retired employees of the Employer Group who (i) are eligible for Medicare based on end stage renal disease (also known as "ESRD" or "permanent kidney failure") and (ii) have passed the 30-month "coordination period" that begins when an individual becomes eligible for Medicare based on ESRD.
- d. Active employees of an Employer Group with fewer than 20 employees (as defined by Medicare regulations).
5. Not be enrolled in a Medicare Advantage plan under Medicare Part C.

The Plan must receive the premium amount due for the Subscriber's Medicare Enhance coverage from the Employer Group.

The Plan does not offer dependent coverage. A dependent cannot be added onto a Subscriber's coverage. However, if spousal enrollment is permitted by the Employer Group a dependent spouse of a Subscriber who meets all of the eligibility requirements stated above may enroll in

the Plan under a separate Contract.

The Plan must receive notice of enrollment from the Employer Group using Plan enrollment forms or in a manner otherwise agreed to in writing by the Plan and the Employer Group. The Plan must receive proper notice from the Employer Group of any Subscriber enrollment in, or termination from, the Plan no more than 60 days after such change is to be effective, unless otherwise required by law. Please see your Employer Group for information, effective dates or coverage, and Plan enrollment forms.

Please note that if an individual is re-employed by the Employer Group on a part time basis after retirement, the Employer Group must assume primary coverage for the individual (and his or her spouse) if the amount of work performed would be sufficient, based on hours, productivity or other criteria established by the Employer Group, to entitle an employee to coverage under the Employer Group's health plan for active employees. Such an individual (and his or her spouse) may not be deemed "retired" and is not eligible for enrollment in the Plan. The only exceptions apply to (1) persons with ESRD and (2) persons eligible for Medicare based on age employed by Employer Groups with 19 employees or less in accordance with the requirements of 42 CFR Section 411.170.

B. ENROLLMENT

1. During the period established by the Plan and the Employer Group, individuals who meet the eligibility requirements may enroll in Medicare Enhance by submitting completed application forms for enrollment on the forms supplied by the Plan.
2. Subscribers or applicants will complete and submit Plan enrollment forms and such other information as the Plan may reasonably request. Subscribers and applicants agree that all information contained in the enrollment form or other forms or statements submitted are true, correct, and complete. All rights to benefits are subject to the condition that all information provided to the Plan is true, correct, and complete.
3. By enrolling in the Plan, all Subscribers legally capable of contracting and the legal representatives of

all Subscribers incapable of contracting, agree to all the terms, conditions, and provisions in this *Benefit Handbook*, including any amendments.

C. EFFECTIVE DATE OF ENROLLMENT

Subject to the payment of premiums and the Plan's receipt and acceptance of the completed enrollment form within 60 days of the enrollment date, an individual who meets the eligibility requirements stated above may be enrolled on any one of the following dates:

1. The date the individual retiree becomes enrolled in Medicare Part A and Part B;
2. The date an eligible individual loses eligibility for the Employer Group's health coverage due to retirement;
3. The date the individual loses eligibility for the Employer Group's health coverage through his or her spouse's employment, due to the spouse's death, loss of employment, reduction in hours, divorce, leave of absence, or retirement;
4. The date an active employee who is enrolled in Medicare Parts A and B based on ESRD completes the 30-month coordination period during which the Employer Group health plan is the primary payer to Medicare; or
5. The Employer's Anniversary Date.

Except as otherwise provided by law, individuals are eligible for coverage under this *Benefit Handbook* as of the effective date unless the individual is a Hospital inpatient on that date. If the individual is a Hospital inpatient on the effective date, coverage will begin on the individual's date of discharge.

D. IDENTIFICATION CARD

Each Subscriber will receive a Medicare Enhance identification card. This card must be presented along with the Medicare identification card whenever a Subscriber receives health care services. Possession of a Plan identification card is not a guarantee of benefits. The holder of the card must be a current Subscriber on whose behalf the Plan has received all applicable premium payments. In addition, the health care services received must be Covered Services. Fraudulent use of an identification card may result in the immediate termination of the Subscriber's coverage.

VIII. TERMINATION OF SUBSCRIBER'S COVERAGE

A. TERMINATION

The coverage of a Subscriber may be terminated as follows:

1. HPHC Insurance Company (HPIC) may terminate a Subscriber's coverage under the Plan for non-payment of premium by the Subscriber's Employer Group. Premium payments are due at the beginning of the coverage period. Thereafter, there is a ten-day grace period for the payment of each month's premium. HPIC will notify you in writing, if your coverage is terminated for non-payment of premium by your Employer Group. In that event, HPIC will elect to follow one of two options: 1) continue your coverage up to the date you receive notice of termination, or 2) offer you continued coverage on a temporary basis.
2. HPIC may terminate a Subscriber's coverage under the Plan for misrepresentation or fraud, including, but not limited to:
 - a. If the Subscriber permits the use of his or her Medicare Enhance identification card by any other person, or uses another person's card, the card may be retained by HPIC and coverage of the Subscriber may be terminated effective immediately upon written notice.
 - b. If the Subscriber provides HPIC with any information that is untrue, inaccurate or incomplete, HPIC will have the right to declare this *Benefit Handbook* null and void or, HPIC, at its option, will have the right to exclude or deny coverage for any claim or condition related in any way to such untrue, inaccurate or incomplete information.
3. HPIC may terminate a Subscriber's coverage under the Plan if the Subscriber commits acts or physical or verbal abuse which pose a threat to Providers or other Subscribers and which are unrelated to the physical or mental condition of the Subscriber. HPIC will give the Subscriber notice at least 31 days before the date of termination.
4. HPIC may terminate a Subscriber's coverage under the Plan if the Subscriber ceases to be eligible under Section VII, above, including, but not limited to, the loss of Medicare Parts A or B. Coverage will terminate on the date on which eligibility ceased.
5. HPIC may terminate a Subscriber's coverage upon the termination or non-renewal of the *Employer Agreement* under which the Subscriber is enrolled.
6. A Subscriber may terminate his or her enrollment

under the Plan with the approval of his or her Employer Group. HPIC must receive a completed Enrollment/Change form from the Employer Group within 60 days of the date membership is to end.

B. REINSTATEMENT

A Subscriber's coverage will not be reinstated automatically if it is terminated. Reapplication is necessary.

C. CONTINUATION OF COVERAGE UNDER FEDERAL LAW

If you lose Employer Group eligibility and the Employer Group has twenty (20) or more employees, you may be eligible for continuation of Employer Group coverage under the Federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA). You should contact the Employer Group for more information if health coverage ends due to 1) bankruptcy; or 2) loss of dependency status, such as divorce. Continuation of coverage may not be extended beyond the applicable time allowed under federal law.

D. CONTINUATION OF COVERAGE UNDER MASSACHUSETTS LAW

1. CONTINUATION FOLLOWING TERMINATION OF GROUP AFFILIATION

Provided premium is received by HPHC Insurance Company, coverage under this Employer Group Plan shall continue for a period of thirty-one days following termination of a Subscriber's affiliation with the Employer Group. No coverage under this provision shall be available during any portion of such thirty-one day period if (1) the Subscriber is entitled to similar health coverage or (2) loses coverage under Medicare Parts A or B.

2. CONTINUATION FOLLOWING INVOLUNTARY LAYOFF OR DEATH OF THE SUBSCRIBER

A Subscriber may elect to continue coverage under this Employer Group Plan in the event that coverage terminates due to involuntary layoff or death of the Subscriber who is the employee or retiree of the Employer Group. In such event, a spouse of the laid-off or diseased Subscriber who is enrolled in the Plan on the date of layoff or death shall also be entitled to continuation of coverage under this provision.

Continued coverage under this provision shall only be available if an eligible Subscriber (1) elects continuation of coverage in writing, (2) pays his or her Employer Group the required premium within thirty days from the

date coverage would otherwise terminate and (3) maintains coverage under Medicare Parts A and B, The required premium will be the full amount of premium for Plan coverage, including both the amounts normally paid by the Employer Group and the Subscriber.

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

- a. Thirty-nine weeks from the date the coverage would otherwise cease;
- b. The amount of time during which the Subscriber who was the employee or retiree of the Employer Group was covered under the Plan prior to the beginning of coverage under this provision, if less than thirty-nine weeks;
- c. The last day for which HPHC Insurance Company has received the required premium from the Employer Group;
- d. The date the Subscriber becomes eligible for another group medical plan; or
- e. The date the Employer Group ceases to offer in the Plan.

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

- a. Ninety days from the date the coverage would otherwise cease;
- b. The last day for which HPHC Insurance Company has received the required premium from the Employer Group;
- c. The date a Subscriber becomes eligible for another group medical plan;
- d. The date the Employer Group ceases to participate in the Plan.

3. FOLLOWING PLANT CLOSING OR PARTIAL CLOSING

A Subscriber may elect to continue coverage under the Employer Group Plan if coverage under the Plan terminates because his or her employment at the Employer Group terminates due to plant closing or covered partial closing as defined by Chapter 151A, section 71A of Massachusetts law. In such event, a spouse of the laid-off Subscriber who is enrolled in the Plan on the date of layoff shall also be entitled to continuation of coverage under this provision.

Continued coverage shall be available under this provision only if the Subscriber (1) elects continuation of coverage in writing, (2) pays his or her Employer Group the required premium within thirty days from the date coverage would otherwise terminate, and (3) maintains coverage under Medicare Parts A and B. The required premium will include only that amount normally paid by the Subscriber for coverage through the Employer Group, if any.

The Employer Group is required to pay the full premium, including the amount normally paid by the Employer Group, to HPHC Insurance Company.

IX. WHEN YOU HAVE OTHER COVERAGE

A. COORDINATION OF BENEFITS (COB)

Medicare Enhance benefits are in addition to benefits provided under the Medicare program. No benefits will be provided that duplicate Medicare benefits. To the extent that the Subscriber also has health benefits coverage provided by another source, the Plan will coordinate coverage with the other payer, according to Massachusetts Coordination of Benefits regulations.

Benefits under this *Benefit 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, homeowners insurance, governmental benefits (including Medicare), and all Health Benefit Plans.

The term "Health Benefit Plan" means all HMO and other prepaid health plans, Medical or Hospital Service Corporation plans, commercial health insurance and self-insured health plans. There is no coordination of benefits with Medicaid plans or with Hospital indemnity benefits amounting to less than \$100 per day.

Coordination of benefits will be based upon the reasonable and customary charge 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 such services will be used as the basis for coordination. No duplication in coverage of services shall occur among plans.

When a Subscriber 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 and secondary:

- a. The benefits of the plan that covers the person as an employee or subscriber are determined before those of the plan that covered the person as a dependent.
- b. The benefits of a plan, which covers a person as an employee who is neither laid off nor retired (or as

that employee's dependent) are determined before those of a plan, which covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

- c. If none of the above rules determines the order of benefits, the benefits of the plan, which covered a person longer, are determined before those of the plan, which covered a person for the shorter term.
 - i. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.
 - ii. The start of a new plan does not include: (a) a change in the amount or scope of a plan's benefits; (b) a change in the entity which pays, provides or administers the plan's benefits; or (c) a change from one type of plan to another (such as, from a single Employer plan to that of a multiple employer plan).
 - iii. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available, the date the person first became a Subscriber of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

B. SUBROGATION

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

If another person or entity is, or may be, liable to pay for services related to a Subscriber's illness or injury which have been paid for or provided by the Plan, the Plan will be subrogated and succeed to all rights of the Subscriber to recover against such person or entity 100% of 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 the injury or illness, his/her liability carrier or the Subscriber's own auto insurance carrier, in cases of uninsured or underinsured motorist coverage. The Plan will also be entitled to recover from a Subscriber 100% of the value of services provided or paid for by the Plan when a Subscriber has been, or could be, reimbursed for the cost of care by another party.

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

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

C. MOTOR VEHICLE ACCIDENTS

When a Subscriber is involved in a motor vehicle accident, the Plan will coordinate benefits with the Subscriber's automobile insurance company. If a Subscriber is involved in a motor vehicle accident, the Subscriber must notify the attending physician(s) that the injuries are accident related. The Subscriber must also notify the Plan of the accident, the name and address of the Subscriber's automobile insurance carrier, and such other information as the Plan may reasonably request. Subscribers agree to complete the questionnaire provided by the Plan to obtain information regarding the accident.

D. DOUBLE COVERAGE

1. WORKER'S COMPENSATION/ GOVERNMENT PROGRAMS

If the Plan has information indicating that services provided to a Subscriber are covered under Worker's Compensation, Employer's liability or other program of similar purpose, or by a federal, state or other government agency, the Plan may suspend payment for such services until a determination is made whether payment will be made by such program. If the Plan provides or pays for services for an illness or injury covered under Worker's 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.

2. OTHER GOVERNMENT PROGRAMS

Except as otherwise provided by applicable law that would require the Plan to be the primary payer, the benefits under this *Benefit Handbook* will not duplicate any benefits to which Subscribers are entitled or for which they are eligible under any government program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for benefits provided by the Plan are payable to and may be retained by the Plan.

3. SUBSCRIBER COOPERATION

The Subscriber agrees to cooperate with the Plan in exercising its rights of subrogation and coordination of benefits under this *Benefit Handbook* and the *Schedule of Benefits*. Such cooperation will include, but not be limited to: a) the provision of all information and documents requested by the Plan, b) the execution of any instruments deemed necessary by the Plan to protect its rights, c) the prompt assignment to the Plan of any monies received for benefits 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. The Subscriber further agrees to do nothing to prejudice or interfere with the Plan's rights to subrogation or coordination of benefits.

4. ASSIGNMENT

Coverage under this *Benefit Handbook* is not assignable by any Subscriber without the written consent of the Plan.

X. MISCELLANEOUS PROVISIONS

A. COMMENCEMENT AND DURATION OF BENEFITS

1. Except when an individual is hospitalized on the date of enrollment, all benefits under the Plan begin at 12:01AM on the effective date of enrollment. No benefits will be provided for any services rendered prior to the effective date of enrollment. If the individual is a Hospital inpatient on the effective date of enrollment, coverage will begin as of the individual's date of discharge.
2. No benefits will be provided for services rendered after coverage under this *Benefit Handbook* is terminated.
3. In computing the number of days of inpatient care benefits under the Plan, the day of admission will be counted but not the day of discharge. If a Subscriber remains in a Hospital, Skilled Nursing Facility, or other facility, for his or her convenience beyond the discharge hour, any additional charge will be the responsibility of the Subscriber.

B. TERMINATION AND MODIFICATION OF BENEFIT HANDBOOK

This *Benefit Handbook*, the *Schedule of Benefits*, and *Prescription Drug Brochure* (if any) may be amended by the Plan upon 60 days notice to your Employer Group or as otherwise stated in an agreement between the Plan and your Employer Group. Subscribers will be given written notice of any material changes in covered benefits. Amendments do not require the consent of Subscribers.

This *Benefit Handbook* (including your Employer Group's Employer Agreement), the *Schedule of Benefits*, the *Prescription Drug Brochure* (if any) and any riders or amendment thereto, are the entire contract between you and the Plan and, as of the effective date of this *Benefit Handbook*, supersede all other agreements between you and the Plan. The *Benefit Handbook*, the *Schedule of Benefits*, the *Prescription Drug Brochure* (if any) and any riders or amendment thereto, can only be modified in writing by an authorized office of the Plan. No other action by the Plan, including the deliberate non-enforcement of any benefit limit, shall be deemed to waive or alter any part of the *Benefit Handbook*, the *Schedule of Benefits*, the *Prescription Drug Brochure* (if any) and any riders or amendments issued by the Plan.

HPIC may terminate this *Benefit Handbook*, the *Schedule of Benefits* and the *Prescription Drug Brochure* (if any) by giving written notice to your

Employer Group at least 60 days before the Contract Anniversary Date or as otherwise stated in an agreement between the Plan and your Employer Group.

C. PROCESS TO DEVELOP CLINICAL GUIDELINES AND UTILIZATION REVIEW CRITERIA

The Plan uses clinical review criteria and guidelines to make fair and consistent utilization management decisions. Criteria and guidelines are developed in accordance with standards established by The National Committee for Quality Assurance (NCQA), and reviewed (and revised, if needed) at least biennially, or more often if needed to accommodate current standards of practice.

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

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

The Plan's Clinician Advisory Committees, comprised of actively practicing physicians from throughout the network, serve as the forum for the discussion of specialty-specific clinical specialty-specific clinical programs and initiatives, and provide guidance on strategies and initiatives to evaluate or improve care and service. Clinician Advisory Committees work in collaboration with Medical Management leadership to develop and approve utilization review criteria

D. RELATIONSHIP TO MEDICARE COVERAGE

As described in Section III, above, the Plan covers the Medicare Deductible and Coinsurance amounts for all services covered by Medicare Parts A and B. If a benefit is added to the Medicare program, that benefit will be automatically added to the plan on the effective date of the benefit, subject to the terms of the *Employer Agreement* between HPHC Insurance Company and the Employer Group.

The Plan reserves the right to communicate with Medicare about whether a Medicare coverage decision

has been properly made for any reason, including, but not limited to, suspected fraud. However, the Plan is not required to do so in any case. Any decision by Medicare to cover, or not to cover, a product or service, is entirely the decision of Medicare. The Plan will not conduct utilization review of any charge for which Medicare has made a final decision to provide coverage.

E. UTILIZATION REVIEW PROCEDURES

The Plan may conduct utilization review of any product or service covered under the Plan that is not covered by Medicare, including a product or service for which Medicare coverage has ended for any reason. The goal of such review is to evaluate the Medical Necessity of selected health care services and to facilitate clinically appropriate, cost-effective management of Subscribers' care. The Plan uses the following utilization review procedures:

- Concurrent utilization review of admissions to Hospitals and extended care facilities, and skilled home health services. Concurrent review decisions will be made within one working day of obtaining all necessary information. In the case of a determination to approve additional services, the Plan 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 the Subscriber and the Provider within one working day thereafter. In the case of 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 the Subscriber and the Provider within one working day thereafter.
- Retrospective utilization review may be utilized in situations where coverage is requested for services that, in the judgment of the Plan, may not be Medically Necessary

Active case management and discharge planning is incorporated as part of the concurrent review process.

Subscribers who wish to determine the status or outcome of utilization review decisions should call Member Services toll-free at (888) 333-4742.

In the event of an adverse determination involving clinical review, your treating Provider may discuss your case with a Plan physician reviewer or may seek reconsideration of the decision. The reconsideration will take place within one working day of your Provider's request. If the adverse determination is not reversed on reconsideration, you may appeal. Your appeal rights are described in Section VI ("Appeals

and Complaints"). Your right to appeal does not depend on whether or not your Provider sought reconsideration.

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

The Plan covers medical devices, diagnostic, medical and surgical procedures and drugs as described in your *Benefit Handbook*, *Schedule of Benefits*, and, if applicable to your Employer Group, the *Prescription Drug Brochure*. This includes new devices, procedures and drugs, as well as those with new applications, as long as they are not Experimental or Unproven.

The Plan has a dedicated team of staff that evaluates diagnostics, medical therapies, surgical procedures, medical devices and drugs. The team manages the evidence-based evaluation process from initial inquiry to final policy recommendation. The team researches the safety and effectiveness of these new technologies by reviewing published 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.

G. CONSENT TO DISCLOSURE OF MENTAL HEALTH INFORMATION

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 the Medical Necessity of mental health services will be made in consultation with a Licensed Mental Health Professional.

H. LEGAL ACTIONS AND PROVIDER MALPRACTICE

No legal action may be brought against the Plan based upon this *Benefit Handbook*, or related to benefits provided by the Plan, unless brought within two (2) years from the time the cause of action arises.

The Plan will not be liable to Subscribers for injuries, loss, or damage resulting from negligence, misfeasance, malfeasance, nonfeasance, or malpractice on the part of any Provider, any Hospital, or any other institution or person providing health care services or supplies to any Subscriber.

I. MAJOR DISASTER, WAR, OR EPIDEMIC

In the event of a natural disaster, war, riot, civil insurrection, epidemic, or any other emergency or similar event not within the control of the Plan, the

obligations of the Plan under this *Benefit Handbook* will be limited to making good faith effort to provide benefits covered by this *Benefit Handbook*.

J. NOTICES

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

K. GOVERNING LAW

The *Benefit Handbook*, *Schedule of Benefits* and *Prescription Drug Brochure* shall be interpreted in accordance with the laws of the Commonwealth of Massachusetts.

XI. GLOSSARY

The Plan follows the definitions adopted by the Medicare program in providing benefits for services covered by Medicare. The following terms, as used in this *Benefit Handbook*, will have the meanings indicated below:

Anniversary Date

The date agreed to by the Plan and your Employer Group upon which the yearly Employer Group premium rate is adjusted and benefit changes become effective. This *Benefit Handbook*, the *Schedule of Benefits*, and the *Prescription Drug Brochure* (if any) will terminate unless renewed on the Anniversary Date.

Benefit Handbook (or Handbook)

This legal document, including the *Benefit Handbook*, the *Schedule of Benefits*, and the *Prescription Drug Brochure* (if any) and any applicable riders or amendments which set forth the services covered by the Plan, the exclusions from coverage and the terms and conditions of coverage for Subscribers.

Benefit Period

A Benefit Period is a way of measuring your use of services under Medicare Part A to determine Medicare coverage and your benefits under this *Benefit Handbook*. A Benefit Period begins with the first day of a Medicare covered inpatient Hospital stay and ends with the close of a period of 60 consecutive days during which you were neither an inpatient of a Hospital nor of a Skilled Nursing Facility (SNF). Generally, you are an inpatient of a Hospital if you are receiving inpatient services in the Hospital. The type of care actually received is not relevant. However, for purposes of determining when a Benefit Period starts and ends, you are an inpatient of a Skilled Nursing Facility only when your care in the Skilled Nursing Facility meets certain skilled level of care standards established by the Medicare program. Please refer to the definition of "Skilled Nursing Care."

Centers for Medicare and Medicaid Services (CMS)

The Centers for Medicare and Medicaid Services is the federal agency responsible for administering the Medicare program.

Coinsurance

Cost sharing amounts established by Medicare that Medicare beneficiaries must pay after any Medicare Deductible has been met. Coinsurance is usually a percentage. (For example, many services covered under Medicare Part B require beneficiaries to pay a 20% Coinsurance amount.) As used in this Handbook, "Coinsurance" also includes fixed dollar amounts established by Medicare that Medicare beneficiaries must pay for certain services.

The Plan provides coverage for Medicare established Coinsurance amounts minus any Deductibles or Copayments required by the Plan.

Copayments

Cost sharing amounts established by the Plan that are payable by Subscribers for certain Covered Services under the Plan. Copayments are usually fixed dollar amounts payable at the time services are rendered or when billed by the Provider. The Copayments that apply to your Employer Group's coverage are listed in the *Schedule of Benefits*.

Covered Services

Health care services or supplies for which benefits are provided under this *Benefit Handbook*. Covered Services are described in Section III of this *Benefit Handbook*, the *Schedule of Benefits* and the *Prescription Drug Brochure* (if applicable).

Custodial Care

Personal care that does not require the continuing attention of trained medical personnel. Custodial Care services assist a person in activities such as mobility, dressing, bathing, eating, food preparation, including the preparation of special diets, and taking medications that usually can be self-administered.

Deductible

A Deductible is a dollar amount that is payable each calendar year for Covered Services before benefits are available under an insurance plan. The Plan provides coverage for Medicare Deductible amounts minus any Plan Deductibles or Copayments required by the Plan. Please see *Medicare and You* for information on Medicare's Deductibles.

Some Employer Group plans include a Plan Deductible that applies to specific Covered Services. If your Plan includes a Deductible, it will be listed in your *Schedule of Benefits*.

Dental Services

Services furnished for the care, treatment, removal or replacement of teeth or the structures directly supporting teeth.

Durable Medical Equipment

Equipment that can withstand repeated use; is primarily and usually used to serve a medical purpose; is generally not useful to a person in the absence of illness or injury; and is appropriate for use in the home. However, an institution may not be considered a Subscriber's home if it meets the basic requirements of a Hospital or Skilled Nursing Facility. Durable Medical Equipment includes items such as oxygen equipment, wheelchairs, hospital beds and other items that are determined to be Medically Necessary.

Employer Agreement

The agreement between HPHC Insurance Company and an Employer Group under which the Employer elects Medicare Enhance coverage for eligible Subscribers.

Employer Group (or Employer)

An employer that has entered into an agreement with HPHC Insurance Company for the provision of Medicare Enhance benefits to eligible individuals.

Experimental and Unproven

The Plan does not cover Experimental or Unproven drugs, devices, medical treatment or procedures. A service, procedure, device, or drug will be deemed Experimental or Unproven by the Plan for use in the diagnosis or treatment of a particular medical condition if any of the following is true:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. The service, procedure, device, or drug is not recognized in accordance with generally accepted medical standards as being safe and effective for the use in the evaluation or treatment of the condition in question. In determining whether a service has been recognized as safe or effective in accordance with generally accepted medical standards, primary reliance will be placed upon data from published reports in authoritative medical or scientific publications that are subject to peer review by qualified medical or scientific experts prior to publication. In the absence of any such reports, it will generally be determined that a service, procedure, device or drug is not safe and effective for the use in question.

The Plan will not determine that a product or service that is covered by Medicare is Experimental or Unproven if such determination would conflict with a National Coverage Decision or a local coverage

determination issued the Centers for Medicare and Medicaid Services or its contractors.

Home Health Agency

A Medicare-certified agency that provides Medically Necessary Skilled Nursing Care and other therapeutic services in your home.

Home Health Care Services

Medically Necessary health care services provided at a Subscriber's residence (other than a Hospital, Skilled Nursing Facility, rehabilitation facility, Religious Nonmedical Health Care Institution) rendered by a Home Health Agency. Home health services must be provided by an organization eligible to receive payment from Medicare.

Hospice

A Medicare-certified organization or agency that is primarily engaged in providing pain relief, symptom management and supporting services to terminally ill people and their families.

Hospital

A Medicare-certified institution licensed by the state in which it is located, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services or, when used in connection with Massachusetts mandated benefits, an accredited or licensed hospital. The term "Hospital" does not include a Skilled Nursing Facility, convalescent nursing home, rest facility or a facility for the aged that primarily provides Custodial Care, including training in routines of daily living.

HPHC Insurance Company, Inc (HPIC)

HPHC Insurance Company, Inc. is the company that underwrites the Plan. HPIC may also be referred to as "we," "us" and the "Plan."

Inpatient Mental Health Facility

An inpatient mental health facility is one of the following: a general Hospital licensed to provide Mental Health services; a facility under the direction and supervision of the Massachusetts Department of Mental Health; a private mental hospital licensed by the Massachusetts Department of Mental Health; or a substance abuse facility licensed by the Massachusetts Department of Public Health.

Licensed Mental Health Professional

A Licensed Mental Health Professional is one of the following 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;

or a licensed mental health counselor. The benefits provided under Section III.D.2. (“Massachusetts Mandated Coverage For Mental Health Care and Drug And Alcohol Rehabilitation Services”) may be provided by any Licensed Mental Health Professional, including an individual who is not eligible for payment by Medicare.

Medical Emergency

A medical condition, whether physical or mental, 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 Subscriber or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part. With respect to a pregnant woman who is having contractions, Medical Emergency also means that there is inadequate time to effect a safe transfer to another Hospital before delivery or that transfer may pose a threat to the health or safety of the woman or the unborn child.

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

Medically Necessary

In the case of services eligible for coverage by Medicare, Medically Necessary means that the service is reasonable and necessary in accordance with Medicare criteria. In the case of services not eligible for coverage by Medicare, Medically Necessary means that the service that is consistent with generally accepted principles of professional medical practice as determined by whether: (a) it is the most appropriate supply or level of service for the Subscriber’s condition, considering the potential benefit and harm to the individual; (b) it is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; and (c) for a service that is not widely used, its use for the Subscriber’s condition is based on scientific evidence.

Medicare

A program of health benefits established by federal law and administered by the Centers for Medicare and Medicaid Services (CMS). The Plan covers services in conjunction with a Subscriber’s benefits under Medicare Parts A and B. (It does not cover services in conjunction with Medicare Advantage Plan under Medicare Part C or a prescription drug plan under Medicare Part D.) Unless otherwise stated, when term

“Medicare” is used in this *Benefit Handbook* it refers to Medicare Parts A and B.

Medicare Part B Premium

The monthly premium paid by Medicare beneficiaries for coverage under Medicare Part B.

Medicare Participating Provider

A Hospital, SNF, Hospice, Home Health Agency or other facility identified by Medicare that satisfies Medicare’s conditions of participation and enters into a participation agreement with Medicare.

Outpatient Mental Health Facility

An Outpatient Mental Health Facility is one of the following: a licensed Hospital; a mental health or substance abuse clinic licensed by the Department of Public Health; a public community mental health center; a professional office; or home-based services.

Payment Maximum

The maximum amount the Plan will pay for any Covered Service. The Payment Maximum is as follows:

- a. For Medicare Covered Items. If Medicare covers a product or service, the Payment Maximum is the Medicare Coinsurance amount plus any unmet Medicare Deductible amount. The Medicare Coinsurance amount is the portion or percentage of the Medicare-approved payment amount for a product or service that a beneficiary is responsible for paying.

In some cases, Providers may bill Medicare patients for amounts that exceed the Medicare-approved payment amount. Any amount that exceeds the Medicare-approved amount is the Subscriber’s responsibility and is not payable either by Medicare or the Plan. Please see the discussion of “assignment” in the Medicare publication *Medicare and You* for information on limits that apply to Provider charges.

- b. For Items Not Covered by Medicare. If Medicare does not cover a product or service, the Payment Maximum depends upon whether the Provider is under contract to provide services to Subscribers of HPHC Insurance Company (HPIC). If a Provider is under contract to HPIC, the Payment Maximum is the contract rate for the service. If the Provider is not under contract to HPIC, the Payment Maximum is the amount, as determined by HPIC, that is within the normal range of charges made by health care Providers for the same, or similar, products or services in Boston, Massachusetts.

Prosthetic Devices

Prosthetic Devices replace all or part of an internal body organ or all or part of the function of a permanently inoperative or malfunctioning internal body organ. Examples of Prosthetic Devices are cardiac pacemakers, prosthetic lenses, breast prostheses, maxillofacial devices, colostomy bags and supplies.

Provider

A doctor, Hospital, health care professional or health care facility licensed and/or certified by the state or Medicare to deliver or furnish health care services. Provider includes but is not limited to: physicians, podiatrists, optometrists, nurse practitioners, nurse midwives, nurse anesthetists, physician's assistants, psychiatrists, psychologists, licensed independent clinical social workers, licensed nurse mental health clinical specialists, and licensed mental health counselors.

Skilled Nursing Care

Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that:

1. Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and
2. Must be provided directly by, or under the general supervision of, skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

Skilled Nursing Facility (SNF)

A facility (or distinct part of a facility), which is primarily engaged in providing to its residents skilled nursing or rehabilitation services and is certified by Medicare. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility or a facility for the aged, which primarily furnishes Custodial Care, including training in routines of daily living.

Special Services

Those services and supplies a facility ordinarily furnishes to its patients for diagnosis or treatment during the time the patient is in the facility. Special Services include:

1. The use of special rooms and their equipment, such as operating rooms or treatment rooms;
2. Tests and exams, including electrocardiograms, laboratory, and x-ray;

3. Use of special equipment on the facility premises, and the services of persons hired by the facility to operate the equipment;
4. Services by a person with whom the Hospital or Skilled Nursing Facility, public community mental health center, or similar facility has a contractual agreement, by salary or otherwise, in conjunction with the use of the equipment specified above;
5. Drugs, medications, solutions, and biological preparations;
6. Administration of infusions or transfusions and other charges for services related to the administration of infusions or transfusions, (excluding the cost of whole blood, packed red blood cells, and donor fees); and
7. Internal Prosthetic Devices or appliances (artificial replacements of part of the body) that are an integral part of an operation. This includes hip joints, skull plates, and pacemakers. You are also covered for breast prostheses following mastectomy and surgery for treatment of breast cancer as required by federal law. These items are covered by Medicare Part A.

Subscriber

An individual who (1) meets all applicable eligibility requirements for enrollment in the Plan, (2) is enrolled in the Plan through an Employer, and (3) for whom the premium been received by the Plan.

Schedule of Benefits

A document that accompanies this *Benefit Handbook* that summarizes the Subscriber's coverage under the Plan and states the Copayments, benefit maximums and any special benefits provided by the Subscriber's Employer Group.

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.

Terminal Illness

A Terminal Illness is an illness that is likely to cause death within six months, as determined by a physician.



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