Harvard Pilgrim Health Care

Benefit Handbook

Medicare Enhance Plan For Self-Insured Members

(A Medicare Plan for Retirees)

This benefit plan is provided to you by your Plan Sponsor on a self-insured basis. Harvard Pilgrim Health Care, Inc. administers the Plan on behalf of the Plan Sponsor.

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I. INTRODUCTION

Welcome to the Medicare Enhance Plan (the "Plan") and thank you for choosing us to help meet your health care needs.

Medicare Enhance is a self-insured plan financed by your Plan Sponsor and administered by Harvard Pilgrim Health Care, Inc. ("HPHC").

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

1. Paying most Medicare deductible and coinsurance amounts for Medicare covered services;
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.D, 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 & You*. *Medicare & 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 or by calling Medicare at **1-800-633-4227**. (TTY service is available at **711**.) A number of publications explaining Medicare benefits may be obtained on the Internet at the following web address: **https://www.medicare.gov/publications**

Changes in Medicare benefits or the Medicare program itself may result in changes to this *Benefit Handbook*. HPHC is not responsible for notifying the Plan Sponsor 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, the Plan Sponsor 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 A PLAN SPONSOR. IF A SUBSCRIBER'S ELIGIBILITY FOR COVERAGE THROUGH THE PLAN SPONSOR ENDS, ENROLLMENT IN THE PLAN MUST ALSO END.

Contacting Member Services

You may contact a Plan Member Services representative by calling **1-888-333-4742**. Deaf and hard-of-hearing Subscribers may communicate directly with the Member Services Department by calling 711.

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

Language Assistance Services

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

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

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

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

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

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

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

ខ្មែរ (Cambodian) ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ, សេវាកម្មបកប្រែ ជូនលោកអ្នកដោយ គិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

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

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

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

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

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

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

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

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

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

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of 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, sex, sexual orientation, or gender identity. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

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, sex, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Compliance Officer, 1 Wellness Way, Canton, MA 02021-1166, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@point32health.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

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

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

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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 Plan Sponsor provides prescription drug coverage) make up the legal agreement stating the terms and conditions of the Plan. 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 Plan. It also may be used as a brief summary of your benefits. Although some materials may reference you as a member of one of HPHC's products, HPHC is not the issuer, insurer or provider or your coverage.

If your Plan Sponsor provides 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 & You* for information on your Medicare benefits. You may obtain a copy of *Medicare & You* at most Social Security Offices or by calling Medicare at **1-800-633-4227**. (TTY service is available at **711**.) A number of publications explaining Medicare benefits may be obtained on the Internet at the following web address: **https://www.medicare.gov/publications**

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 Plan Sponsored health coverage for persons enrolled in Medicare Parts A and B. A Medicare eligible Spouse of an eligible Subscriber may also be enrolled if he or she meets the eligibility requirements of the Plan and the Plan Sponsor. The Plan complements Medicare coverage by:

- Paying most Medicare deductible and coinsurance amounts for services covered by Medicare;
- Covering a number of preventive care services not covered by Medicare;
- Covering services received in a Medical Emergency outside the United States; and
- Covering a number of special services, if your Plan Sponsor provides such coverage.

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.D, 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. For 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. 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.

The Plan also covers care in a Medical Emergency that is received in a foreign country. (With very limited exceptions, Medicare does not cover any services receive outside of the United States.) Please see Section III.D.1 of this Handbook for a description of the Plan's 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. 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.

HPHC values individuals' privacy rights and is committed to safeguarding protected health information (PHI) and personal information (PI). To support this commitment, HPHC has established a number of Privacy and Security policies, including those describing the administration of its privacy and security programs, requirements for staff training, and permitted uses and disclosures of PHI and PI. We may collect, use, and disclose financial and medical information about you when doing business with you or with others. We do this in accordance with our privacy policies and applicable state and federal laws. HPHC also requires its business partners who administer health care coverage to you on our behalf to protect your information in accordance with applicable state and federal laws.

E. SUBSCRIBERS' RIGHTS AND RESPONSIBILITIES

- Subscribers have a right to receive information about the Plan, its services, its practitioners and providers, and Subscribers' rights and responsibilities.
- Subscribers have a right to be treated with respect and recognition of their dignity and right to privacy.
- Subscribers have a right to participate with practitioners in decision-making regarding their health care.
- Subscribers have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Subscribers have a right to voice complaints or appeals about the Plan or the care provided.
- Subscribers have a responsibility to provide, to the extent possible, information that the Plan, practitioners and providers need in order to care for them.
- Subscribers have a responsibility to follow the plans and instructions for care that they have agreed on with their practitioners.

III. COVERED BENEFITS

A. INTRODUCTION

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

It is important for you to note that some of the benefits listed in this section may not be available to you under the benefits chosen by your Plan Sponsor. All coverage is subject to the Copayments 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.

The Plan covers services in conjunction with your Medicare benefits. 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 services that Medicare does not cover. These services are described in Sections III.C ("Preventive Care Services") and III.D ("Additional Covered Services"), below.

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 duly enrolled as a Subscriber in the Plan;
- It must be either covered by Medicare or specifically 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.

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 most Medicare covered services. The only services covered by Medicare for which no coverage is provided by the Plan are the services specifically listed as exclusions in Section IV ("Exclusions from Coverage"), below. 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. (Please see "Medicare & You" for additional information on Medicare coverage.) When Medicare 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. The only Medicare covered services for which no coverage is provided by the Plan are those specifically listed as exclusions from coverage in Section IV of this Handbook.

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, liver, lung, heart and heart-lung transplants must be obtained at a Hospital that has been approved by Medicare for the type of transplant required. These Hospitals are required to meet strict quality standards. Neither the Medicare nor the Plan will provide any coverage for a liver, lung, heart or heart-lung transplant that is not provided at a Medicare approved transplant 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 for mental health and substance use disorder treatment 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 Plan Sponsors purchase coverage for care in an acute or rehabilitation Hospital in excess of the Medicare limits described above. If your Plan Sponsor provides such coverage, it will be listed in the *Schedule of Benefits*. Benefits for Hospital care in excess of Medicare limits will only be paid by the Plan if (1) the Hospital services are Medically Necessary and (2) all 60 Medicare Lifetime Reserve Days have been used.

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 deductible and coinsurance 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. Ambulance Services

The Plan will pay the Medicare Part B Deductible and Coinsurance 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.

b. Coverage for Clinical Trials

The Plan will pay the Medicare Deductible and Coinsurance 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.

c. 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 Deductible and Coinsurance amounts for the services of dentists and oral surgeons that have been covered by Medicare. No other Dental Services are covered unless your Plan Sponsor 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*.

(Please note this benefit may not be covered by all Plan Sponsors. If your Plan Sponsor provides coverage for this benefit, it will be listed in your *Schedule of Benefits*.)

d. Diagnostic Tests and Procedures

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

The Plan will pay the Medicare Deductible and Coinsurance amounts for Medicare-covered advanced radiology, such as CT scans, PET scans, MRI, MRA and nuclear medicine services.

e. Durable Medical Equipment and Prosthetic Devices

The Plan will pay the Medicare Deductible and Coinsurance 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.

(Please note this benefit may not be covered by all Plan Sponsors. If your Plan Sponsor provides coverage for this benefit, it will be listed in your *Schedule of Benefits*.)

f. Emergency Room Care

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

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 the following:

i. The Plan covers Medicare Deductible and Coinsurance amounts for Medicare covered Durable Medical Equipment furnished in connection with the home health care services. Please see Section III.B.2.e, above, for information on benefits for Durable Medical Equipment.

ii. The Plan covers home infusion therapy when Medicare coverage is not available. Please see Section III.C.6., below, for information on this benefit.

h. 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.

i. Kidney Dialysis

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

j. Medical Therapies

The Plan will pay the Medicare Deductible and Coinsurance amounts for Medicare-covered therapeutic services. These include 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 Plan Sponsor provides Plan 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.

k. Outpatient Methadone Maintenance

The Plan will provide coverage for Outpatient Methadone Maintenance as part of Medically Necessary Mental Health Care and Substance Abuse Disorder Treatment Services.

(Please note this benefit may not be covered by all Plan Sponsors. If your Plan Sponsor provides coverage for this benefit, it will be listed in your *Schedule of Benefits*.)

l. Outpatient Surgery

The Plan will provide coverage, less any payments made by Medicare, for Outpatient Surgery, including related services. Outpatient Surgery is defined as any surgery or procedure in a day surgery department, ambulatory surgery department or outpatient surgery center.

m. Partial Hospitalization

The Plan will pay the Medicare Deductible and Coinsurance 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.

(Please note this benefit may not be covered by all Plan Sponsors. If your Plan Sponsor provides coverage for this benefit, it will be listed in your *Schedule of Benefits*.)

n. Physical, Occupational and Speech Therapy

The Plan will pay the Medicare Deductible and Coinsurance 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.15., below, for further information.)

o. Prescription Drug Coverage

If your Plan Sponsor 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.

Even if your Plan Sponsor does not purchase the Plan's drug coverage, the Plan will pay the Medicare Deductible and Coinsurance 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.

(Please note this benefit may not be covered by all Plan Sponsors. If your Plan Sponsor provides coverage for this benefit, please see your *Prescription Drug Brochure*.)

p. Services of Physicians and Other Health Professionals

The Plan will pay the Medicare Deductible and Coinsurance 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, registered dieticians, and acupuncturists. Please see Section III.B.2.l, 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 by Medicare 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 Plan Sponsors 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.c. ("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.

Medicare also provides limited coverage for acupuncture treatment. The Plan will pay the Medicare Deductible and Coinsurance amounts for Medicare covered acupuncture treatment. Medicare covers up to 12 acupuncture visits in 90 days for chronic low back pain, and an additional 8 sessions may be available if you show improvement.

q. Telemedicine Virtual Visits

The Plan will pay the Medicare Deductible and Coinsurance amounts less any applicable member cost share for Medicare-covered telemedicine virtual visits.

r. Urgent Care Services

The Plan covers the Medicare Deductible and Coinsurance and Deductible amounts, less any applicable member cost share, for Medicare covered Urgent Care you receive at an urgent care facility. Urgent care facilities provide treatment for minor and moderate illnesses and injuries that require urgent attention but are not life threatening. Covered Services include but are not limited to the following:

- Care for minor cuts, burns, rashes, bites, bruises or abrasions, including suturing
- Treatment for minor illnesses and infections, including coughs, cold and flu
- Treatment for minor injuries including sprains or strains

Important Notice: Urgent Care is not emergency care. You should call 911 or go directly to a Hospital emergency room if you suspect you are having a Medical Emergency. These include heart attack or suspected heart attack, shock, major blood loss, or loss of consciousness. Please see Section II.C. Coverage in a Medical Emergency for more information.

C. ADDITIONAL COVERED SERVICES

This section lists additional Plan benefits that are generally not 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. ADDITIONAL COVERAGE FOR MENTAL HEALTH CARE AND SUBSTANCE USE DISORDER TREATMENT SERVICES

The Plan provides coverage for Medicare Deductible and Coinsurance amounts for mental health substance use disorder treatment services covered by Medicare. The Plan also covers additional benefits for such services that are explained in this subsection. Such additional coverage: (1) allows you to receive coverage for services provided by certain Providers that are not eligible for payment by Medicare, (2) provides you with minimum benefits you may use if Medicare coverage is not available, and (3) provides you with special benefits that may increase your coverage for certain medical conditions.

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

a. Covered Inpatient and Outpatient Facilities

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 mental health and drug and substance use disorder treatment services may be obtained from any of the following types of Providers.

Inpatient Care: In addition to Medicare-certified institutions, the Plan will cover the Massachusetts mandated mental health and substance use disorder treatment 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 use disorder treatment 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 mental health and substance use disorder treatment 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: physicians; psychologists; psychiatrists; psychiatric social workers; certified psychiatric nurses; psychotherapists; licensed independent clinical social workers; licensed nurse mental health clinical specialists; licensed mental health counselors; or clinical specialists in psychiatric and mental health nursing.

(Please note this benefit may not be covered by all Plan Sponsors. If your Plan Sponsor provides coverage for this benefit, it will be listed in your *Schedule of Benefits*.)

b. Additional Benefits for Mental Health and Substance Use Disorder Treatment Services

There are some circumstances in which Medicare does not provide benefits for mental health and substance use disorder treatment services. 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, when services are Medically Necessary and Medicare coverage is not available, the Plan will provide additional coverage for mental health and substance use disorder treatment services as follows:

Minimum Benefits for Mental Health Services. 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 when provided at an Inpatient Mental Health Facility.

ii. **Outpatient Treatment:** The Plan will cover Medically Necessary outpatient mental health services when services are rendered by a Licensed Mental Health Professional.

Minimum Benefits for Substance Use Disorder Treatment. The Plan will provide coverage, less any payments made by Medicare, for the diagnosis and treatment of drug abuse and alcoholism as follows:

i. **Inpatient Treatment:** The Plan will cover Medically Necessary inpatient substance use disorder treatment at a Mental Health Inpatient Facility.

ii. **Outpatient Treatment:** The Plan will cover Medically Necessary substance use disorder treatment services when services are rendered by a Licensed Mental Health Professional.

iii. **Services in Conjunction with Mental Health Treatment:** :

(1) For inpatient treatment at an Inpatient Mental Health Facility to the same extent as the benefits available for hospital care, including any benefit in addition to Medicare benefits provided by your Plan Sponsor. Please see Sections III.B.1.a ("Hospital Care") and your *Schedule of Benefits* for information on your coverage for acute hospital care.

(2) For outpatient care by a Licensed Mental Health Professional to the extent Medically Necessary.

(Please note this benefit may not be covered by all Plan Sponsors. If your Plan Sponsor provides coverage for this benefit, it will be listed in your *Schedule of Benefits*.)

c. Special Benefits for Certain Conditions

Special benefits are also 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) any mental disorder designated a biologically-based mental disorder by the Commissioner of the Massachusetts Department of Mental Health.

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 provide the following coverage, less any payments by Medicare:

- 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.

(Please note this benefit may not be covered by all Plan Sponsors. If your Plan Sponsor provides coverage for this benefit, it will be listed in your *Schedule of Benefits*.)

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.

(Please note this benefit may not be covered by all Plan Sponsors. If your Plan Sponsor provides coverage for this benefit, it will be listed in your *Schedule of Benefits*.)

2. APPLIED BEHAVIORAL ANALYSIS

The Plan provides coverage for Medically Necessary Applied Behavioral Analysis services for the treatment of Autism as required by law.

(Please note this benefit may not be covered by all Plan Sponsors. If your Plan Sponsor provides coverage for this benefit, it will be listed in your Schedule of Benefits.)

3. 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.

4. CARDIAC REHABILITATION

The Plan will provide coverage, less any payments made by Medicare, for Medically Necessary inpatient and outpatient cardiac rehabilitation. Cardiac Rehabilitation is a multidisciplinary treatment of persons with documented cardiovascular disease. It may be provided in a Hospital or outpatient setting and must meet standards promulgated by the Commissioner of Public Health, including, but not limited to, outpatient treatment initiated within 26 weeks after the diagnosis of the disease.

5. 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 Plan Sponsor has selected prescription drug coverage. If such coverage is available, please see your *Prescription Drug Brochure* for details.

6. DIABETES TREATMENT

The Plan will provide coverage, less any payments made by Medicare, for:

- Outpatient diabetes self-management training;
- Diabetic laboratory tests;
- Blood glucose monitors, including coverage for voice-synthesizers and visual magnifying aids when Medically Necessary for use of blood glucose monitors for the legally blind;
- Dosage gauges, injectors, lancet devices, molded shoes needed to prevent or treat complications of diabetes;
- Insulin pumps and infusion devices; and
- Insulin, insulin syringes, insulin pump supplies, insulin pens with syringe; oral agents for controlling blood sugar; lancets; blood test strips; and glucose, ketone, and urine test strips.

Pharmacy items are subject to the prescription Copayment listed on your ID card, if your Plan Sponsor has selected prescription drug coverage. If prescription drug coverage is not available, then the Subscriber will pay a $5 copayment for Generic, a $10 Copayment for Select Brand and a $25 Copayment for Non-Select Brand drugs and supplies.
(Please note this benefit may not be covered by all Plan Sponsors. If your Plan Sponsor provides coverage for this benefit, it will be listed in your *Schedule of Benefits*.)

7. 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.

8. HOSPICE CARE

In addition to the benefit for Medicare covered Hospice care described in Section III.B.2.h, 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.

9. HUMAN LEUKOCYTE ANTIGEN TESTING

The Plan will provide coverage, less any payments made by Medicare, for the cost of human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish bone marrow transplant donor suitability. Such coverage will cover the costs of testing for A, B, or DR antigens, or any combination thereof, consistent with the guidelines, criteria, and rules or regulations established by the Massachusetts Department of Public Health.

10. 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

11. NON-MEDICARE COVERED HOSPITAL SERVICES

The Plan will cover 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, the Plan will provide coverage beyond the last day of Medicare Hospital coverage up to the benefit limit listed in your *Schedule of Benefits*. If your Plan has this coverage, benefits for Hospital care in excess of Medicare limits will 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.

(Please note this benefit may not be covered by all Plan Sponsors. If your Plan Sponsor provides coverage for this benefit, it will be listed in your Schedule of Benefits.)

12. 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 Deductible and Coinsurance 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.

13. 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 emergency 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 a covered by Medicare or the Plan in the United States.

14. 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, gastroesophogeal reflux, gastrointestinal motility, and chronic pseudo-obstruction. In order to be covered, formulas for these conditions must be ordered by a physician.

15. SPECIAL PLAN SPONSOR BENEFITS

Some Plan Sponsor's purchase coverage for services that are not covered by Medicare, in addition to those listed above. Any such service will be listed in your *Schedule of Benefits*.

16. 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.

17. WIGS

The Plan covers wigs and scalp hair prostheses when needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis or permanent hair loss due to injury up to the Benefit Limit listed in the *Schedule of Benefits*.

(Please note this benefit may not be covered by all Plan Sponsors. If your Plan Sponsor provides coverage for this benefit, it will be listed in your *Schedule of Benefits*.)

IV. EXCLUSIONS FROM COVERAGE

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*.

2. Any product or service that is not Medically Necessary.

3. 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.

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 for inpatient care over the semi-private room rate, except when a private room is Medically Necessary.

6. Any product or service for which no charge would be made in the absence of insurance.

7. 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 a covered by Medicare or the Plan in the United States.

8. Any product or service that is Experimental or Unproven. (Please see the Glossary for the definition of "Experimental or Unproven.")

9. Cosmetic surgery except for: (1) services covered by Medicare and (2) any additional services required to be covered under the Women's Health and Cancer Rights Act of 1998.

10. Rest or Custodial Care.

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. Any form of hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. (Please see Section III.D.4. for the coverage provided for wigs)

13. Ambulance services except as specified in this *Benefit Handbook*. No benefits will be provided for transportation other than by ambulance.

14. Exercise equipment; or personal comfort or convenience items such as radios, telephone, television, or haircutting services.

15. Any product or service provided by (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.

16. Refractive eye surgery, including laser surgery, orthokeratology or lens implantation for correction of myopia, hyperopia and astigmatism.

17. 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 Deductible and Coinsurance amounts for professional services or surgery covered by Medicare for the treatment of obesity.)

18. 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.

19. Planned home births.

20. Transsexual surgery or any related drugs and procedures.

21. Devices or special equipment needed for sports or occupational purposes.

22. 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*.

23. 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.

24. Any charges that exceed the Payment Maximum. (Please see the Glossary for the definition of "Payment Maximum.")

25. Any charges for a liver, lung, heart or heart-lung transplant that is not provided at a Hospital approved by Medicare for the type of transplant required.

26. Care outside the scope of standard chiropractic practice by a chiropractor, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial x-ray. (Note that Medicare provides limited benefits for chiropractic services to correct a subluxation of the spine.)

27. Telemedicine services involving e-mail, fax or non-secure texting.

28. Provider fess for technical costs for the provision of telemedicine services.

29. Hearing aid batteries.

30. Any service you supply (with the exception of contact lenses) purchased from the internet

No benefits will be provided by the Plan for any of the following, unless coverage is provided by your Plan Sponsor. If your Plan Sponsor provides such coverage, the following products or services will be listed in your *Schedule of Benefits*:

1. Chiropractic care, except for manual manipulation of the spine to correct a subluxation.

2. Hearing aids

3. Foot orthotics, except as required for the treatment of severe diabetic foot disease or systemic circulatory diseases.

4. 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 Deductible and Coinsurance 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 Plan Sponsor. (Please see the Glossary for the definition of "Dental Services.")

5. 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 or Surrogacy. (Please see the Glossary for the definition of "Surrogacy.")

6. Eyeglasses and contact lenses, or examinations to prescribe, fit, or change eyeglasses or contact lenses, except when covered by Medicare after cataract surgery.

7. Aromatherapy, or alternative medicine.

8. Drugs or medications that can be self-administered unless (1) the Plan Sponsor 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.

9. Private duty nursing.

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
Harvard Pilgrim Health Care Inc.
P.O. Box 699183
Quincy, MA 02269-9183

2. MENTAL HEALTH OR DRUG AND ALCOHOL REHABILITATION CLAIMS

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

HPHC - Behavioral Health Access Center
c/o United Behavioral Health
P.O. Box 30602
Salt Lake City, UT 84130-0602
Telephone: 1-888-777-4742

3. PHARMACY CLAIMS

If your Plan Sponsor has purchased Plan coverage for outpatient prescription drugs, requests for the reimbursement of pharmacy expenses should 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. Claims for Medicare Part A services should first be submitted 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 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.

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 Medical Insurance. 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; (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 & 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 would file a claim with the Plan for the balance due the Provider. For most physician services the Plan would 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 would 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 would be 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 would responsible for paying that excess. You would pay the physician.

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 Sections III.C ("Preventive Care Services") and III.D ("Additional Covered Services"), above, and in your *Schedule of Benefits*. In addition, professionals or institutions that are not eligible to bill Medicare may provide certain Covered Services under the Plan. 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. For Covered Services rendered outside the United States, please follow the procedures outlined in the next section.

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

To file a claim with the Plan for services received while traveling in a foreign country, the Subscriber must 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 Plan Sponsor provides prescription drug coverage, please consult your *Prescription Drug Brochure* for the details of your coverage. As explained in that Brochure, you should only need to file a claim for the reimbursement of covered pharmacy expenses if you do not use a participating pharmacy. In that event, you will have to pay the retail price for the medication and submit a claim for reimbursement.

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 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. If a Provider is under contract to HPHC, the Payment Maximum is the contract rate for the service. If the Provider is not under contract to HPHC, the Payment Maximum is the amount, as determined by HPHC, that is within the normal range of charges made by health care Providers for the same, or similar, products or services in the place where the product or service was rendered. If HPHC cannot reasonably determine the normal range of charges where the product or service was rendered, HPHC may utilize the normal range of charges in Boston, Massachusetts.

VI. APPEALS AND COMPLAINTS

This section explains the procedures for processing appeals and complaints and 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. BEFORE YOU FILE AN APPEAL

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

B. MEMBER APPEAL PROCEDURES

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

A Subscriber may also appeal a rescission of coverage. A rescission of coverage is defined in section VI.C.2., External Review.

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

1. INITIATING YOUR APPEAL

To initiate your appeal, you or your representative should write or FAX a letter to us about the coverage you are requesting and why you feel it should be granted. (If your appeal qualifies as an expedited appeal, you may contact us by telephone. See Section VI.B.3., below, for the expedited appeal process.)

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

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

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

HPHC Appeals and Grievance Department
1 Wellness Way
Canton, MA 02021

1-888-333-4742
FAX: 1-617-509-3085
www.harvardpilgrim.org

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

United Behavioral Health
Attn: Appeals Department
P.O. Box 30512
Salt Lake City, UT 84130-0512

1-877-447-6002
FAX: 1-855-312-1470

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

When we receive your appeal, we will assign an Appeals and Grievances Analyst to coordinate your appeal throughout the appeal process. We will send you an acknowledgement letter identifying your Appeals and Grievances Analyst. That letter will include detailed information on the appeal process. Your Appeals and

Grievances Analyst is available to answer any questions you may have about your appeal. Please feel free to contact your Appeals and Grievances Analyst if you have any questions or concerns about the appeal process.

There are two types of appeal processes, the standard process, which applies to most denied claims and the expedited appeal process which is only available for claims involving claims for Urgent Care services.

2. THE STANDARD APPEAL PROCESS

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

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

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

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

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

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

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

3. THE EXPEDITED APPEAL PROCESS

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

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

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

You, your representative or a provider acting on your behalf may request an expedited appeal by telephone or fax. Please see VI.B.1., above, "Initiating Your Appeal," for the telephone and fax numbers.

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

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

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

Important Notice: If you are filing an expedited appeal with HPHC, you may also file a request for expedited external review at the same time. You do not have to wait until HPHC completes your expedited appeal to file for expedited external review. Please see section VI.C.2., ("External Review"), for information on how to file for external review.

C. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED:

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

1. RECONSIDERATION OF AN APPEAL DECISION

Many Plan Sponsors provider for voluntary reconsideration of an appeal denial either by HPHC or directly through the Plan Sponsor. Please contact your Appeals and Grievances Analyst or your Plan Sponsor for information on whether reconsideration of your appeal is available under your Plan. Your HPHC Appeals and Grievances Analyst can be reached at 1-888-333-4742.

Please note that by seeking reconsideration you will not lose the right to obtain external review of your appeal, as described below. You may seek external review after reconsideration. However, you cannot obtain reconsideration of your appeal after seeking external review. Seeking reconsideration also does not affect your right to bring legal action, as referenced below.

2. EXTERNAL REVIEW

If you disagree with the denial of your appeal you may be entitled seek external review though an Independent Review Organization (IRO). However, this right does not apply if your Plan is a grandfathered health plan under the Patient Protection and Affordable Care Act. Contact your Plan Sponsor to find out whether your Plan is a grandfathered health plan.

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

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

HPHC Appeals and Grievance Department
1 Wellness Way
Canton, MA 02021

1-888-333-4742
FAX: 1-617-509-3085
www.harvardpilgrim.org

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

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

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

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

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

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

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

  Medical Judgment. A "medical judgment" includes, but is not limited to, the following types of decisions: (i) whether the service is Medically Necessary; (ii) whether the health care facility, level of care, or service is appropriate for treatment of the Member's condition; (iii) whether the service is likely to be effective, or more effective than an alternative service, in treating a Member's condition; or (iv) whether the service is Experimental, Unproven or

Investigational. A medical judgement does not include a decision that is based on an interpretation of the law, or the benefits or wording of your Plan, without consideration of your clinical condition or what is best for you medically.

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

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

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

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

3. ALTERNATIVE DISPUTE RESOLUTION

You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.

4. LEGAL ACTION

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

D. FORMAL COMPLAINT PROCESS

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

HPHC Appeals and Grievances Department
1 Wellness Way
Canton, MA 02021

Telephone: **1-888-333-4742**
Fax: 1-617-509-3085
www.harvardpiligrim.org

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

HPHC Behavioral Complaints
c/o Optum Behavioral Complaints
P.O. Box 30768
Salt Lake City, UT 84130-0768

Telephone: **1-888-777-4742**
FAX: **1-248-524-7603**

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

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. PLAN SPONSORS MAY NOTIFY THE PLAN OF ENROLLMENT CHANGES RETROACTIVELY. AS A RESULT, THE PLAN'S ENROLLMENT INFORMATION MAY NOT BE UP TO DATE. ONLY YOUR PLAN SPONSOR 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 a Plan Sponsor that has entered into an agreement with HPHC 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 Plan Sponsor. In general, these individuals are:

   a. Retired employees of the Plan Sponsor who are eligible for Medicare based on age;

   b. Retired employees of the Plan Sponsor who are eligible for Medicare based on disability;

   c. Active or retired employees of the Plan Sponsor 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; and

The Plan must receive payment for services and the administrative fee due for the Subscriber's *Medicare Enhance* coverage from the Plan Sponsor.

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 Plan Sponsor, 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 Plan Sponsor using Plan enrollment forms or in a manner otherwise agreed to in writing by the Plan and the Plan Sponsor. The Plan must receive proper notice from the Plan Sponsor 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 Plan Sponsor for information, effective dates or coverage, and Plan enrollment forms.

Please note that if an individual is re-employed by the Plan Sponsor on a part time basis after retirement, the Plan Sponsor 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 Plan Sponsor, to entitle an employee to coverage under the Plan Sponsor'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 persons with ESRD and to Plan Sponsors with 19 employees or less.

B. ENROLLMENT

1. During the period established by the Plan and the Plan Sponsor, 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 administrative fees 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 the individual loses eligibility for 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;

3. The date a active employee who is enrolled in Medicare Parts A and B based on ESRD completes the 30-month coordination period during which the Plan Sponsor health plan is the primary payer to Medicare; or

4. The Plan Sponsor'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 administrative fees. 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 may terminate a Subscriber's coverage under the Plan for non-payment for services or the administrative fee by the Subscriber's Plan Sponsor.

2. HPHC 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 HPHC and coverage of the Subscriber may be terminated effective immediately upon written notice.

   b. If the Subscriber provides HPHC with any information that is untrue, inaccurate or incomplete, HPHC will have the right to declare this *Benefit Handbook* null and void or, HPHC, 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. HPHC 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. HPHC will give the Subscriber notice at least 31 days before the date of termination.

4. HPHC 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. HPHC may terminate a Subscriber's coverage upon the termination or non-renewal of the agreement between HPHC and the Plan Sponsor 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 Plan Sponsor. HPHC must receive a completed Enrollment/Change form from the Plan Sponsor 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 Plan Sponsor eligibility and the Plan Sponsor has twenty (20) or more employees, you may be eligible for continuation of Plan Sponsor coverage under the Federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA). You should contact the Plan Sponsor for more information if health coverage ends due to 1) 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. CERTIFICATE OF CREDITABLE COVERAGE

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Subscribers are entitled to a Certificate of Creditable Coverage, which verifies the most recent period of coverage under the Subscriber's Group. The certificate shows how many months of coverage a Subscriber has, up to a maximum of 18 months. It also shows the date coverage ended. Either the Plan or the Plan Sponsor will automatically send this Certificate to Subscribers upon termination of enrollment. However, Subscribers may contact the Plan by calling the Member Services Department at **1-888-333-4742** at any time within 2 years from the date coverage ended to request a free copy of their certificate from the Plan.

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. For prescription drug claims, we will coordinate benefits pursuant to our secondary payer allowed amount in all cases.

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 he 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 Plan Sponsor or as otherwise stated in an agreement between the Plan and your Plan Sponsor. Subscribers will be given written notice of any material changes in covered benefits. Amendments do not require the consent of Subscribers.

This *Benefit Handbook*, 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.

HPHC may terminate this *Benefit Handbook*, the *Schedule of Benefits* and the *Prescription Drug Brochure* (if any) by giving written notice to your Plan Sponsor at least 60 days before the Contract Anniversary Date or as otherwise stated in an agreement between the Plan and your Plan Sponsor.

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. QUALITY ASSURANCE AND UTILIZATION REVIEW PROCEDURES

The goal of the Plan's Quality Program is to ensure the provision of consistently excellent health care, health information and service to *Medicare Enhance* Subscribers, enabling them to maintain and improve their physical and behavioral health and well being. Some components of the quality program are directed to all Subscribers and others address specific medical issues.

The Plan does not require prior approval of services for the coverage of benefits. 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.

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

E. 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 Plan Sponsor, 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.

F. 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.

G. 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.

H. 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*.

I. 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. It is the Subscriber's responsibility to notify HPHC of an address change to ensure mailed materials are sent to the appropriate address. HPHC is not responsible for mailed materials being sent to the incorrect address if a Subscriber has not updated his/her address with HPHC prior to materials being mailed out.

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 Plan Sponsor upon which the yearly Plan Sponsor administrative fees are 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

Fees payable by Subscribers for certain Covered Services under the Plan. Copayments are payable at the time of service or when billed by the provider. The Copayments that apply to your Plan Sponsor’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 & 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.

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 issued the Centers for Medicare and Medicaid Services.

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 at a 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.

Harvard Pilgrim Health Care, Inc. (HPHC)

Harvard Pilgrim Health Care, Inc. is a Massachusetts corporation that administers the Plan on behalf of the Plan Sponsor. Under self-insured plans such as this one, HPHC adjudicates and pays claims, and manages benefits on behalf of the Plan Sponsor. HPHC 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 use disorder treatment facility licensed by the Massachusetts Department of Public Health.

Licensed Mental Health Professional

A Licensed Mental Health Professional is one of the following providers: physicians; psychologists; psychiatrists; psychiatric social workers; certified psychiatric nurses; psychotherapists; licensed independent clinical social workers; licensed nurse mental health clinical specialists; licensed mental health counselors; or clinical specialists in psychiatric and mental health nursing. The benefits provided under Section III.C.1. ("Additional Coverage for Mental Health Care and Substance Use Disorder Treatment") 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 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 the 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.

Member

A term sometimes used for Subscriber.

Outpatient Mental Health Facility

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

Outpatient Surgery

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

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 & 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 Harvard Pilgrim Health Care, Inc. (HPHC). If a Provider is under contract to HPHC, the Payment Maximum is the contract rate for the service. If the Provider is not under contract to HPHC, the Payment Maximum is the amount, as determined by HPHC, that is within the normal range of charges made by health care Providers

for the same, or similar, products or services in the place where the product or service was rendered. (This is sometimes referred to as the "Usual, Customary and Reasonable Charge".) If HPHC cannot reasonably determine the normal range of charges where the product or service was rendered, HPHC may utilize the normal range of charges in Boston, Massachusetts.

Plan

The program where health care services and supplies are covered under the contract between the Plan Sponsor and HPHC through which the Subscriber is a participant.

Plan Sponsor

The entity, normally your former employer or your spouse's former employer, that has contracted with HPHC to administer the benefits of the Plan. The Plan Sponsor is responsible for payment for all covered services under the Plan.

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, certified psychiatric nurses, clinical specialists in psychiatric and mental health nursing, psychotherapists, licensed independent clinical social workers, licensed nurse mental health clinical specialists, and licensed mental health counselors.

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 Plan Sponsor.

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 (1) who meets all applicable eligibility requirements for enrollment in the Plan, (2) who is enrolled in the Plan through a Plan Sponsor, and (3) for whom the administrative fee has been received by the Plan. In some materials, a Subscriber may also be referred to as a Member.

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.

Urgent Care

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

XII. RIDERS

The HPHC Insurance Company, Inc. Rider for
Oral Medication For The Treatment of Cancer

This rider modifies the terms of your Benefit Handbook. Specifically, it addresses coverage for certain prescribed oral medications for the treatment of cancer. Please keep this rider with your Benefit Handbook for easy reference. Except as described in this rider, all other provisions of the Plan remain as described in your Benefit Handbook, Schedule of Benefits, and, if you have outpatient pharmacy coverage, your Prescription Drug Brochure.

Your Benefit Handbook may provide coverage 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.

Please Note: Please contact Member Services to confirm coverage for orally administered medications for the treatment of cancer under your Plan.

Form No. ASO_Medicare Enhance

Harvard Pilgrim Health Care

1 Wellness Way
Canton, MA 02021

1-800-333-4742
www.harvardpilgrim.org

cc 1512/si/m.enh 01/23