Harvard Pilgrim Health Care

Benefit Handbook

THE UHH LOCAL 26 SELECT PLAN FOR *UNITE HERE HEALTH* LOCAL 26 MEMBERS *MASSACHUSETTS*

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

Important Notice: This plan utilizes the UHH Local 26 Select provider network which provides access to a network that is smaller than Harvard Pilgrim's full provider network. Providers are available in Massachusetts, Maine, New Hampshire, Rhode Island, and Vermont.

EFFECTIVE DATE: 05/01/2025
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INTRODUCTION

Welcome to The UHH Local 26 Select Plan for *UNITE HERE HEALTH* Local 26 Members (the Plan). Thank you for choosing us to help meet your health care needs. Your benefits are provided by your Plan Sponsor, *UNITE HERE HEALTH*. Harvard Pilgrim Health Care (Harvard Pilgrim or HPHC) administers the plan's benefits on behalf of your Plan Sponsor.

Your health care under the Plan is administered by HPHC through the UHH Local 26 Select network of Primary Care Providers, specialists and other Plan Providers. With very limited exceptions, you must receive care from Plan Providers to obtain coverage. Your Plan is subject to a network smaller than HPHC's full provider network.

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

The words "we," "us," and "our" used in this Handbook refer to Harvard Pilgrim Health Care (HPHC). The words "you" or "your" used in this Handbook refer to Members as defined in the Glossary.

You must choose a Primary Care Provider (PCP) for yourself and each of your family members when you join the Plan.

Your Covered Benefits are described in this Handbook, the Schedule of Benefits, and any riders or amendments to those documents. Services under the Plan must be provided or arranged by your PCP, except as described in section *I.D.1. Your PCP Manages Your Health Care*.

We provide helpful online tools and resources at **www.harvardpilgrim.org/local26**.

Your secure online account offers a safe way to help manage your health care. You can check your Schedule of Benefits and Benefit Handbook. You can look up:

- benefits,
- Member Cost Sharing,
- claims history,
- Deductible status, and
- Prior Approvals and Referrals.

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

You can use the cost transparency tool to compare cost and quality on many types of services, including surgical procedures and office visits. This tool provides estimated costs only. Your Member Cost Sharing may be different.

To use the tools and resources online, visit **www.harvardpilgrim.org/local26** and select the Member Login button. First time users must create an account and then log in. After you log in, click on the "Tools and Resources" link from your Member dashboard. Look for the Estimate My Cost link to get to the cost transparency tool.

For any questions, call Member Services at **1-877-594-7196**. Member Services staff can help you with questions about the following:

- Selecting a PCP
- Your Benefit Handbook
- Your benefits
- Your claims
- Provider information
- Requesting a Provider Directory
- Requesting ID cards
- Registering a complaint

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

Deaf and hard-of-hearing Members may call Member Services at **711** for TTY service.

We value your input. We appreciate any comments or suggestions that will help us improve the quality of our services.

Harvard Pilgrim Health Care
Member Services Department
1 Wellness Way
Canton, MA 02021
Phone: 1-877-594-7196
www.harvardpilgrim.org

Medical Necessity Guidelines. We use evidence based clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for your care. To get Medical Necessity Guidelines, you or your provider may call Member Services at **1-877-594-7196** or go to **www.hphc.org/provider/medical-necessity-guidelines/**.

Exclusions or Limitations for Preexisting Conditions. The Plan has no pre-existing condition restrictions, limitations or exclusions on your Covered Benefits.

Prescription Drug Coverage Your outpatient prescription drug coverage is not administered by HPHC. Please see your Summary Plan Description or call **Hospitality Rx** at **1-844-813-3860** for information on outpatient prescription drugs. Regardless of whether the Summary Plan Description is specifically noted in a handbook section, any reference to outpatient drugs found within this handbook is governed by the Summary Plan Description.

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 اللُّغة **العربية** ، خدمات المساعدة اللُّغوية متوفرة لك مجانا. **إتصل على 1 888-333-4742**
(TTY: 711)

ខ្មែរ (Cambodian) ប្រសិនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, បើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយ ឥតគិតថ្លៃ។ 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, or sex (including pregnancy, sexual orientation, and gender identity). HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and 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, or sex (including pregnancy, sexual orientation, and 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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TABLE OF CONTENTS

Benefit Handbook

I. How the Plan Works

This section describes:

- how to use your Benefit Handbook, and
- how your coverage works.

A. HOW TO USE THIS BENEFIT HANDBOOK

1. Why This Benefit Handbook Is Important

This Benefit Handbook and the Schedule of Benefits make up the agreement stating the terms of the Plan. Please contact your Plan Sponsor, *UNITE HERE HEALTH*, for information.

The Benefit Handbook describes how your Plan works. It explains what you must do to obtain coverage for services and what you can expect from Harvard Pilgrim and the Plan. It's your guide to the most important things you need to know, including:

- Covered Benefits
- Exclusions
- The requirement to receive services from a Plan Provider
- The requirement to go to your PCP for most services

You can view your Benefit Handbook, Schedule of Benefits, and any applicable riders online with **your secure online account** at **www.harvardpilgrim.org/local26**.

2. Words With Special Meaning

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

3. How To Find What You Need To Know

This Handbook's Table of Contents will help you find the information you need. The following describes important sections of the Handbook.

We put the most important information first. For example, section *I. How the Plan Works* explains important requirements for coverage.

Benefit details are described in section *III. Covered Benefits* and in your Schedule of Benefits. Please review these together for a complete understanding of your benefits.

Section *VI. Appeals and Complaints* provides information on how to appeal a denial of coverage or file a complaint.

B. HOW TO USE YOUR PROVIDER DIRECTORY

The Provider Directory will list only those Plan Providers that participate in the UHH Local 26 Select Network. You can view the Provider Directory online at **www.harvardpilgrim.org/local26**. Call Member Services at **1-877-594-7196** to get a free copy of the Provider Directory.

You can search the online Provider Directory for Plan Providers by:

- name,
- gender,
- specialty,
- hospital affiliations,
- languages spoken, and
- office locations.

You can also get information about which Plan Providers are accepting new patients. The online Directory is updated according to state and Federal laws. As a result, it is more current than the paper directory.

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

Please Note: Plan Providers are contracted to be part of the UHH Local 26 Select Network. Contracts can be terminated either by a provider or by us. A Plan Provider may leave the UHH Local 26 Select Network to retire, relocate or for other reasons. This means that we cannot guarantee that your Plan Provider will be in the UHH Local 26 Select Network for the duration of your membership. If your PCP leaves the UHH Local 26 Select Network for any reason, we will make every effort to notify you in advance. We will help you find a new Plan Provider. Under certain circumstances you may be eligible for transition services if your provider leaves the UHH Local 26 Select Network. Please see section *I.G. SERVICES PROVIDED BY A DISENROLLED OR NON-PLAN PROVIDER* for details.

C. MEMBER OBLIGATIONS

1. Choose a Primary Care Provider (PCP)

Under this Plan you must choose a Primary Care Provider (PCP) for yourself and each covered person

in your family. You may choose a different PCP for each family member. We will assign a PCP:

- if you do not choose a PCP when you first enroll, or
- if the PCP you select is not available.

A PCP may be a physician, a physician assistant or a nurse practitioner. A PCP may specialize in one or more of the following:

- internal medicine,
- adult medicine,
- adolescent medicine,
- geriatric medicine,
- pediatrics,
- family practice, or
- gynecology and reproductive health.

PCPs are listed in the Provider Directory on our website. Call Member Services at **1-877-594-7196** to confirm that the PCP you select is available.

We suggest calling your PCP for an appointment if you have not seen him/her before. **Please do not wait until you are sick**. Your PCP can take better care of you when he or she knows your health history.

You may change your PCP at any time. Just choose a new PCP from the Provider Directory. You can change your PCP online using **your secure online account** at **www.harvardpilgrim.org/local26** or call Member Services. The change is effective immediately.

2. Obtain Referrals to Specialists
Most care must be provided or arranged by your PCP. For more information, please see section *I.D. HOW TO OBTAIN CARE*.

If you need to see a specialist, you must contact your PCP for a Referral before your appointment. In most cases, you will be referred to a Plan Provider who:

- is affiliated with the same hospital as your PCP, or
- has a working relationship with your PCP.

Referrals to Plan Providers must be given in writing.

3. Show Your Identification Card
Please show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may not bill us for Covered Benefits. You may be responsible for the cost of the service. You can order a new ID card online. Log in to **your secure online account** at **www.harvardpilgrim.org/local26** or call Member Services.

4. Share Costs
You must share the cost of Covered Benefits provided under the Plan. Your Member Cost Sharing may include one or more of the following:

- Copayments
- Coinsurance
- Deductibles

Your Plan has an Out-of-Pocket Maximum. This limits the amount of Member Cost Sharing you will be required to pay. Your specific Member Cost Sharing is listed in your Schedule of Benefits. See section *I.E. MEMBER COST SHARING* for more information.

5. Obtain Prior Approval
Your Plan Provider must obtain Prior Approval from Harvard Pilgrim before receiving certain Covered Benefits. See section *I.F. PRIOR APPROVAL* for more information.

6. Your Plan Does Not Pay for All Health Services
There may be health products or services you need that are not covered by the Plan. Please review section *IV. Exclusions* for more information. In addition, some services that are covered by the Plan are limited. See your Schedule of Benefits for the limits that apply to your Plan.

D. HOW TO OBTAIN CARE

IMPORTANT POINTS TO REMEMBER

1) You and each Member of your family must select a PCP.
2) To receive Covered Benefits you must use Plan Providers in the UHH Local 26 Select Network, except as described in section *I.D.3. Using Plan Providers*.
3) If you need care from a specialist, you must contact your PCP for a Referral. See section *I.D.6. Services That Do Not Require a Referral* for exceptions.
4) If you have a Medical Emergency, you should go to the nearest emergency facility or call 911 (or other local emergency number). You do not need a Referral for Medical Emergency Services.

1. Your PCP Manages Your Health Care
When you need care, call your PCP. Most services must be provided or arranged by your PCP. The only exceptions are:

- Care in a Medical Emergency.
- Mental health and substance use disorder care. See section *III. Covered Benefits*, *Mental Health and Substance Use Disorder Treatment* for more information.
- Special services that do not require a Referral that are listed in section *I.D.6. Services That Do Not Require a Referral*.

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

You may change your PCP at any time. Choose a new PCP from the Provider Directory. You can change your PCP online. Go to **your secure online account** or call Member Services. The change is effective immediately. If you choose a new PCP, you cannot use the Referrals from your prior PCP. Your new PCP will need to provide new Referrals.

2. Referrals for Hospital and Specialty Care

When you need hospital or specialty care, you must call your PCP first. Your PCP will arrange your care. Your PCP generally uses one hospital for inpatient care. This is where you will go for care. There is an exception if going to a different hospital is Medically Necessary.

You may need specialty care. Your PCP will refer you to a Plan Provider who uses the same hospital your PCP uses. This helps your PCP coordinate and maintain the quality of your care. Please ask your PCP about his/her Referral network.

If the services you need are not available in your PCP's referral network, your PCP may refer you to any Plan Provider. We can help you or your PCP find a Plan Provider. Call Member Services for help finding a medical, mental health or substance use disorder treatment provider. If there is no Plan Provider who can provide the Medically Necessary Covered Benefit, we will help you find a Non-Plan Provider. Prior Approval is required from Harvard Pilgrim in order to receive services from a Non-Plan Provider.

Plan Providers with recognized expertise in specialty pediatrics are covered with a Referral from your PCP.

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

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

You will be directed to a Center of Excellence for certain specialized services. See section *I.D.4. Centers of Excellence* for more information.

You do not need to ask your PCP to receive some specialty services. See section *I.D.6. Services That Do Not Require a Referral*.

3. Using Plan Providers

Under this Plan, you must get Covered Benefits from a Plan Provider. Covered Benefits from a provider who is not a Plan Provider are covered only if one of the following exceptions applies:

1) The service, including ambulance transport, was received in a Medical Emergency. See section *I.D.5. Medical Emergency Services* and section *III. Covered Benefits* for more information.
2) An Urgent Care Service was received while you were outside the network Service Area.
3) There is no Plan Provider who has the professional expertise needed to provide the Medically Necessary Covered Benefit. Unless 1) or 2) above applies, services by a Non-Plan Provider require Prior Approval and must be approved by us in advance.
4) An exception applies as described in section *I.G. SERVICES PROVIDED BY A DISENROLLED OR NON-PLAN PROVIDER* because: (i) your provider is disenrolled as a Plan Provider; or (ii) you are a new Plan Member.
5) The Plan's provider directory or Harvard Pilgrim incorrectly states that a Non-Plan Provider is a Plan Provider. Contact Member Services if you think this rule applies to your claim. The non-participating provider may bill you.

Please Note: A Surprise Bill is an unexpected bill received from a Non-Plan Provider. This can happen when you can't control who is involved in your care, such as in an emergency or when an out-of-network provider treats you at an In-network hospital, hospital outpatient department, or ambulatory surgery center. If you receive a Surprise Bill, you are only responsible

for the applicable Member Cost Sharing that would apply if the covered service was provided by a Plan Provider, unless you gave informed consent agreeing to give up your protections from balance billing in accordance with the No Surprises Act.

To check a provider's status, see the Provider Directory online at **www.harvardpilgrim.org/local26** or call Member Services at **1-877-594-7196**.

4. Centers of Excellence
Plan Providers with special training, experience, facilities or protocols for certain specialized services are designated as "Centers of Excellence." Certain specialized services are only covered when received from a Centers of Excellence. We choose Centers of Excellence based on the findings of recognized specialty organizations or government agencies such as Medicare.

You must get care at a Center of Excellence for the following service:

- Weight loss surgery (bariatric surgery)

Important Notice: There is no coverage for the service listed above unless it is received from a Center of Excellence. See your Provider Directory online at **www.harvardpilgrim.org/local26** or call Member Services at **1-877-594-7196**.

We may change the list of services upon 60 days' notice.

- Services may be added to the list if we determine that significant improvements in the quality of care may be gained by having care at a Center of Excellence.
- Services may be removed from the list if we determine that the care advantages of a Center of Excellence no longer exist.

5. Medical Emergency Services
In a Medical Emergency, including an emergency related to a substance use disorder or mental health condition, you should go to the nearest emergency facility or call 911 (or other local emergency number). A Referral from your PCP is not needed. See your Schedule of Benefits for your Member Cost Sharing. If you are admitted to the hospital, you must call the Plan at **1-877-594-7196** within 48 hours or as soon as you can. This telephone number is on your ID card. If an attending emergency physician contacts us or your PCP, then no further notice is needed. Your PCP will help to arrange for any follow-up care you may need. See the *Glossary* for more information on Medical Emergency Services.

6. Services That Do Not Require a Referral
In most cases you need a Referral from your PCP to get care from any other Plan Provider. However, the services listed below do not require a Referral when received from a Plan Provider. Plan Providers are listed in the Provider Directory. We urge you to keep your PCP informed about care you get without a Referral. This ensures your PCP is aware of your medical situation and keeps your medical records up-to-date. Contact Member Services at **1-877-594-7196** to confirm if a service requires a Referral.

i. Family Planning Services:

- Contraceptive monitoring
- Family planning consultation, including pregnancy testing
- Tubal ligation
- Voluntary termination of pregnancy (if a covered benefit - Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.)

ii. Outpatient Maternity Services
The following services do not require a Referral when provided by an obstetrician, gynecologist, certified nurse midwife or family practitioner:

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

iii. Gynecological Services
The following services do not require a Referral when provided by an obstetrician, gynecologist, certified nurse midwife or family practitioner:

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

- Treatment of amenorrhea
- Treatment of condyloma

iv. Dental Services:

- Emergency Dental Care
- Extraction of teeth impacted in bone (if a covered benefit - Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.)

v. Other Services:

- Medical Emergency Services
- Mental health and substance use disorder services (including medication assisted treatment)
- Nutritional counseling
- Chiropractic care
- Urgent Care services

E. MEMBER COST SHARING

Member Cost Sharing may include Copayments, Coinsurance and/or Deductible amounts. See your Schedule of Benefits for your specific Member Cost Sharing amounts.

Please Note: If you receive a Surprise Bill, you are only responsible for the Member Cost Sharing that would apply if the covered service was provided by a Plan Provider.

1. Copayment

A Copayment is a fixed dollar amount you must pay for certain Covered Benefits. Copayments are due at the time of service or when billed by the provider.

Your Plan may have other Copayment amounts. See your Schedule of Benefits for more information on your specific Copayments.

2. Deductible

A Deductible is a specific dollar amount that is paid by a Member for Covered Benefits received each Calendar Year. See your Schedule of Benefits to see which type of year applies to your Plan.

A Deductible is applied:

- before any benefits subject to the Deductible are paid by the Plan.
- on the date the benefit is received.

When your Plan has a Deductible, it has both an individual Deductible and a family Deductible. The family Deductible only applies if you have Family Coverage. When a family Deductible does not apply, you must pay the individual Deductible.

If you are a Member with Family Coverage, the Deductible can be satisfied in one of two ways:

a. A Member of a covered family meets an individual Deductible, then there are no additional Deductible costs for that Member for the rest of the year.

b. Any number of Members in a covered family collectively meet the family Deductible, then all Members of the covered family have no additional Deductible costs for the rest of the year. No one family member may contribute more than the individual Deductible amount toward the family Deductible.

Once a Deductible is met, coverage by the Plan is subject to any other Member Cost Sharing that may apply. Plan Deductible amounts are listed on your Schedule of Benefits.

A Member may change from Family Coverage to Individual Coverage or from Individual Coverage to Family Coverage within a Calendar Year. In either case:

- costs the Member paid toward the Deductible under the prior coverage will apply toward the Deductible limit under their new coverage.
- the Member or family will only need to pay the Copayment or Coinsurance amounts listed on the new Schedule of Benefits, if the previously paid Deductible amount is more than the new Deductible limit.

3. Coinsurance

After your Deductible is met, you may have to pay Coinsurance. Coinsurance is a percentage of the Allowed Amount or the Recognized Amount, if applicable. For Plan Providers, the Allowed Amount is based on the contracted rate between HPHC and the provider. Coinsurance amounts are listed on your Schedule of Benefits.

4. Out-of-Pocket Maximum

An Out-of-Pocket Maximum is the total amount of Member Cost Sharing you may pay in a Calendar Year for covered medical and prescription drug expenses. Member Cost Sharing includes any Copayments, Deductible and Coinsurance payments.

Once the Out-of-Pocket Maximum is reached, there is no additional Member Cost Sharing for the rest of the year. HPHC will pay 100% of the Allowed Amount for the remainder of the Calendar Year.

Charges above the Allowed Amount and amounts you pay for services or supplies that are not Covered Benefits never apply to the Out-of-Pocket Maximum.

Your Plan has both an individual Out-of-Pocket Maximum and a family Out-of-Pocket Maximum. The family Out-of-Pocket Maximum only applies if you have Family Coverage. When a family Out-of-Pocket Maximum does not apply, you must pay the individual Out-of-Pocket Maximum.

If you have Family Coverage, your Out-of-Pocket Maximum can be reached in one of two ways:

a. A Member of a covered family meets the individual Out-of-Pocket Maximum, then that Member has no additional Member Cost Sharing for the rest of the year.

b. Any number of Members in a covered family collectively meet the family Out-of-Pocket Maximum, then all Members of the family have no additional Member Cost Sharing for the rest of the year.

A Member may change from Family Coverage to Individual Coverage or from Individual Coverage to Family Coverage within a Calendar Year. In either case:

- costs the Member paid toward the Out-of-Pocket Maximum under the prior coverage will apply toward the Out-of-Pocket Maximum limit under their new coverage.
- the Member or family will have no additional Member Cost Sharing for that Calendar Year, if the Out-of-Pocket Maximum amount paid is greater than the new Out-of-Pocket Maximum limit.

F. PRIOR APPROVAL

Your Plan Provider must obtain Prior Approval before you receive certain medical services, Medical Drugs or mental health and substance use disorder treatment.

Your Plan Provider is responsible for the cost of services if he/she does not get Prior Approval. This section explains when Prior Approval is required and how to meet those requirements.

Important Notice: For a detailed list of services that require Prior Approval or for updates and revisions to the Prior Approval list, please visit our website at **www.hphc.org/provider/medical-necessity-guidelines/**. If you have questions regarding services that require Prior Approval, contact Member Services at **1-877-594-7196**.

Please Note: Prior Approval is not required if services are needed in a Medical Emergency.

1. When Prior Approval is Required

Prior Approval must be obtained for any services listed below.

1) **Intermediate Care for Substance Use Disorder Treatment from a Provider not certified or licensed by the Massachusetts Department of Public Health** Except for Acute Treatment Services and Clinical Stabilization Services, Prior Approval must be obtained before receiving substance use disorder treatment from a provider not certified or licensed by the Massachusetts Department of Public Health (i.e. providers located outside the Commonwealth of Massachusetts). To obtain Prior Approval for substance use disorder treatment you should call **1-800-708-4414**.

   Please Note: Prior Approval is not required to obtain Acute Treatment Services or Clinical Stabilization Services from a Plan Provider. The terms "Acute Treatment Services" and "Clinical Stabilization Services" are defined in the *Glossary* of this Benefit Handbook. Services beyond the 14 day period may be subject to concurrent review as described in Section of this Handbook.

2) **For the following mental health treatment:**
   - In-home behavioral services (IHBS)
   - In-home therapy (IHT)
   - Psychological and neuropsychological testing
   - Applied Behavioral Analysis (ABA) services for the treatment of Autism
   - Repetitive Transcranial Magnetic Stimulation (rTMS)

3) **For the following Medical Services or Medical Drugs:**
   - **Inpatient services**
   - **Outpatient services and treatments** including but not limited to: infertility treatment; genetic testing; home health care; advanced radiology; and pain management. See the detailed list of all the services and treatments that require Prior Approval, on our website at **www.harvardpilgrim.orgprovider/medical-necessity-guidelines/**

- **Outpatient surgery**
- **Medical Drugs**
- **Medical formulas**
- **Positive airway pressure devices, including CPAP and BIPAP devices**
- **Power wheelchairs**
- **Diabetic equipment**
- **Non-emergency medical transportation**
  Please note, Prior Approval is not required for transportation provided by a wheelchair van.
- **Prosthetic arms and legs**
- **Dental services**
  Please note, the Plan provides very limited coverage for Dental Care. (See "Dental Services" in section III. Covered Benefits and your Schedule of Benefits for details.)

Please Note: Not all plans cover every service listed on the Prior Approval List. Please see your Schedule of Benefits to determine if your Plan provides coverage for a specific benefit or call Member Services at **1-877-594-7196**.

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

If your Plan Provider leaves the network, HPHC will notify you of your transitional care rights. Please contact Member Services directly to request transitional care or work with your disenrolled provider. Prior Authorization is required to continue services as outlined in this section, with your disenrolled provider at the In-network benefit level. A completed 'Out-of-Network Coverage at In-Network Level of Benefits and Continuity of Care Prior Authorization Form' must be submitted and approved by Harvard Pilgrim in order to be covered at the In-network level. This form can be found within the Medical Necessity Guidelines for Out-of-Network Coverage at the In-Network Level of Benefits and Continuity of Care. Go to **www.hphc.org/provider/medical-necessity-guidelines/**, then enter 'Out-of-Network Coverage at the In-Network Level of Benefits and Continuity of Care' in the search bar, and click the link to access the form.

Requests for transitional care must be submitted before the service is rendered. Approved services will be covered as In-network in the timeframes noted below.

1. Disenrollment of Primary Care Provider (PCP)

If your PCP is disenrolled as a Plan Provider, we do our best to notify you in writing at least 30 days prior to the date of disenrollment. That notice will explain how to select a new PCP. If disenrollment was not related to fraud or quality of care, you may be able to continue to receive Covered Benefits from the disenrolled PCP. Coverage will continue for at least 30 days after the disenrollment date. The terms of this Handbook and your Schedule of Benefits apply.

You may also be able to continue to receive coverage from the disenrollment date or the date of the disenrollment member notice (whichever is later).

2. Disenrollment of other Plan Providers (other than your PCP)

When a provider you are receiving services from is disenrolled as a Plan Provider, you may be able to continue to receive Covered Benefits from that provider.

If disenrollment was not related to fraud or quality of care, you may be eligible to continue coverage from the disenrollment date or the date of disenrollment member notice (whichever is later). Only the following are eligible for this coverage:

a. **Active Course of Treatment**

Except for pregnancy and terminal illness as described below, if you are undergoing an active course of treatment for an illness, injury or condition, we may approve additional coverage through the active course of treatment or up to 90 days, (whichever is shorter). An active course of treatment is when you:

- have a "serious and complex condition."
- are undergoing a course of institutional or inpatient care.
- have scheduled nonelective surgery including any related postoperative care.

The term "serious and complex condition" is an acute illness that requires specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or is a chronic illness that is (a) life-threatening, degenerative, potentially disabling, or congenital; and (b) requires specialized medical care over a prolonged period of time.

b. **Pregnancy**

When you are pregnant, you may continue to receive benefits from your disenrolled provider.

Coverage will be up to 90 days or through the postpartum period, whichever is later.

c. **Terminal Illness**

When the Member is terminally ill (defined as life expectancy of 6 months or less) and is receiving treatment for such illness from such provider or facility. The Member may continue such treatment through death.

3. New Membership

If you are a new Member, we may provide coverage for services from a provider who is not a Plan Provider. The terms of this Handbook and your Schedule of Benefits apply. This will be provided for up to 30 days from your effective date of coverage if the provider is providing you with an ongoing course of treatment or is your PCP.

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

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

Subject to applicable law, Non-Plan Providers providing continuity of care, shall:

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

H. MEDICAL NECESSITY GUIDELINES

We use evidence based clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for your care. You or your provider may obtain a copy of the Medical Necessity Guidelines applicable to a service or procedure for which coverage is requested. Medical Necessity Guidelines may be obtained by calling Member Services at **1-877-594-7196** or going to **www.hphc.org/provider/medical-necessity-guidelines/**.

I. PROVIDER FEES FOR SPECIAL SERVICES (CONCIERGE SERVICES)

Certain physician practices charge extra fees for special services or amenities. Examples of such special physician services might include:

- telephone access to a physician 24-hours a day;
- waiting room amenities;
- assistance with transportation to medical appointments;
- guaranteed same day or next day appointments when not Medically Necessary;
- providing a physician to accompany a patient to an appointment with a specialist.

Such services are not covered by the Plan. The Plan does not cover fees for any service not included as a Covered Benefit under your Plan.

In considering arrangements with physicians for special services, you should understand exactly what services are to be provided. You will need to decide if these services are worth the fee you must pay. For example, the Plan does not require Plan Providers to be available by telephone 24-hours a day. However, the Plan does require Plan Primary Care Providers (PCPs) to provide both an answering service that can be contacted 24-hours a day and prompt appointments when Medically Necessary.

J. BUNDLED PAYMENT ARRANGEMENTS

The Plan may participate in bundled payment arrangements with certain Plan Providers. Under these arrangements, a specific service or treatment is paid for based on a fixed sum for all of services you receive. Member Cost Sharing for Covered Benefits under a bundled payment arrangement may be less than if the Covered Benefits were received without the bundled payment arrangement. Please refer to **www.harvardpilgrim.org** or call Member Services at **1-877-594-7196** for a list of Plan Providers with bundled payment arrangements and their corresponding services. We may revise the list of services or Plan Providers who have bundled payment arrangements upon 30 days notice to Members.

K. CARE MANAGEMENT PROGRAMS

The Plan provides care management programs for Members with certain illnesses and injuries. These programs are designed to encourage the use of the most appropriate and cost-effective treatment and to provide support for the Member's care.

Care management may include programs for medical and behavioral health care including, but not limited to:

- cancer;
- heart, lung and kidney diseases;
- severe traumatic injuries;
- behavioral health disorders;
- substance use disorders;
- high risk pregnancies and newborn care.

The Plan may work with certain providers to establish care management programs. The Plan or providers affiliated with the care management program may contact Members that may be candidates for its programs. The Plan or providers may also contact Members to:

- assist with enrollment.
- develop treatment plans.
- establish goals.
- determine alternatives to a member's current treatment plan.

Member Cost Sharing may apply to Covered Benefits provided through a care management program may apply Member Cost Sharing.

II. Glossary

This section lists words with special meaning within the Handbook.

Glossary Term	Definition
1 . Activities of Daily Living	
	The basic functions of daily life include bathing, dressing, and mobility, including, but not limited to, transferring from bed to chair and back, walking, sleeping, eating, taking medications and using the toilet.
2 . Acute Treatment Services	
	24-hour medically supervised addiction treatment for adults or adolescents provided in a medically managed or medically monitored inpatient facility, as defined by the Massachusetts Department of Public Health. Acute Treatment Services provide evaluation and withdrawal management and may include biopsychological assessment, individual and group counseling, psychoeducational groups and discharge planning.
3 . Allowed Amount	
	The Allowed Amount is the maximum amount the Plan will pay for Covered Benefits minus any applicable Member Cost Sharing. The Allowed Amount depends upon whether a Covered Benefit is provided by a Plan Provider or a Non-Plan Provider, as follows: 1. Plan Providers. If a Covered Benefit is provided by a Plan Provider, the Allowed Amount is the contracted rate HPHC has agreed to pay Plan Providers. The Plan Providers are not permitted to charge the Member any amount for Covered Benefits, except the applicable Member Cost Sharing amount for the service, in addition to the Allowed Amount. 2. Non-Plan Providers. Most services that are Covered Benefits under your Plan must be provided by a Plan Provider to be covered by HPHC, except care listed in section *I.D.3. Using Plan Providers*. If services provided by a Non-Plan Provider are Covered Benefits under your Plan, the Allowed Amount for such services depends upon where the Member receives the service, as explained below except where a different Allowed Amount is required by federal law. a. If a Member receives Covered Benefits from a Non-Plan Provider in the states of Massachusetts, New Hampshire, Maine, Rhode Island, or Vermont, the Allowed Amount is defined as follows: The Allowed Amount is the lower of the provider's charge or a rate determined as described below: An amount that is consistent, in the judgment of the Plan, with the normal range of charges by health care providers for the same, or similar, products or services provided to a Member. If the Plan has appropriate data for the area, the Plan will determine the normal range of charges in the geographic area where the product or services were provided to the Member. If the Plan does not have data to reasonably determine the normal range of charges where the products or services were provided, the Plan will utilize the normal range of charges in Boston, Massachusetts. Where services are provided by non-physicians but the data on provider charges available to the Plan is based on charges for services by physicians, the Plan will, in its discretion, make reasonable reductions in its determination of the allowable charge for such non-physician providers. b. If a Member receives Covered Benefits from a Non-Plan Provider outside of Massachusetts, New Hampshire, Maine, Rhode Island, or Vermont, the Allowed Amount is defined as follows:

Glossary Term	Definition
Allowed Amount (Continued)	
	The Allowed Amount is the lower of the provider's charge or a rate determined as described below: The Allowed Amount is determined based on 150% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market. When a rate is not published by CMS for the service, we use other industry standard methodologies to determine the Allowed Amount for the service as follows: For services other than Pharmaceutical Products, we use a methodology called a relative value scale, which is based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by Optuminsight, Inc. If the Optuminsight, Inc. relative value scale becomes no longer available, a comparable scale will be used. For Pharmaceutical Products, we use industry standard methodologies that are similar to the pricing methodology used by CMS and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource. When a rate is not published by CMS for the service and no industry standard methodology applies to the service, or the provider does not submit sufficient information on the claim to pay it under CMS published rates or an industry standard methodology, the Allowed Amount will be 50% of the provider's billed charge. Pricing of the Allowed Amount will be conducted by UnitedHealthcare, Inc. UnitedHealthcare, updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data. As stated above, the Allowed Amount is the maximum amount the Plan will pay for Covered Benefits minus any applicable Member Cost Sharing. Most Non-Plan Providers are permitted to charge amounts for Covered Benefits in excess of the Allowed Amount. In that event, the Plan is responsible for payment of the Allowed Amount, minus any applicable Member Cost Sharing. The Member is responsible for paying the applicable Member Cost Sharing amount and any additional amount charged by the Non-Plan Provider above the Allowed Amount.
4 . Anniversary Date	
	The date agreed to by HPHC and your Plan Sponsor upon which the yearly benefit changes normally become effective. This Benefit Handbook and Schedule of Benefits, and any applicable riders will terminate unless renewed on the Anniversary Date. **For Example:** If your Anniversary Date is April 1st, this is the date when the Plan goes into effect and begins to pay for Covered Benefits.
5 . Benefit Handbook (or Handbook)	
	This document that describes the terms and conditions of the Plan, including but not limited to, Covered Benefits and exclusions from coverage.

Glossary Term	Definition
6 . Benefit Limit	
	The day, visit or dollar limit maximum that applies to certain Covered Benefits, up to the Allowed Amount, or Recognized Amount, if applicable. Once the Benefit Limit has been reached, no more benefits will be paid for such services or supplies. If you exceed the Benefit Limit, you are responsible for all charges incurred. The Benefit Limits applicable to your Plan are listed in your Schedule of Benefits. **For Example:** If your Plan offers 30 visits per Calendar Year for physical therapy services, once you reach your 30 visit limit for that Calendar Year, no additional benefits for that service will be covered by the Plan.
7 . Calendar Year	
	The one-year period beginning on January 1 for which benefits are purchased and administered. Benefits for which limited yearly coverage is provided renew at the beginning of the Calendar Year. Benefits for which limited coverage is provided every two years renew at the beginning of every second Calendar Year. Benefits under your Plan are administered on a Calendar Year basis.
8 . Centers of Excellence	
	Plan Providers with special training, experience, facilities or protocols for certain services. Centers of Excellence are selected by us based on the findings of recognized specialty organizations or government agencies such as Medicare. Certain specialized services are only covered when received from designated Centers of Excellence.
9 . Clinical Stabilization Services	
	24-hour clinically managed post detoxification treatment for adults or adolescents, as defined by the Massachusetts Department of Public Health. Clinical Stabilization Services usually follow Acute Treatment Services for substance use disorders. Clinical Stabilization Services may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others and after care planning, for individuals beginning to engage in recovery from addiction.
10 . Coinsurance	
	A percentage of the Allowed Amount, or Recognized Amount, if applicable, for certain Covered Benefits that must be paid by the Member. Coinsurance amounts applicable to your Plan are stated in your Schedule of Benefits. **For Example:** If the Coinsurance for a service is 20%, you pay 20% of the Allowed Amount while we pay the remaining 80%.
11 . Copayment	
	A fixed dollar amount you must pay for certain Covered Benefits. The Copayment is usually due at the time services are rendered or when billed by the provider. Your specific Copayment amounts, and the services to which they apply, are listed in your Schedule of Benefits. **For Example:** If your Plan has a $20 Copayment for outpatient visits, you'll pay $20 at the time of the visit or when you are billed by the provider.
12 . Cosmetic Services	
	Cosmetic Services are surgery, procedures or treatments that are performed primarily to reshape or improve the individual's appearance.
13 . Covered Benefit(s)	
	The products and services that a Member is eligible to receive, or obtain payment for, under the Plan.

Glossary Term	Definition
14 . Custodial Care	
	Services provided to a person for the primary purpose of meeting non-medical personal needs (e.g., bathing, dressing, preparing meals, including special diets, taking medication, assisting with mobility).
15 . Deductible	
	A specific dollar amount that is payable by the Member for Covered Benefits received each Calendar Year before any benefits subject to the Deductible are payable by the Plan. There may be an individual Deductible and a family Deductible, and you may have different Deductibles that apply to different Covered Benefits under your Plan. If a Deductible applies to your Plan, it will be stated in your Schedule of Benefits. **For Example:** If your Plan has a $500 Deductible and you have a claim with the Allowed Amount of $1,000, you will be responsible for the first $500 to satisfy your Deductible requirement before the Plan begins to pay benefits.
16 . Dental Care	
	Any service provided by a licensed dentist involving the diagnosis or treatment of any disease, pain, injury, deformity or other condition of the human teeth, alveolar process, gums, jaw or associated structures of the mouth. However, surgery performed by an oral maxillofacial surgeon to correct positioning of the bones of the jaw (orthognathic surgery) is not considered Dental Care within the meaning of this definition.
17 . Dependent	
	A Member of the Subscriber's family who (1) meets the eligibility requirements for coverage through a Subscriber determined by *UNITE HERE HEALTH* and (2) is enrolled in the Plan. Please contact *UNITE HERE HEALTH* for the definition of Dependent.
18 . Enrollment Area	
	The geographic area in which you must live in order to be eligible to enroll as a Member under the Plan. The Enrollment Area includes the states of Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Please see section *VII. Eligibility, Enrollment and Continuing Eligibility* for additional information.
19 . Experimental, Unproven, or Investigational	
	Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests, will be deemed Experimental, Unproven, or Investigational by us under this Benefit Handbook for use in the diagnosis or treatment of a particular medical condition if any the following is true: (a) The product or service is not recognized in accordance with generally accepted medical standards as being safe and effective for the use in the evaluation or treatment of the condition in question. In determining whether a service has been recognized as safe or effective in accordance with generally accepted evidence-based medical standards, primary reliance will be placed upon data from published reports in authoritative medical or scientific publications that are subject to established peer review by qualified medical or scientific experts prior to publication. In the absence of any such reports, it will generally be determined a service, procedure, device or drug is not safe and effective for the use in question. (b) In the case of a drug, the drug has not been approved by the United States Food and Drug Administration (FDA) (this does not include off-label uses of FDA approved drugs) or if approved for lawful marketing by the FDA and reliable scientific evidence does not support that the treatment is effective in improving health outcomes or that appropriate patient selection has not been determined.
20 . Family Coverage	
	Coverage for a Member and one or more Dependents.

Glossary Term	Definition
21 . Habilitation Services	
	Health care services that help a person keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapies and speech-language services.
22 . Harvard Pilgrim Health Care, Inc. (HPHC or Harvard Pilgrim)	
	Harvard Pilgrim Health Care, Inc. is an insurance company that provides, arranges or administers health care benefits for Members through a network of Plan Providers. Under self insured plans such as this one, HPHC adjudicates and pays claims, and manages benefits on behalf of the Plan Sponsor.
23 . Health Benefit Plans	
	A group HMO and other group prepaid health plan, medical or hospital service corporation plan, commercial health insurance and self-insured health plan, which is separate from this Plan.
24 . Individual Coverage	
	Coverage for a Subscriber only. No coverage for Dependents is provided.
25 . Licensed Mental Health Professional	
	For services provided in Massachusetts a Licensed Mental Health Professional is any one of the following: a licensed physician who specializes in the practice of psychiatry; a licensed psychologist; a licensed independent clinical social worker; a licensed certified social worker; a licensed mental health counselor; a licensed supervised mental health counselor; a licensed psychiatric nurse mental health clinical specialist; a licensed psychiatric mental health nurse practitioner; a licensed physician assistant who practices in the area of psychiatry; a level I licensed alcohol and drug counselor; a clinician practicing under the supervision of a licensed professional and working towards licensure in a clinic licensed under chapter 111; or a licensed marriage and family therapist. For services provided outside of Massachusetts, a Licensed Mental Health Professional is independently licensed or certified in accordance with applicable law. The term "clinical mental health discipline" includes the following: psychiatry; psychology; clinical social work; marriage and family therapy; clinical counseling; developmental psychology; pastoral counseling; psychiatric nursing; developmental or educational psychology; counselor education; or any other discipline deemed acceptable by the Plan.
26 . Medical Drugs	
	A prescription drug that is administered to you either (1) in a doctor's office or other outpatient medical facility, or (2) at home while you are receiving home health care services or receiving drugs administered by home infusion services. Medical Drugs cannot be self-administered. The words "cannot be self-administered" mean that the active participation of skilled medical personnel is always required to take the drug. When a Member is receiving drugs in the home, the words "cannot be self-administered" will also include circumstances in which a family member or friend is trained to administer the drug and ongoing supervision by skilled medical personnel is required.

Glossary Term	Definition
27 . Medical Emergency	
	A medical condition, whether physical or behavioral health (including a condition resulting from a substance use disorder), manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the Member or her unborn child in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part. With respect to a pregnant woman who is having contractions, Medical Emergency also means that there is inadequate time to effect a safe transfer to another hospital before delivery or that transfer may pose a threat to the health or safety of the woman or the unborn child. Examples of Medical Emergencies are: heart attack or suspected heart attack, stroke, shock, major blood loss, choking, severe head trauma, loss of consciousness, seizures and convulsions. Please remember that if you are hospitalized, you must call HPHC within 48 hours or as soon as you can. If the notice of hospitalization is given to HPHC or your PCP by an attending emergency physician, no further notice is required.
28 . Medical Emergency Services	
	Services provided during a Medical Emergency, including: • A medical screening examination (as required under section 1867 of the Social Security Act or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital, or an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Medical Emergency, and • Further medical examination and treatment, within the capabilities of the staff and facilities available at the hospital or independent freestanding emergency department, as applicable, as are required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further exam or treatment is provided). • Items and services, otherwise covered under the Plan, that are provided by a Non-Plan Provider or facility (regardless of the department of the hospital in which the items and services are provided) after the Member is stabilized and as part of an inpatient stay or outpatient services that are connected to the original Medical Emergency, unless each of the following conditions are met, consistent with federal surprise billing protections: a. The provider or facility, as described above, determines the Member is able to travel using non-medical transportation or non-emergency medical transportation. b. The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law. c. The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law. d. Any other conditions as specified under applicable law.

Glossary Term	Definition
29 . Medically Necessary or Medical Necessity	
	Those health care services that are consistent with generally accepted principles of professional medical practice as determined by whether: (a) the service is the most appropriate supply or level of service for the Member's condition, considering the potential benefit and harm to the individual; (b) the service is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; and, (c) for services and interventions that are not widely used, the use of the service for the Member's condition is based on scientific evidence. To determine coverage of Medically Necessary services, we use Medical Necessity Guidelines (MNG) created using clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of the Medical Necessity Guideline(s) applicable to a service or procedure for which coverage is requested by going online or calling Member Services at **1-877-594-7196**.
30 . Member	
	Any Subscriber or Dependent covered under the Plan.
31 . Member Cost Sharing	
	The responsibility of Members to assume a share of the cost of the benefits provided under the Plan. Member Cost Sharing may include Copayments, Coinsurance and Deductibles. Please refer to your Schedule of Benefits for the specific Member Cost Sharing that applies to your Plan.
32 . Non-Plan Provider	
	Providers of health care services that are not under contract with us to provide care to Members. Generally, these providers are not covered, except for services outlined in section *I.D.3. Using Plan Providers*.
33 . Out-of-Network Rate	
	With respect to a Surprise Bill, the total amount paid by the Plan to a Non-Plan Provider for Covered Benefits under section 2799A-1 and 2799A-2 of the Public Service Act and their implementing regulations for: (1) Emergency Medical Services, (2) non-emergency ancillary services, (3) non-emergency, non-ancillary services, and (4) air ambulance services. The amount is based on: (1) Applicable state law, (2) an All Payer Model Agreement if adopted, (3) the initial payment made by us or the amount subsequently agreed to by the Non-Plan Provider and us, or (4) the amount determined by Independent Dispute Resolution between us and the Non-Plan Provider.
34 . Out-of-Pocket Maximum	
	An Out-of-Pocket Maximum is a limit on the amount of Copayments, Coinsurance and Deductibles that you must pay for covered medical and prescription drug expenses in a Calendar Year. The Out-of-Pocket Maximum is specified in your Schedule of Benefits. **Hospitality Rx** administers the pharmacy benefit. You can reach **Hospitality Rx** at **1-844-813-3860** for information on coverage of outpatient prescription drugs. **Please Note:** Charges above the Allowed Amount never apply to the Out-of-Pocket Maximum.

Glossary Term	Definition
35 . Physical Functional Impairment	
	A condition in which the normal or proper action of a body part is damaged, and affects the ability to participate in Activities of Daily Living. Physical Functional Impairments include, but are not limited to, problems with ambulation, communication, respiration, swallowing, vision, or skin integrity. A physical condition may impact an individual's emotional well-being or mental health. However such impact is not considered in determining whether or not a Physical Functional Impairment exists. Only the physical consequences of a condition are considered.
36 . Plan	
	This package of health care benefits that is administered by HPHC on behalf of your Plan Sponsor. HPHC or your Plan Sponsor may take any action on behalf of the Plan.
37 . Plan Provider	
	Providers of health care services in the Service Area that are under contract to provide care to Members of your Plan. Care must be provided within the lawful scope of the provider's license. Plan Providers include but are not limited to: facilities, hospitals, physicians, podiatrists, psychologists, psychiatrists, nurse practitioners, advanced practice registered nurses, physician's assistants, psychiatric social workers, certified psychiatric nurses, licensed nurse mental health clinical specialists, psychotherapists, licensed independent clinical social workers, licensed mental health counselors, level I licensed alcohol and drug counselors, physicians with recognized expertise in specialty pediatrics (including mental health and substance use disorder treatment), chiropractors, nurse midwives, nurse anesthetists, optometrists, speech-language pathologists and audiologists, and early intervention specialists who are credentialed and certified by the Massachusetts Department of Public Health. Dentists may also be Plan Providers when providing services under this Plan. (Please note that coverage for dental services is very limited.) Plan Providers are listed in the Provider Directory.
38 . Plan Sponsor	
	Plan Sponsor is *UNITE HERE HEALTH* who is the entity that has contracted with HPHC to provide health care services and supplies for its members and their dependents under the Plan. The Plan Sponsor pays for the health care coverage provided under the Plan.
39 . Premium	
	A payment made to us for health coverage under the Plan.
40 . Primary Care Provider (PCP)	
	A Plan Provider designated to help you maintain your health and to provide and authorize your medical care under the Plan. A PCP may be a physician, a physician assistant or a nurse practitioner specializing in one or more of the following specialties: internal medicine, adult medicine, adolescent medicine, geriatric medicine, pediatrics, family practice, or gynecology and reproductive health. A PCP may designate other Plan Providers to provide or authorize a Member's care.
41 . Prior Approval (also known as Prior Authorization)	
	A program to verify that certain Covered Benefits are, and continue to be, Medically Necessary and provided in an appropriate and cost-effective manner. See section *I.F. PRIOR APPROVAL* for more information.
42 . Provider Directory	
	A directory that identifies Plan Providers. We may revise the Provider Directory from time to time without notice to Members. The most current listing of Plan Providers is available on **www.harvardpilgrim.org/local26**.

Glossary Term	Definition
43 . Recognized Amount	
	With respect to a Surprise Bill, the amount on which a Copayment, Coinsurance or Deductible is based for Medical Emergency Services and certain non-emergency Covered Benefits when provided by Non-Plan Providers. The amount under sections 2799A-1 and 2799A-2 of the Public Service Act and their implementing regulations is based on the lesser of the amount billed by the provider or the qualifying payment amount as determined under applicable law. **Please Note:** Member Cost Sharing based on the Recognized Amount may be higher or lower than Member Cost Sharing based on the Allowed Amount.
44 . Referral	
	An instruction from your PCP that gives you the ability to see another Plan Provider for services that may be out of your PCP's scope of practice. Please see section *III. Covered Benefits* for other requirements of coverage. **For Example:** If you need to visit a specialist, such as a dermatologist or cardiologist, you must contact your PCP first. Your PCP will refer you to a specialist who is a Plan Provider. Your PCP will generally refer you to a specialist with whom he or she is affiliated or has a working relationship.
45 . Rehabilitation Services	
	Rehabilitation Services are treatments for disease or injury that restore or move an individual toward functional capabilities prior to disease or injury. For treatment of congenital anomalies with significant functional impairment, Rehabilitation Services improve functional capabilities to or toward normal function for age appropriate skills. Only the following are covered: cardiac rehabilitation therapy; occupational therapy; physical therapy; pulmonary rehabilitation therapy; speech therapy; or an organized program of these services when rendered by a health care professional licensed to perform these therapies.
46 . Schedule of Benefits	
	A summary of the benefits selected by your Plan Sponsor and covered under your Plan are listed in the Schedule of Benefits. The Schedule of Benefits states the Copayments, Coinsurance or Deductible you must pay and any limitations on coverage.
47 . Service Area	
	The geographic area where Plan Providers are available to manage a Member's care.
48 . Skilled Nursing Facility	
	An inpatient extended care facility, or part of one, that is operating pursuant to law and provides skilled nursing services.
49 . Subscriber	
	The person who meets the eligibility requirements and is enrolled in the Plan as determined by *UNITE HERE HEALTH*.
50 . Summary Plan Description	
	An ERISA Summary Plan Description (SPD) is a document that outlines the plan's benefits, rights, and obligations, which the Plan Sponsor is legally required to provide to participants. It is important to note that the SPD responsibility and requirements lies with the Plan Sponsor, and not with HPHC.
51 . Surgery - Outpatient	
	A surgery or procedure in a day surgery department, ambulatory surgery department or outpatient surgery center that requires operating room, anesthesia and recovery room services.

Glossary Term	Definition
52 . Surprise Bill	
	An unexpected bill you may receive if: (1) you obtain services from a Non-Plan Provider in an emergency, (2) you obtain services from a Non-Plan Provider while you were receiving a service in an In-network hospital, hospital outpatient department, or ambulatory surgical center, and you did not knowingly select the Non-Plan Provider, (3) you obtain air ambulance services from a Non-Plan Provider, or (4) you obtain services from a Non-Plan Provider during a service previously approved or authorized by HPHC where you did not knowingly select a Non-Plan Provider.
53 . 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.
54 . UHH Local 26 Select Network	
	Providers of health care services, including but not limited to, physicians, hospitals and other health care facilities that are under contract with the Plan to provide services to Members in the states of Massachusetts, Maine, New Hampshire, Rhode Island, and Vermont.
55 . *UNITE HERE HEALTH*	
	UNITE HERE HEALTH is the Plan Sponsor who contracts with HPHC, the Plan's third party administrator, for the provision of certain services and availability of the UHH Local 26 Select Network of Plan Providers to the Plan, and *UNITE HERE HEALTH* is responsible for funding all Covered Benefits under the Plan and described in this Description of Benefits.
56 . Urgent Care	
	Medically Necessary services for a condition that requires prompt medical attention but is not a Medical Emergency.

III. Covered Benefits

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

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

Basic Requirements for Coverage

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

- Listed as a Covered Benefit in this section.
- Medically Necessary.
- Not excluded in section *IV. Exclusions*.
- Received while an active Member of the Plan.
- Provided by or upon Referral from your PCP. This requirement does not apply to care needed in a Medical Emergency. Please see section *I.D.1. Your PCP Manages Your Health Care* for other exceptions that apply.
- Provided by a Plan Provider. This requirement does not apply to care needed in a Medical Emergency. Please see section *I.D.3. Using Plan Providers* for other exceptions that apply.
- Some services require Prior Approval by the Plan. Your Plan Provider is responsible for requesting Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for information on the Prior Approval Program.

Please Note: No Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice at: **www.harvardpilgrim.org/local26**.

Benefit	Description
1 . Ambulance and Medical Transport	
	Emergency Ambulance Transport If you have a Medical Emergency (including an emergency related to a substance use disorder or mental health condition), your Plan covers ambulance transport (ground and air) to the nearest hospital that can provide you with Medically Necessary care. **Non-Emergency Medical Transport** You're also covered for non-emergency medical ambulance transport, including but not limited to ambulance and wheelchair vans, between hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary. Services must be arranged by a Plan Provider. **Prior Approval Required:** Prior Approval is required for non-emergency medical transportation. Please note Prior Approval is not required for transportation provided by a wheelchair van. Your Plan Provider will seek Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for more information.

Benefit	Description
2 . Autism Spectrum Disorders Treatment	
	Coverage is provided for the diagnosis and treatment of Autism Spectrum Disorders, as defined below. Covered Benefits include the following: • Diagnosis of Autism Spectrum Disorders. This includes Medically Necessary assessments, evaluations, including neuropsychological evaluations, genetic testing or other tests to diagnose whether an individual has one of the Autism Spectrum Disorders. • Professional services by Plan Providers. This includes care by physicians, Licensed Mental Health Professionals, speech therapists, occupational therapists, and physical therapists. • Rehabilitation and Habilitation Services, including, but not limited to, applied behavior analysis supervised by a board certified behavior analyst as defined by law. Autism Spectrum Disorders include any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. These include Autistic Disorder; Asperger's Disorder; and Pervasive Developmental Disorders Not Otherwise Specified. Applied behavior analysis is defined as the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior. It includes the use of direct observation, measurement and functional analysis of the relationship between environment and behavior. There is no coverage for services provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor. **Prior Approval Required:** Prior Approval is required for Applied Behavioral Analysis (ABA) services. Your Plan Provider will seek Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for more information.
3 . Bariatric Surgery	
	The Plan covers the surgical treatment of obesity and morbid obesity (bariatric surgery). Services are covered in accordance with the patient qualification and treatment standards set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons. Coverage may be limited or excluded under your Plan unless services are performed at a designated Center of Excellence. Please see the section *I.D.4. Centers of Excellence* for important information concerning your coverage for this service. **Important Notice:** We use clinical guidelines to evaluate whether bariatric surgery is Medically Necessary. If you are planning to receive bariatric surgery services we recommend that you review the current Medical Necessity Guidelines. To obtain a copy, please call Member Services at **1-877-594-7196**.
4 . Cardiac Rehabilitation Therapy	
	The Plan covers cardiac rehabilitation. Coverage includes only Medically Necessary services for Members with established coronary artery disease or unusual and serious risk factors for such disease.

Benefit	Description
5 . Chemotherapy and Radiation Therapy	
	The Plan covers outpatient chemotherapy administration and radiation therapy. Covered Benefits include the facility charge, the charge for related supplies and equipment, and physician services for anesthesiologists, pathologists and radiologists. **Prior Approval Required:** Prior Approval is required for radiation oncology. Your Plan Provider will seek Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for more information.
6 . Chiropractic Care	
	The Plan covers musculoskeletal adjustment or manipulation, including electrical muscle stimulation (EMS), modalities and therapeutic exercise, up to the Benefit Limit listed in the Schedule of Benefits.
7 . Clinical Trials for the Treatment of Cancer or Other Life-Threatening Diseases	
	The Plan covers services for Members enrolled in a qualified clinical trial of a treatment for any form of cancer or other life-threatening disease under the terms and conditions provided under federal law. All of the requirements for coverage under the Plan apply to coverage under this benefit. The following services are covered under this benefit: (1) all services that are Medically Necessary for treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the Plan; and (2) the reasonable cost of an investigational drug or device that has been approved for use in the clinical trial to the extent it is not paid for by its manufacturer, distributor or provider.
8 . COVID-19 Services	
	The Plan covers the following COVID-19 services: • **COVID-19 Vaccines** • **COVID-19 Testing** – COVID-19 polymerase chain reaction (PCR) and antigen tests for symptomatic individuals, individuals identified as close contacts by state or local health officials, and asymptomatic individuals. Antibody tests are covered when Medically Necessary in order to support treatment for COVID-19, or for a Member whose immune system is compromised and/or knowledge of COVID-19 antibodies may impact the future outcome of treatment. COVID-19 testing solely intended for return to work, school, or other locations is not Medically Necessary and accordingly not covered. • **COVID-19 Treatment** – COVID-19-related treatment for all emergency, inpatient services, outpatient services, and cognitive rehabilitation services, including all related professional, diagnostic, and laboratory services.
9 . Dental Services	
	Important Notice: The Plan does not provide dental insurance. It covers only the limited Dental Care described below. No other Dental Care is covered under your medical benefits. **Cleft Palate:** For coverage of orthodontic and dental care related to the treatment of cleft lip or cleft palate for children up to the age of 18, please see section *III. Covered Benefits*, *Reconstructive Surgery,* for information on this benefit. **Emergency Dental Care:** The Plan covers emergency Dental Care needed due to an injury to sound, natural teeth. All services, except for suture removal, must be received within three days of injury. Only the following services are covered:

Benefit	Description
Dental Services (Continued)	
	• Extraction of the teeth damaged in the injury when needed to avoid infection • Reimplantation and stabilization of dislodged teeth • Repositioning and stabilization of partly dislodged teeth • Suturing and suture removal • Medication received from the provider **Outpatient Surgery Expenses for Dental Care:** The Plan covers the expenses of a hospital or outpatient surgery center and expenses for general anesthesia administered by an appropriately licensed Plan Provider for such services for the performance of Dental Care covered under the Plan's dental benefit if: • A Member is determined by his or her PCP to require dental treatment in a hospital or surgical day care facility due to exceptional medical circumstances or a developmental disability, which places the Member at serious risk. Your PCP must arrange for all hospital or outpatient surgery. The only expenses covered under this benefit are hospital charges, surgical day charges and anesthesia charges. **Extraction of Teeth Impacted in Bone:** The Plan covers extraction of teeth impacted in bone. The following services are covered: • Extraction of teeth impacted in bone • Pre-operative and post-operative care, immediately following the procedure • Anesthesia • Bitewing x-rays **Prior Approval Required:** Prior Approval is required for treatment of cleft palate and the extraction of teeth impacted in bone. Your Plan Provider will seek Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for more information.
10 . Diabetes Services and Supplies	
	Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care: The Plan covers outpatient self-management education and training for the treatment of diabetes, including medical nutrition therapy services, used to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes. Services must be provided on an individual basis by a Plan Provider. Benefits also include medical eye exams (dilated retinal exams) and preventive foot care. Diabetes equipment and supplies are also covered. Some equipment and supplies listed below may be furnished by a Durable Medical Equipment (DME) provider. The following items are covered: **Diabetes Equipment (covered under your DME benefit):** • Blood glucose monitors

Benefit	Description
Diabetes Services and Supplies (Continued)	
	• Continuous glucose monitors • Dosage gauges • Injectors • Insulin pumps (including supplies) and infusion devices • Lancet devices • Therapeutic molded shoes and inserts • Visual magnifying aids • Voice synthesizers Please see the "Durable Medical Equipment (DME)" benefit for more information. **Prior Approval Required:** Prior Approval is required for certain diabetic equipment and supplies. Your Plan Provider will seek Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for more information.
11 . Dialysis	
	The Plan covers dialysis on an inpatient, outpatient or at home basis. When federal law permits Medicare to be the primary payer, you must apply for Medicare and also pay any Medicare premium. When Medicare is primary, the Plan will cover only those costs that exceed what would be payable by Medicare even if you do not enroll in Medicare. Coverage for dialysis in the home includes non-durable medical supplies, and drugs and equipment necessary for dialysis. HPHC must approve dialysis services if you are temporarily traveling outside of the network Service Area. The Plan will cover dialysis services for up to 30 days of travel per Calendar Year. You must make arrangements in advance with your Plan Provider. **Prior Approval Required:** Prior Approval is required for any planned inpatient admission or for any service provided in the home. Your Plan Provider will seek Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for more information.
12 . Drug Coverage	
	1) Drug Coverage under this Benefit Handbook Drugs Received During Outpatient or Home Care. A Medical Drug is administered to you either (1) in a doctor's office or other outpatient medical facility, or (2) at home while you are receiving home care services or receiving drugs administered by home infusion services. Medical Drugs cannot be self-administered. The words "cannot be self-administered" mean that the active participation of skilled medical personnel is always required to take the drug. When a Member is receiving drugs in the home, the words "cannot be self-administered" will also include circumstances in which a family member or friend is trained to administer the drug and ongoing supervision by skilled medical personnel is required. An example of a drug that cannot be self-administered is a drug that must be administered intravenously. Examples of drugs that can be self-administered are drugs that can be taken in pill form and drugs that are typically self-injected by the patient. **Prior Approval Required:** Prior Approval is required for select Medical Drugs. Your Plan Provider will seek Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for more information.

Benefit	Description
Drug Coverage (Continued)	
	See your Schedule of Benefits for your Medical Drug Member Cost Sharing. No coverage is provided under this Benefit Handbook for: (1) drugs that have not been approved by the United States Food and Drug Administration; (2) drugs the Plan excludes or limits, including, but not limited to, drugs for cosmetic purposes; and (3) any drug that is obtained at an outpatient pharmacy except as explained above. **2) Hospitality Rx Prescription Drug Coverage** In addition to the coverage provided under this Benefit Handbook, you also have outpatient prescription drug coverage. Your outpatient prescription drug coverage is not administered by HPHC. Please see your Summary Plan Description or call **Hospitality Rx** at **1-844-813-3860** for information on coverage of outpatient prescription drugs. Regardless of whether the Summary Plan Description is specifically noted in a handbook section, any reference to outpatient drugs found within this handbook is governed by your Hospitality Rx benefits.
13 . Durable Medical Equipment (DME)	
	The Plan covers DME when Medically Necessary and ordered by a Plan Provider. The Plan may rent or buy all equipment. The cost of the repair and maintenance of covered equipment is also covered. In order to be covered, all equipment must be: • Able to withstand repeated use; • Not generally useful in the absence of disease or injury; • Normally used in the treatment of an illness or injury or for the rehabilitation of an abnormal body part; and • Suitable for home use. Coverage is only available for: • The least costly equipment adequate to allow you to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports; and • One item of each type of equipment. No back-up items or items that serve a duplicate purpose are covered. For example, the Plan covers a manual or an electric wheelchair, not both. Covered equipment and supplies include: • Canes • Certain diabetes supplies and equipment (See the "Diabetes Services and Supplies" benefit for details) • Certain types of braces • Crutches • Hospital beds • Oxygen and oxygen equipment • Respiratory equipment • Walkers • Wheelchairs Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan.

Benefit	Description
Durable Medical Equipment (DME) (Continued)	
	Prior Approval Required: Prior Approval is required for positive airway pressure devices, including CPAP and BIPAP devices, and power wheelchairs. Your Plan Provider will seek Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for more information.
14 . Early Intervention Services	
	The Plan covers early intervention services provided for Members until three years of age. Covered Benefits include: • Nursing care • Physical, speech, and occupational therapy • Psychological counseling • Screening and assessment of the need for services
15 . Emergency Room Care	
	If you have a Medical Emergency, you are covered for care in a hospital or an independent freestanding emergency department. Please remember the following: • If you need follow-up care after you are treated in an emergency room, you must call your PCP. Your PCP will provide or arrange for the care you need. • If you are hospitalized, you must call HPHC at **1-877-594-7196** within 48 hours or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to HPHC or your PCP by an attending emergency physician no further notice is required.
16 . Family Planning Services	
	The Plan covers family planning services, including the following: • Contraceptive monitoring • Family planning consultation • Pregnancy testing • Genetic counseling • FDA approved birth control drugs, implants or devices. • Services relating to the injection of birth control drugs and the insertion or removal of birth control implants or devices.
17 . Gender Affirming Services	
	Coverage is provided to the extent Medically Necessary for gender affirming surgery, pre-operative and post-operative services related to the surgery, for Members who are at least 18 years of age undergoing the gender reassignment process, and for hormone therapy and behavioral health care services. Gender affirming surgery and related services only qualify as Covered Benefits when they are obtained within the 50 United States. The Plan will cover those surgical procedures related to reassigning a person's gender only once during the person's lifetime. This limit does not apply to remedial measures necessary to correct a prior surgical procedure. The Plan only covers the following gender affirming surgeries: chest feminization surgery, chest masculinization surgery, and genital reconstructive surgery. Covered services include: • Inpatient services, including covered female to male or male to female gender affirming surgery and related surgical procedures; • Outpatient surgery for surgical procedures related to the covered female to male or male to female gender affirming surgery.

Benefit	Description
Gender Affirming Services (Continued)	
	• Outpatient medical care (pre-operative and post-operative) related to covered gender affirming surgery. • Hormone therapy for gender affirmation if such hormone therapy can only be administered by a health care professional. **Please Note:** Electrolysis is not covered under this plan. Benefits for gender affirming services are in addition to other benefits provided under the Plan. HPHC does not consider gender affirming surgery to be reconstructive surgery to correct a Physical Functional Impairment or Cosmetic Services. Coverage for reconstructive surgery or Cosmetic Services is limited to the services described under the Reconstructive Surgery benefit in this Benefit Handbook. **Prior Approval Required:** Prior Approval for is required for coverage under this benefit. Your Plan Provider will seek Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for more information..
18 . Hearing Aids	
	The Plan covers hearing aids up to the limit listed in your Schedule of Benefits. A hearing aid is defined as any instrument or device, excluding a surgical implant, designed, intended or offered for the purpose of improving a person's hearing. The Plan will pay the full cost of each medically necessary hearing aid up to the limit listed in your Schedule of Benefits, minus any applicable Member Cost Sharing. If you purchase a hearing aid that is more expensive than the limit listed in your Schedule of Benefits, you will be responsible for the additional cost. No back-up hearing aids that serve a duplicate purpose are covered. Covered services and supplies related to your hearing aid are not subject to the dollar limit listed in your Schedule of Benefits. Covered Benefits include the following: • One hearing aid per hearing impaired ear • Except for batteries, any necessary parts, attachments or accessories, including ear moldings; and • Services provided by a licensed audiologist, hearing instrument specialist, licensed physician, or an appropriately licensed Plan Provider for services that are necessary to assess, select, fit, adjust or service the hearing aid. **Prior Approval Required:** Prior Approval is required for cochlear implants. Your Plan Provider will seek Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for more information.
19 . Home Health Care	
	If you are homebound for medical reasons, you are covered for home health care services listed below. To be eligible for home health care, your Plan Provider must determine that skilled nursing care or physical therapy is an essential part of active treatment. There must also be a defined medical goal that your Plan Provider expects you will meet. When you qualify for home health care services as stated above, the Plan covers the following services when Medically Necessary: • Durable medical equipment and supplies (must be a component of the home health care being provided) • Medical and surgical supplies • Medical social services

Benefit	Description
Home Health Care (Continued)	
	• Nutritional counseling • Physical therapy • Occupational therapy • Palliative care • Services of a home health aide • Skilled nursing care • Speech therapy **Prior Approval Required:** Prior Approval is required for coverage under this benefit. Your Plan Provider will seek Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for more information.
20 . Hospice Services	
	The Plan covers hospice services for terminally ill Members who need the skills of qualified technical or professional health personnel for palliative care. Care may be provided at home or on an inpatient basis. Inpatient care is also covered in an acute hospital or extended care facility when it is Medically Necessary to control pain and manage acute and severe clinical problems that cannot be managed in a home setting. Covered Benefits include: • Care to relieve pain • Counseling • Drugs that cannot be self-administered • Durable medical equipment appliances • Home health aide services • Medical supplies • Nursing care • Physician services • Occupational therapy • Physical therapy • Speech therapy • Respiratory therapy • Social services **Prior Approval Required:** Prior Approval is required for hospice care. Your Plan Provider will seek Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for more information.
21 . Hospital – Inpatient Services	
	The Plan covers acute hospital care including, but not limited to, the following inpatient services: • Semi-private room and board • Doctor visits, including consultation with specialists • Palliative care • Medications • Laboratory, radiology and other diagnostic services • Intensive care • Surgery, including related services

Benefit	Description
Hospital – Inpatient Services (Continued)	
	• Anesthesia, including the services of a nurse-anesthetist • Radiation therapy • Physical therapy • Occupational therapy • Speech therapy In order to be eligible for coverage, the following service must be received at a Center of Excellence: • Weight loss surgery (bariatric surgery) Please see section *I.D.4. Centers of Excellence* for more information. **Prior Approval Required:** Prior Approval is required for any planned inpatient admission. Your Plan Provider will seek Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for more information.
22 . House Calls	
	The Plan covers house calls.
23 . Human Organ Transplant Services	
	The Plan covers human organ transplants, including bone marrow transplants for a Member with metastasized breast cancer in accordance with the criteria of the Massachusetts Department of Public Health. The Plan covers the following services when the recipient is a Member of the Plan: • Care for the recipient • Donor search costs through established organ donor registries • Donor costs that are not covered by the donor's health plan **Prior Approval Required:** Prior Approval is required for any planned inpatient admission. Your Plan Provider will seek Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for more information.
24 . Infertility Services and Treatment	
	Infertility is defined as the inability of a woman aged 35 or younger to conceive or produce conception during a period of one year. In the case of a woman over age 35, the time period is reduced to 6 months. If a woman conceives but is unable to carry the pregnancy to live birth, the time she attempted to conceive prior to that pregnancy is included in the one year or 6 month period, as applicable. The Plan covers the following diagnostic services for infertility: • Consultation • Evaluation • Laboratory tests **Please Note:** The plan does not cover infertility treatment.

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

Benefit	Description
28 . Medical Formulas	
	The Plan covers the following: • Non-prescription enteral formulas for home use for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction and inherited diseases of amino acids and organic acids. • Prescription formulas for the treatment of phenylketonuria, tyrosinemia, homocystrinuria, maple syrup urine disease, propionic acidemia or methylmalonic acidemia in infants and children or to protect the unborn fetuses of pregnant women with phenylketonuria. **Prior Approval Required:** Prior Approval is required for outpatient formulas and enteral nutrition. Your Plan Provider will seek Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for more information.
29 . Mental Health and Substance Use Disorder Treatment	
	The Plan covers both inpatient and outpatient mental health and substance use disorder treatment to the extent Medically Necessary as outlined below. As used in this section the term "mental health" includes the Medically Necessary treatment of substance use disorders. For coverage of mental health and substance use disorder treatment, you should obtain care from a Plan Provider. The only exceptions to this rule are listed in section *I.D.3. Using Plan Providers*. In a Medical Emergency you do not need to use a Plan Provider. You should go to the nearest emergency facility or call 911 or your local emergency number. If you are admitted, you must call the Plan at **1-877-594-7196** within 48 hours or as soon as you can. This phone number is also on your ID card. If an attending emergency physician contacts us or your PCP, then no further notice is needed. See section II. Glossary for more information on Medical Emergency Services. The Plan requires consent to the disclosure of information regarding services for mental disorders to the same extent it requires consent for disclosure of information for other medical conditions. Any determination of Medical Necessity for mental health and substance use disorder treatment will be made in consultation with a Licensed Mental Health Professional. **Minimum Requirements for Covered Providers** To be eligible for coverage under this benefit, all services must be provided either (1) at the office of a Licensed Mental Health Professional, or (2) at a facility licensed or approved by the health department or mental health department of the state in which the service is provided. (In Massachusetts those departments are the Department of Public Health and the Department of Mental Health, respectively.) To qualify, a facility must be both licensed as, and function primarily as, a health or mental health and substance use disorder treatment facility. A facility that is also licensed as an educational or recreational institution will not meet this requirement unless the predominate purpose of the facility is the provision of mental health and substance use disorder treatment. In addition to numbers (1) and (2) above, services to treat child-adolescent mental health disorders may be provided in the least restrictive clinically appropriate setting. This may include the Member's home or a program in another community-based setting. Please see below for additional information on services to treat child-adolescent mental health disorders. To qualify for coverage, all services rendered outside of a state licensed or approved facility must be provided by an independently Licensed Mental

Benefit	Description
Mental Health and Substance Use Disorder Treatment (Continued)	
	Health Professional. If a provider of intermediate care or outpatient services to treat child-adolescent mental health disorders is not independently licensed at the Masters/PhD/MD level, then the supervisor – who must be a Masters Level independently Licensed Mental Health Professional – must sign off on the treatment plan whenever the child's or adolescent's condition changes. For services provided in Massachusetts, a Licensed Mental Health Professional must be one of the following types of providers: a licensed physician who specializes in the practice of psychiatry; a licensed psychologist; a licensed independent clinical social worker; a licensed certified social worker; a licensed psychiatric nurse mental health clinical specialist; a licensed psychiatric mental health nurse practitioner; a licensed physician assistant who practices in the area of psychiatry; a licensed mental health counselor; a level I licensed alcohol and drug counselor; a clinician practicing under the supervision of a licensed professional and working towards licensure in a clinic licensed under chapter 111; or a licensed marriage and family therapist. For services provided outside of Massachusetts, a Licensed Mental Health Professional is an independently licensed clinician with at least a Masters degree in a clinical mental health discipline from an accredited educational institution and at least two years of clinical experience. The term "clinical mental health discipline" includes the following: psychiatry; psychology; clinical social work; marriage and family therapy; clinical counseling; developmental psychology; pastoral counseling; psychiatric nursing; developmental or educational psychology; counselor education; or any other discipline deemed acceptable by the Plan. **Medically Necessary Emergency Services Programs** Coverage is provided for Medically Necessary Emergency Services Programs. The term "Emergency Services Programs" is defined as all programs subject to contract between the Massachusetts Behavioral Health Partnership (MBHP) and nonprofit organizations for the provisions of community-based emergency psychiatric services, including but not limited to, behavioral health crisis assessment, intervention and stabilization services 24 hours per day, 7 days per week, through: (i) mobile crisis intervention services for youth: (ii) mobile crisis intervention services for adults; (iii) emergency services provider community-based locations; and (iv) adult community crisis stabilization services. In Massachusetts, designated Community Based Health Centers (CBHCs) serve as regional hubs of coordinated and integrated mental health and substance use disorder treatment and provide routine and urgent outpatient services, crisis services for adults and youth, and community crisis stabilization services for adults and youth. CBHCs will also provide community-based Mobile Crisis Intervention (MCI) for both youths and adults. **Benefits** The Plan will provide coverage for the care of all conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. Covered mental health and substance use disorder treatment services include the following: **a) Mental Health and Substance Use Disorder Treatment** Subject to the Member Cost Sharing and any benefit limits stated in your Schedule of Benefits, the Plan provides coverage for the following Medically Necessary mental health and substance use disorder treatment: 1) **Inpatient Services**

Benefit	Description
Mental Health and Substance Use Disorder Treatment (Continued)	
	• Hospitalization, including detoxification 2) **Intermediate Care Services** • Acute residential treatment (including detoxification) • Intensive Outpatient Programs (IOPs) and Partial Hospitalization Programs (PHPs) • Mobile Crisis Intervention (MCI) • Adult Mobile Crisis Intervention (AMCI) – provides a course of treatment intended to promote recovery, ensure safety, and stabilize the crisis. For individuals who do not require inpatient services or another 24-hour level of care, AMCI provides up to three days of daily post-stabilization follow-up care. • Youth Mobile Crisis Intervention (YMCI) - provides crisis assessment and crisis stabilization intervention to youth under the age of 21. Each YMCI encounter, including ongoing coordination following the crisis assessment and stabilization intervention, may last up to seven days. 3) **Outpatient Services** • Annual mental health wellness examination performed by a Licensed Mental Health Professional or by a PCP during a routine physical exam. A mental health wellness examination is a screening or assessment that seeks to identify any behavioral or mental health needs and appropriate resources for treatment. • Care by a Licensed Mental Health Professional (including online counseling through secure digital messaging) • Crisis intervention services • Crisis stabilization and in-home family stabilization • Detoxification • Medication assisted treatment, including methadone maintenance • Medication management • Psychological testing and neuropsychological assessment • Treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS) including, but not limited to, the use of intravenous immunoglobulin therapy (IVIG). **b) Coverage for Child-Adolescent Mental Health Disorder Treatment** In addition to the benefits listed above, your Plan covers services on a non-discriminatory basis for the diagnosis and treatment of child-adolescent mental health disorders that substantially interfere with or substantially limit the functioning and social interactions of a child or adolescent through the age of 18. Substantial interference with, or limitation of, function must be documented by the Member's PCP, primary pediatrician or HPHC Licensed Mental Health Professional, or when evidenced by conduct including, but not limited to: • the inability to attend school as a result of the disorder; • the need for hospitalization as a result of the disorder; or • pattern of conduct or behavior caused by the disorder that poses a serious danger to self or others.

Benefit	Description
Mental Health and Substance Use Disorder Treatment (Continued)	
	Child-adolescent mental health services shall take place in the least restrictive clinically appropriate setting and shall consist of a range of inpatient, intermediate, and outpatient services that shall permit Medically Necessary, active care expected to lead to improvement of the condition in a reasonable period of time. The covered services may be provided to the child, the child's parent(s), and/or other appropriate caregivers. Coverage under this subsection shall continue after the child's 19th birthday until either the course of treatment specified in the child's treatment plan is completed or coverage under this Handbook is terminated, whichever comes first. If treatment of a 19 year old, as specified in his or her treatment plan, has not been completed at the time coverage under this Handbook is terminated, such treatment may be continued under a replacement plan issued by HPHC. 1) **Inpatient Services for Children and Adolescents** • Hospitalization 2) **Intermediate Care Services for Children and Adolescents** • Community-based acute treatment (CBAT) – intensive therapeutic services provided in a staff-secure setting on a 24-hour basis, with sufficient staffing to ensure safety, while providing intensive therapeutic services including but not limited to: daily medication monitoring; psychiatric assessment; nursing availability; specialing (as needed); individual group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from inpatient services. • Intensive community-based acute treatment (ICBAT) – provides the same services as CBAT but at a higher intensity, including more frequent psychiatric and psychopharmacological evaluation and treatment and more intensive staffing and service delivery. ICBAT programs have the capability to admit children and adolescents with more acute symptoms than those admitted to CBAT. ICBAT programs are able to treat Children and adolescents with clinical presentations similar to those referred to inpatient mental health services but who are able to be cared for safely in an unlocked setting. Children and adolescents may be admitted to an ICBAT directly from the community as an alternative to inpatient hospitalization. ICBAT is not used as a step-down placement following discharge from a locked, 24-hour setting. 3) **Outpatient Services for Children and Adolescents** • Intensive care coordination (ICC) – a collaborative service that provides targeted case management services to children and adolescents with a serious emotional disturbance, including individuals with co-occurring conditions, in order to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality, cost effective outcomes. This service includes an assessment, the development of an individualized care plan, referrals to appropriate levels of care, monitoring of goals, and coordinating with other services and social supports and with state agencies, as indicated. The service shall be based upon a system of care philosophy and the individualized care plan shall be tailored to meet the needs of the individual. The service is delivered in office, home or other settings and shall include both face-to-face and telephonic meetings, as indicated and as clinically appropriate.

Benefit	Description
Mental Health and Substance Use Disorder Treatment (Continued)	

	• In-home behavioral services (IHBS) - a combination of behavior management therapy and behavior management monitoring. Services shall be available, when indicated, where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. In-home behavioral services include:
	  • *Behavior management monitoring* of a child's behavior, the implementations of a behavior plan and reinforcing implementation of a behavior plan by the child's parent or other care giver.
	  • *Behavioral management therapy* that addresses challenging behaviors that interfere with a child's successful functioning. That therapy shall include a functional behavioral assessment and observation of the youth in the home and/or community setting, development of a behavior plan, and supervision and coordination of interventions to address specific behavioral objectives or performance, including the development of a crisis-response strategy and may include short-term counseling and assistance.
	• In-home therapy (IHT) - therapeutic clinical intervention or ongoing therapeutic training and support. The intervention or support shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting.
	  • *Therapeutic clinical intervention* shall include: (i) a structured and consistent therapeutic relationship between a licensed clinician and a child and the child's family to treat the child's mental health needs, including improvement of the family's ability to provide effective support for the child and promotion of healthy functioning of the child within the family; (ii) the development of a treatment plan; and (iii) the use of established psychotherapeutic techniques, working with the family or a subset of the family to enhance problem solving, limit setting, communication, emotional support or other family or individual functions.
	  • *Ongoing therapeutic training and support* of a treatment plan pursuant to therapeutic clinical intervention that includes but is not limited to, teaching the child to understand, direct, interpret, manage and control feelings and emotional responses to situation and assisting the family in supporting the child and addressing the child's emotional and mental health needs.
	• Family support and training (FS&T) – services provided to a parent or other caregiver of a child to improve the capacity of the parent or caregiver to ameliorate or resolve the child's emotional or behavioral needs. Such services shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. Family support and training addresses one or more goals on the youth's behavioral health treatment plan and may include educating parents/caregivers about the youth's behavioral health needs and resiliency factors, teaching parents/caregivers how to navigate services on behalf of the child and how to identify formal and informal services and supports in their communities, including parent support and self-help groups.
	• Therapeutic mentoring (TM) services – services provided to a child designed to support age-appropriate social functioning or to ameliorate deficits in the child's age-appropriate social functioning resulting from a DSM diagnosis. Services may include supporting, coaching,

Benefit	Description
Mental Health and Substance Use Disorder Treatment (Continued)	
	and training the child in age-appropriate behaviors, interpersonal communication, problem solving, conflict resolution, and relating appropriately to other children and adolescents and to adults. Services shall be provided, when indicated, where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. Therapeutic mentoring is a skill building service addressing one or more goals on the youth's behavioral treatment plan. It may also be delivered in the community to allow the youth to practice desired skills in appropriate settings. **Prior Approval Required** You must obtain Prior Approval for the following services: • **In-home behavioral services (IHBS)** • In-home therapy (IHT) • **Psychological and neuropsychological testing** • **Applied Behavioral Analysis (ABA) services for the treatment of Autism** • **Repetitive Transcranial Magnetic Stimulation (rTMS)** Your Plan Provider will seek Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for more information. You do not need to obtain a Referral from your PCP to be covered for Mental Health and Substance Use Disorder Treatment. **Please Note:** Prior Approval is not required to obtain Acute Treatment Services or Clinical Stabilization Services from a Plan Provider. In addition, when services are obtained from a Plan Provider, the Plan will not deny coverage for the first 14 days of (1) Acute Treatment Services or (2) Clinical Stabilization Services for the treatment of substance abuse so long as the Plan receives notice from the Plan Provider within 48 hours of admission. The terms "Acute Treatment Services" and "Clinical Stabilization Services" are defined in the Glossary at Section II of this Benefit Handbook. Services beyond the 14 day period may be subject to concurrent review as described in Section *X.J. UTILIZATION REVIEW PROCEDURES* of this Handbook. Please refer to your Schedule of Benefits for the Member Cost Sharing amounts that apply to your "inpatient," "intermediate" and "outpatient" mental health and substance use disorder treatment services.
30 . Observation Services	
	The Plan covers observation services including short term treatment, assessment and reassessment for up to 48 hours in an acute care facility (i.e. hospital). Observation services determine if a Member needs to be admitted for additional treatment or if the Member is able to be discharged from the hospital.
31 . Ostomy Supplies	
	The Plan covers ostomy supplies. Only the following supplies are covered: • Irrigation sleeves, bags and catheters • Pouches, face plates and belts • Skin barriers

Benefit	Description
32 . Palliative Care	
	The Plan covers palliative care in conjunction with inpatient, home health care, hospice and physician services. Member Cost Sharing for palliative care is included in the cost sharing associated with these services. Palliative care is a medical specialty that supports improved quality of life for Members with chronic or serious illness. Care is focused on providing relief from symptoms and the stress of illness. Palliative care can be provided at any stage of illness, along with treatment for your condition while remaining under the care of your regular provider. This care is offered alongside curative or other treatments you may be receiving. Palliative care may include physician services, nursing care, home health care, pain and symptom management, medication management, rehabilitation therapies (occupational, physical, speech and pulmonary), behavioral health services and durable medical equipment.
33 . Physician and Other Professional Office Visits	

	Physician services, including services of all covered medical professionals, can be obtained on an outpatient basis in a physician's office or a hospital. These services may include:
	• Routine physical examinations, including routine gynecological examination and annual cytological screenings
	• Follow-up care provided by an obstetrician or gynecologist for obstetrical or gynecological conditions identified during maternity care or an annual gynecological visit
	• Psychiatric collaborative care in which a primary care team provides structured behavioral health care management to a Member. A primary care team includes a PCP and a care manager working in collaboration with a psychiatric consultant that provides regular consultations to the team to review the Member's clinical status and care and to make recommendations. **Please Note:** Not all PCP offices provide this service.
	• Immunizations, including childhood immunizations as recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention and the American Academy of Pediatrics
	• Well baby and well child care, including physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and developmental screening, and assessment at the following intervals:
	  • At least six visits per Calendar Year are covered for a child from birth to age one.
	  • At least three visits per Calendar Year are covered for a child from age one to age two.
	  • At least one visit per Calendar Year is covered for a child from age two to age six.
	• Health education and nutritional counseling
	• Sickness and injury care
	• Palliative care
	• Vision and Hearing screenings
	• Medication management
	• Consultations concerning contraception and hormone replacement therapy
	• Chemotherapy
	• Radiation therapy

Benefit	Description
34 . Preventive Services Covered Under the Affordable Care Act	
	The Plan covers preventive care services and tests in accordance with the federal Affordable Care Act as recommended by the following agencies: • United States Preventive Services Task Force (grade "A" and "B" recommendations); • Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; • Health Resources and Services Administration; and • Bright Futures, American Academy of Pediatrics Harvard Pilgrim will add or delete preventive services and tests in accordance with the recommendations of the agencies listed above.
35 . Prosthetic Devices	
	The Plan covers prosthetic devices when ordered by a Plan Provider. The cost of the repair and maintenance of a covered device is also covered. In order to be covered, all devices must be able to withstand repeated use. Coverage is only available for: • The least costly prosthetic device adequate to allow you to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports; and • One item of each type of prosthetic device. No back-up items or items that serve a duplicate purpose are covered. Covered prostheses include: • Breast prostheses, including replacements and mastectomy bras • Prosthetic arms and legs (including myoelectric and bionic arms and legs) • Prosthetic eyes **Prior Approval Required:** You must obtain Prior Approval for prosthetic arms and legs. Your Plan Provider will seek Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for more information.
36 . Reconstructive Surgery	
	The Plan covers reconstructive and restorative surgical procedures as follows: • Reconstructive surgery is covered when the surgery can reasonably be expected to improve or correct a Physical Functional Impairment resulting from an accidental injury, illness, congenital anomaly, birth injury or prior surgical procedure. If reconstructive surgery is performed to improve or correct a Physical Functional Impairment, as stated above, Cosmetic Services that are incidental to that surgery are also covered. After a Physical Functional Impairment is corrected, no further Cosmetic Services are covered by the Plan. • Restorative surgery is covered to repair or restore appearance damaged by an accidental injury. (For example, this benefit would cover repair of a facial deformity following an automobile accident.) Benefits are also provided for post mastectomy care, including coverage for: • Prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient; • Reconstruction of the breast on which the mastectomy was performed; and

Benefit	Description
Reconstructive Surgery (Continued)	
	• Surgery and reconstruction of the other breast to produce a symmetrical appearance. Coverage is also provided for the treatment of cleft lip and cleft palate for children up to the age of 18, including coverage for: • Medical, dental, oral, and facial surgery, including surgery performed by oral and plastic surgeons, and surgical management and follow-up care related to such surgery; • Orthodontic treatment; • Preventative and restorative dentistry to ensure good health and adequate dental structures to support orthodontic treatment or prosthetic management therapy; • Speech therapy; • Audiology services; and • Nutrition services. Coverage is provided for treatment to correct or repair disturbances of body composition caused by HIV-associated lipodystrophy syndrome, including but not limited to coverage for: • Reconstructive surgery; • Restorative procedures; and • Dermal injections or fillers to treat facial lipoatrophy associated with HIV. Benefits include coverage for procedures that must be done in stages, as long as you are an active Member. Membership must be effective on all dates on which services are provided. There is no coverage for Cosmetic Services or surgery except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, (3) post-mastectomy care as described above, and (4) gender affirming procedures and related services (if a covered benefit). **Important Notice:** We use clinical guidelines to evaluate whether different types of reconstructive and restorative procedures are Medically Necessary. If you are planning to receive such treatment, you may review the current Medical Necessity Guidelines online at **www.hphc.org/provider/medical-necessity-guidelines/**. To obtain a copy, please call Member Services at **1-877-594-7196.** **Prior Approval Required:** You must obtain Prior Approval for coverage under this benefit. Your Plan Provider will seek Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for more information.
37 . Rehabilitation Hospital Care	
	The Plan covers care in a facility licensed to provide rehabilitative care on an inpatient basis. Coverage is provided when you need daily Rehabilitation Services that must be provided in an inpatient setting. Rehabilitation Services include cardiac rehabilitation therapy, physical therapy, pulmonary rehabilitation therapy, occupational therapy and speech therapy. **Prior Approval Required:** You must obtain Prior Approval for rehabilitation hospital care. Your Plan Provider will seek Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for more information.

Benefit	Description
38 . Rehabilitation and Habilitation Services – Outpatient	
	The Plan covers the following outpatient Rehabilitation and Habilitation Services: • Occupational therapy • Physical therapy • Pulmonary rehabilitation therapy Services are covered only: • If, in the opinion of your Plan Provider, there is likely to be significant improvement in your condition; and • When needed to improve your ability to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports. Rehabilitation and Habilitation Services are also covered under your inpatient hospital and home health benefits. **Prior Approval Required:** You must obtain Prior Approval for coverage of outpatient pulmonary rehabilitation therapy. Your Plan Provider will seek Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for more information. **Please Note:** Outpatient physical and occupational therapies for children up to the age of 3 are covered to the extent Medically Necessary.
39 . Scopic Procedures – Outpatient Diagnostic	
	The Plan covers diagnostic scopic procedures and related services received on an outpatient basis. Diagnostic scopic procedures are those for visualization, biopsy and/or polyp removal. Scopic procedures are: • Colonoscopy • Endoscopy • Sigmoidoscopy
40 . Skilled Nursing Facility Care	
	The Plan covers care in a health care facility licensed to provide skilled nursing care on an inpatient basis. Coverage is provided only when you need daily skilled nursing care that must be provided in an inpatient setting. **Prior Approval Required:** You must obtain Prior Approval for Skilled Nursing Facility care. Your Plan Provider will seek Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for more information.
41 . Speech-Language and Hearing Services	
	The Plan covers diagnosis and treatment of speech, hearing and language disorders to the extent Medically Necessary by speech-language pathologists and audiologists.
42 . Surgery - Outpatient	
	The Plan covers outpatient surgery, including related services. Outpatient surgery is defined as any surgery or procedure in a day surgery department, ambulatory surgery department or outpatient surgery center. There are certain specialized services for which you will be directed to a Center of Excellence for care. See section *I.D.4. Centers of Excellence* for more information. **Prior Approval Required:** You must obtain Prior Approval for coverage under this benefit. Your Plan Provider will seek Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for more information.

Benefit	Description
43 . Telemedicine Virtual Visit Services	
	The Plan covers Medically Necessary telemedicine virtual visit services for the purpose of evaluation, diagnosis, consultation, monitoring, or treatment of a Member's physical health, oral health, mental health or substance use disorder condition. Telemedicine virtual visit services include the use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology including: (a) interactive audio video technology; (b) remote patient monitoring devices; (c) audio-only telephone; (d) online adaptive interviews; and (e) telemonitoring. Your provider must be appropriately licensed in the state in which you are located when receiving telemedicine services. Member Cost Sharing for telemedicine virtual visit services will be the same or less than the Member Cost Sharing for the same type of service if it had been provided through an in-person consultation. Please refer to your Schedule of Benefits for specific information on Member Cost Sharing you may be required to pay.
44 . Temporomandibular Joint Dysfunction Services	
	The Plan covers medical treatment of Temporomandibular Joint Dysfunction (TMD). Only the following services are covered: • Consultation with a physician • Physical therapy • Surgery • X-rays **Important Notice:** No Dental Care is covered for the treatment of Temporomandibular Joint Dysfunction (TMD). **Prior Approval Required:** You must obtain Prior Approval for surgery under this benefit. Your Plan Provider will seek Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for more information.
45 . Travel Reimbursement Benefit	
	The Plan will reimburse you up to the limit listed in your Schedule of Benefits for travel expenses related to Covered Benefits that are restricted by law in the state where you reside. You are eligible for this benefit when: • your Plan includes coverage for the services you will be receiving. • you reside in a state where access to the Covered Benefit is not available because state law restricts a provider from providing you with the service. • you are required to travel at least 100 miles from your residence to obtain the Covered Benefit. When the above criteria are met, you will be reimbursed for certain transportation and lodging expenses. These services must be "primarily for and essential to" receiving medical care (per Internal Revenue Code (IRC) § 213(d)). Reimbursement is for you and one companion when necessary to enable you to receive the Covered Benefit, as follows: 1. **Round trip transportation** including air, train, bus, taxi and ride-sharing service, car rental, tolls, and parking expenses will be reimbursed for travel between your home and the location at which you receive the Covered Benefit. • Travel by air and train is limited to commercially scheduled coach-class tickets.

Benefit	Description
Travel Reimbursement Benefit (Continued)	
	• Mileage is based on the current Internal Revenue Service (IRS) medical mileage reimbursement, which includes gasoline. 2. **Lodging expenses** will be reimbursed up to $50 per person per night (up to $100 if you travel with a companion) when the medical care is provided by a physician in a licensed hospital (or in a medical care facility which is related to, or the equivalent of, a licensed hospital). **Please Note:** Reimbursement for travel expenses for transportation and lodging is only available for the Member receiving the Covered Benefit and one companion. In accordance with the IRC, companion coverage is allowed only when the assistance of a companion is necessary for the Member to receive the covered medical services (e.g., parental consent is required, there is sedation that causes the Member to require assistance). PLR 8516025; IRS Pub. 502. To be eligible for this benefit, you must attest to satisfying the eligibility criteria above, travel expenses incurred, and, if applicable, the necessity of companion travel. You will need to complete a reimbursement form that includes this attestation information and provide the Plan with proof of membership and proof of payment. Please see section *V. Reimbursement and Claims Procedures* for information on how to submit for reimbursement. To obtain a reimbursement form, please contact Member Services at **1-877-594-7196** or by going to **www.harvardpilgrim.org**. **Important Notice:** Failure to adhere to reimbursement requirements explained above may result in your reimbursement being considered taxable income.
46 . Urgent Care Services	
	The Plan covers Urgent Care services you receive at (1) a convenience care clinic, (2) an urgent care center, including mobile urgent care providers, or (3) a hospital urgent care center. (1) **Convenience care clinics:** Convenience care clinics provide treatment for minor illnesses and injuries. They are usually staffed by non-physician providers, such as nurse practitioners, and are located in stores, supermarkets or pharmacies. To see a list of convenience care clinics covered by the Plan, please refer to your Provider Directory and search under "convenience care." (2) **Urgent care centers:** Urgent care centers provide treatment for illnesses and injuries that require urgent attention but are not life threatening. Urgent care centers are independently owned and operated centers that are considered standalone facilities, not departments of a hospital. They are staffed by doctors, nurse practitioners, and physician assistants. To see a list of urgent care centers covered by the Plan, please refer to your Provider Directory and search under "urgent care." **Please Note:** You may be eligible to receive mobile urgent care services in your home, at work or anywhere you require Urgent Care. Availability of mobile urgent care services will depend upon your location. Member Cost Sharing for mobile urgent care services will be the same as if the service was provided at an urgent care center. Please refer to your Schedule of Benefits for the specific Member Cost Sharing that applies to urgent care center services under your Plan. You can call Member Services at **1-877-594-7196** or go to, **www.harvardpilgrim.org/local26** to see where these services are available. (3) **Hospital urgent care centers:** Some hospitals provide treatment for urgent care services as part of the hospital's outpatient services. A hospital urgent care center may be located within a hospital, or at a satellite location separate from the hospital. These urgent care centers are owned and operated by the hospital and are considered a department of the hospital. They are

Benefit	Description
Urgent Care Services (Continued)	
	staffed by doctors, nurse practitioners, and physician assistants and provide treatment for illnesses and injuries that require urgent attention but are not life threatening. Because the services provided are considered outpatient hospital services, only the hospitals are listed in the Provider Directory. These services may require higher Member Cost Sharing than urgent care services received at independent urgent care centers. **Please Note:** Hospital urgent care center services are treated differently than similar services received in a hospital emergency room. For information on services received in a hospital emergency room, please see the Emergency Room Care benefit above, and in your Schedule of Benefits. Please refer to your Schedule of Benefits for the Member Cost Sharing applicable to each type of Urgent Care service. Coverage for Urgent Care is provided for services that are required to prevent deterioration to your health resulting from an unforeseen sickness or injury. Covered Benefits include but are not limited to the following: • Care for minor cuts, burns, rashes or abrasions, including suturing • Treatment for minor illnesses and infections, including earaches • Treatment for minor sprains or strains You do not need to obtain a Referral from your PCP to be covered for Urgent Care. Whenever possible, you should contact your PCP prior to obtaining Urgent Care. Your PCP may be able to provide the services you require at a lower out-of-pocket cost. In addition, your PCP is responsible for coordinating your health care services and should know about the services you receive. **Important Notice:** Urgent Care is not emergency care. You should call 911 or go directly to a hospital emergency room if you suspect you are having a Medical Emergency. These include heart attack or suspected heart attack, shock, major blood loss, or loss of consciousness. Please see section *I.D.5. Medical Emergency Services* for more information.
47 . Vision Services	
	Vision Hardware for Special Conditions: The Plan provides coverage for contact lenses or eyeglasses needed for the following conditions: • Keratoconus. One pair of contact lenses is covered per Calendar Year. The replacement of lenses, due to a change in the Member's condition, is limited to 3 per affected eye per Calendar Year. • Post cataract surgery with an intraocular lens implant (pseudophakes). Coverage is limited to $140 per surgery toward the purchase of eyeglass frames and lenses. The replacement of lenses due to a change in the Member's prescription of .50 diopters or more within 90 days of the surgery is also covered up to a limit of $140. • Post cataract surgery without lens implant (aphakes). One pair of eyeglass lenses or contact lenses is covered per Calendar Year. Coverage up to $50 per Calendar Year is also provided for the purchase of eyeglass frames. The replacement of lenses due to a change in the Member's condition is also covered. Replacement of lenses due to wear, damage, or loss, is limited to 3 per affected eye per Calendar Year. • Post retinal detachment surgery. For a Member who wore eyeglasses or contact lenses prior to retinal detachment surgery, the Plan covers the full

Benefit	Description
Vision Services (Continued)	
	cost of one lens per affected eye up to one Calendar Year after the date of surgery. For Members who have not previously worn eyeglasses or contact lenses, the Plan covers either (1) a pair of eyeglass lenses and up to $50 toward the purchase of the frames, or (2) a pair of contact lenses.
48 . Voluntary Sterilization	
	The Plan covers voluntary sterilization, including tubal ligation and vasectomy.
49 . Voluntary Termination of Pregnancy	
	The Plan covers voluntary termination of pregnancy and the following related services provided in conjunction with the covered termination procedure: 1) pre-pregnancy termination evaluation and examination; 2) pre-operative counseling; 3) ultrasounds; 4) laboratory services, including pregnancy testing, blood type, and Rh factor; 5) Rh (D) immune globulin (human); 6) anesthesia (general or local); 7) post-pregnancy termination care; 8) follow-up care; and 9) advice on contraception or referral to family planning services. Care related to a pregnancy or miscarriage is not covered under this benefit.
50 . Wigs and Scalp Hair Prostheses	
	The Plan covers wigs and scalp hair prostheses when needed for hair loss suffered as a result of the treatment for any form of cancer or leukemia or for a certain pathologic condition such as alopecia areata, alopecia totalis, alopecia medicamentosa or permanent loss of scalp hair due to injury up to the Benefit Limit listed in the Schedule of Benefits.

IV. Exclusions

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

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

Exclusion	Description
1 . Alternative Treatments	
	1. Acupuncture care. 2. Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments. 3. Aromatherapy, treatment with crystals and alternative medicine. 4. Any of the following types of programs: Health resorts, spas, recreational programs, camps, outdoor skills programs, therapeutic or educational boarding schools, educational programs for children in residential care, self-help programs, life skills programs, relaxation or lifestyle programs, and wilderness programs (therapeutic outdoor programs). **Please Note:** Covered Benefits received while a Member is participating in a program, such as a wilderness program, may be reimbursed if the provider separately identifies and submits bills for Medically Necessary services that are Covered Benefits and all other terms of coverage under the Plan are met, including any applicable provider network and Member Cost Sharing requirements. 5. Massage therapy. 6. Myotherapy.
2 . Dental Services	
	1. Dental Care, except the specific dental services listed as Covered Benefits in this Benefit Handbook, Schedule of Benefits and any associated riders. 2. Temporomandibular Joint Dysfunction (TMD) care, except the specific medical treatments listed as Covered Benefits in this Benefit Handbook. 3. Preventive dental care for children. 4. Dentures.
3 . Durable Medical Equipment and Prosthetic Devices	
	1. Any devices or special equipment needed for sports or occupational purposes. 2. Any home adaptations, including, but not limited to home improvements and home adaptation equipment. 3. Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. 4. Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.
4 . Experimental, Unproven, or Investigational Services	
	1. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.

Exclusion	Description
5 . Foot Care	
	1. Foot orthotics, except for the treatment of severe diabetic foot disease or systemic circulatory disease. 2. Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members diagnosed with diabetes or systemic circulatory disease.
6 . Maternity Services	
	1. Planned home births. 2. Services provided by a doula. 3. Routine pre-natal and post-partum care when you are traveling outside the Service Area.
7 . Mental Health and Substance Use Disorder Treatment	
	1. Educational services or testing, except services covered under the benefit for Early Intervention Services. No benefits are provided (1) for educational services intended to enhance educational achievement or developmental functioning, (2) to resolve problems of school performance, (3) for driver alcohol education, or (4) for community reinforcement approach and assertive continuing care. 2. Any of the following types of programs: programs in which the patient has a pre-defined duration of care without the Plan's ability to conduct concurrent determinations of continued medical necessity, programs that only provide meetings or activities not based on individualized treatment plans, programs that focus solely on interpersonal or other skills rather than directed toward symptom reduction and functional recovery related to specific mental health disorders, and tuition based programs that offer educational, vocational, recreational, or personal developmental activities. 3. Sensory integrative praxis tests. 4. Mental health and substance use disorder treatment that is (1) provided to Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health.
8 . Physical Appearance	
	1. Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, (3) post-mastectomy care, and (4) covered gender affirming procedures and related services. 2. Electrolysis or laser hair removal. 3. Gender Affirming Services, unless specifically listed as a Covered Benefit 4. Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. 5. Liposuction or removal of fat deposits considered undesirable. 6. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). 7. Skin abrasion procedures performed as a treatment for acne. 8. Treatments and procedures related to appearance including but not limited to abdominoplasty; chemical peels; collagen injections; dermabrasion; implantations (e.g. cheek, calf, pectoral, gluteal); lip

Exclusion	Description
Physical Appearance (Continued)	
	reduction/enhancement; panniculectomy; removal of redundant skin; and silicone injections (e.g. for breast enlargement), except for what is Medically Necessary as part of a Covered Benefit. 9. Treatment for skin wrinkles and skin tags or any treatment to improve the appearance of the skin. 10. Treatment for spider veins. 11. Wigs and scalp hair prostheses when hair loss is due to male pattern baldness, female pattern baldness, or natural or premature aging.
9 . Procedures and Treatments	
	1. Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial X-ray. 2. Commercial diet plans, weight loss programs and any services in connection with such plans or programs. **Please Note:** *UNITE HERE HEALTH* may participate in other wellness and health improvement incentive programs offered by Harvard Pilgrim. Please review all your Plan documents for the amount of incentives, if any, available under your Plan. 3. If a service is listed as requiring that it be provided at a Center of Excellence, no coverage will be provided under this Handbook if that service is received from a provider that has not been designated as a Center of Excellence. Please see section *I.D.4. Centers of Excellence* for more information. 4. Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods), except medical formula and low protein foods as listed in section *III. Covered Benefits*. 5. Physical examinations and testing for insurance, licensing or employment. 6. Services for Members who are donors for non-Members. 7. Group diabetes training, educational programs or camps.
10 . Providers	
	1. Charges for services provided after the date on which your membership ends. 2. Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit under this Handbook. 3. Charges for missed appointments. 4. Concierge service fees. Please see section *I.I. PROVIDER FEES FOR SPECIAL SERVICES (CONCIERGE SERVICES)* for more information. 5. Follow-up care after an emergency room visit, unless provided or arranged by your PCP. 6. Inpatient charges after your hospital discharge.

Exclusion	Description
Providers (Continued)	
	7. Provider's charge to file a claim or to transcribe or copy your medical records. 8. Services or supplies provided by (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
11 . Reproduction	
	1. Any form of Surrogacy or services for a gestational carrier other than covered maternity services for a Member of the Plan. 2. Birth control drugs, implants and devices that must be purchased at an outpatient pharmacy. 3. Infertility drugs. 4. Fertility services. 5. Infertility treatment. 6. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). 7. Sperm collection, freezing and storage. 8. The following fees: wait list fees, non-medical costs, shipping and handling charges etc.
12 . Services Provided Under Another Plan	
	1. Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. 2. Costs for services for which payment is required to be made by a Workers' Compensation plan or an employer under state or federal law.
13 . Telemedicine Services	
	1. Telemedicine services involving e-mail or fax. 2. Provider fees for technical costs for the provision of telemedicine services.
14 . Types of Care	
	1. Custodial Care. 2. Recovery programs including rest or domiciliary care, sober houses, transitional support services, and therapeutic communities. 3. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. 4. Pain management programs or clinics, except as described as covered under section III. Covered Benefits. 5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. 6. Private duty nursing. 7. Sports medicine clinics. 8. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.

Exclusion	Description
15 . Vision and Hearing	
	1. Eyeglasses, contact lenses and fittings, except as listed in this Benefit Handbook. 2. Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD. 3. Over the counter hearing aids. 4. Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism. 5. Routine eye examinations.
16 . All Other Exclusions	
	1. All food or nutritional supplements except those covered under the benefits for (1) low protein foods and (2) medical formulas and prescribed for Members who meet HPHC policies for enteral tube feedings. 2. Any drug or other product obtained at an outpatient pharmacy. 3. Any service or supply furnished in connection with a non-Covered Benefit. 4. Any service or supply (with the exception of contact lenses) purchased from the internet. Please see section *III. Covered Benefits* Vision Services for details. 5. Any service, supply or medication when there is a less intensive Covered Benefit or more cost-effective alternative that can be safely and effectively provided, in accordance with applicable medical necessity guidelines. 6. Any service, supply or medication that is required by a third party that is not otherwise Medically Necessary (examples of a third party are an employer, an insurance company, a school or court). 7. Beauty or barber service. 8. Diabetes equipment replacements when solely due to manufacturer warranty expiration. 9. Donated or banked breast milk. 10. Externally powered exoskeleton assistive devices and orthoses. 11. Guest services. 12. Inpatient respite care. 13. Medical equipment, devices or supplies except as listed in this Benefit Handbook. 14. Medical services that are provided to Members who are confined or committed to jail, house of correction, prison, or custodial facility of the Department of Youth Services. 15. Over-the-counter COVID-19 tests. 16. Reimbursement for travel expenses, except the specific services listed as Covered Benefits in this Handbook. Excluded services include, but are not limited to: • Alcohol and tobacco. • Childcare expenses. • Entertainment.

Exclusion	Description
All Other Exclusions (Continued)	
	• Expenses for anyone other than you and your companion. • First class, business class and other luxury transportation services. • Lodging other than at a hotel or motel. • Lost wages. • Meals. • Personal care and hygiene items. • Telephone calls. • Tips and gratuities. 17. Services for non-Members. 18. Services for which no charge would be made in the absence of insurance. 19. Services for which no coverage is provided in this Benefit Handbook and Schedule of Benefits. 20. Services provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor. 21. Services that are not Medically Necessary. 22. Services your PCP or a Plan Provider has not provided, arranged or approved except as described in sections *I.D.1. Your PCP Manages Your Health Care* and *I.D.3. Using Plan Providers*. 23. School, camp, sports, and premarital exams. 24. Taxes or governmental assessments on services or supplies. 25. Transportation, except for emergency ambulance transport, and non-emergency medical transport needed for transfer between hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary or when specifically listed as a Covered Benefit. 26. Voice modification surgery. 27. The following products and services: • Air conditioners, air purifiers and filters, dehumidifiers and humidifiers • Car seats • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners • Electric scooters • Exercise equipment • Home modifications including but not limited to elevators, handrails and ramps • Hot tubs, jacuzzis, saunas or whirlpools • Mattresses, except for hospital mattresses, which are covered in conjunction with a hospital bed. • Medical alert systems • Motorized beds • Pillows • Power-operated vehicles

Exclusion	Description
All Other Exclusions (Continued)	
	• Stair lifts and stair glides • Strollers • Safety equipment • Vehicle modifications including but not limited to van lifts • Telephone • Television

V. Reimbursement and Claims Procedures

The information in this section applies when you wish to file a claim or seek reimbursement following receipt of Covered Benefits. In most cases, you should not receive bills from Plan Providers. You are only eligible for services from a Non-Plan Provider in the scenarios outlined in section *I.D.3. Using Plan Providers*.

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

A. BILLING BY PROVIDERS

If you get a bill for a Covered Benefit you may ask the provider to:

1) Bill us on a standard health care claim form (such as the CMS 1500 or the UB04 form); and

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

If you receive a Surprise Bill, you are only responsible for the applicable Member Cost Sharing that would apply if the service was provided by a Plan Provider. The Plan will reimburse Non-Plan Providers at the Out-of-Network Rate unless otherwise agreed to by the provider and HPHC. You will not be billed for any charges other than the applicable Member Cost Sharing based on the Recognized Amount. You are not responsible, and a Non-Plan Provider cannot bill you, for:

- Amounts in excess of your Member Cost Sharing, based on the Recognized Amount, for non-emergency ancillary Covered Benefits received at certain In-network facilities by a Non-Plan Provider.
- Amounts in excess of your Member Cost Sharing, based on the Recognized Amount, for non-emergency, non-ancillary Covered Benefits received at certain In-network facilities from a Non-Plan Provider who has not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act.
- Amounts in excess of your Member Cost Sharing, based on the Recognized Amount, for Covered Benefits that are Medically Necessary Emergency Services provided by a Non-Plan Provider.
- Amounts in excess of your applicable Member Cost Sharing, based on the rates that would apply if the service was provided by a Plan Provider, for Covered Benefits that are air ambulance services provided by a Non-Plan Provider.

If you have any questions, call Member Services at **1-877-594-7196**.

B. REIMBURSEMENT FOR BILLS YOU PAY

If you pay a provider who is not a Plan Provider for a Covered Benefit, the Plan will reimburse you less your applicable Member Cost Sharing. Please send any request for reimbursement for claims you have paid to the appropriate address below:

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

If you request a claim form from Member Services, one will be provided to you within 15 days.

To obtain reimbursement for a bill you have paid, you must submit a health care reimbursement claim form with the provider or facility information. A legible claim form from the provider or facility that provided your care may also be included but is not required. The health care reimbursement claim form must include all of the following information:

- The Member's full name and address
- The Member's date of birth
- The Member's Plan ID number (on the front of the Member's Plan ID card)
- The Member's signature
- The name and address of the person or facility providing the services for which a claim is made and their Tax Identification Number (TIN) or National Provider Identification (NPI) number
- The Member's diagnosis description, diagnosis code or ICD 10 code
- The date the service was rendered
- The CPT code (or a brief description of the illness or injury) for which payment is sought
- The amount of the provider's charge
- Proof that you have paid the bill
- Other insurance information

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

Please Note: Prior Approval is required to receive full coverage for certain services. Your Plan Provider

will request Prior Approval for you. Please see section for more information on these requirements.

A health care reimbursement claim form can be obtained online at **www.harvardpilgrim.org** or by calling Member Services at **1-877-594-7196**.

1. International Claims
If you are requesting reimbursement for services received while outside of the United States, you must submit a health care reimbursement claim form along with an itemized bill and proof of payment. We may also require you to provide additional documentation, including, but not limited to: (1) records from financial institutions clearly demonstrating that you have paid for the services that are the subject of the claim; (2) the source of funds used for payment; and (3) an English translated description of the services received.

2. Pharmacy Claims
Your outpatient prescription drug coverage is not administered by HPHC. Please see your Summary Plan Description or call **Hospitality Rx** at **1-844-813-3860** for information on coverage of outpatient prescription drugs.

C. TIME LIMITS ON FILING CLAIMS

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

D. TIME LIMITS FOR THE REVIEW OF CLAIMS

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

- **Pre-service claims.** A pre-Service claim is one in which coverage is requested for a health care service that the Member has not yet received. Pre-service claims will generally be processed within 15 days after receipt of the claim by HPHC.
- **Post-service claims.** A post-service claim requests coverage of a health care service that the Member has already received. Post-service claims will generally be processed within 30 days after the receipt of the claim by HPHC.
- **Urgent Care claims.** Urgent Care claims will generally be processed within 72 hours of receipt of the claim by HPHC. An Urgent Care claim is one in which the use of the standard time period for processing pre-service claims:
  1. Could seriously jeopardize a Member's life or health or ability to regain maximum function; or
  2. Would result in severe pain that cannot be adequately managed without the care or treatment requested.

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

E. PAYMENT LIMITS

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

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

F. NOTICE OF CLAIM

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

G. MISCELLANEOUS CLAIMS PROVISIONS

Generally, benefits will be paid to the Member who received the services for which a claim is made or directly to the health care provider whose charge is the basis for the claim.

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

VI. Appeals and Complaints

This section explains how we process appeals and complaints. It explains your options if an appeal is denied.

A. BEFORE YOU FILE AN APPEAL

Claim denials may result from a misunderstanding with a provider or a claim processing error. Since these problems can be easy to resolve, we recommend that Members contact Member Services prior to filing an appeal. Member Services can be reached toll free at **1-877-594-7196** or call **711** for TTY service. Member Services will investigate the claim and either resolve the problem or explain why the claim is being denied. If you are dissatisfied with the response from Member Services, you may file an appeal using the procedures outlined below.

B. MEMBER APPEAL PROCEDURES

Any Member who is dissatisfied with a decision on the coverage of services may appeal to HPHC. Appeals may be filed by a Member or a Member's authorized representative, including a provider acting on a Member's behalf. HPHC has established the following steps to ensure that Members receive a timely and fair review of internal appeals. An authorized representative can be any individual (including, for example, a family member, an attorney, etc.) whom you designate to act on your behalf with respect to a claim for benefits.

If you need assistance filing your appeal, there may be consumer assistance programs in your state available to you. Also, HPHC staff is available to assist you with the filing of an appeal. If you wish such assistance or would like the telephone number for one of these programs, please call **1-877-594-7196**.

1. Initiating Your Appeal

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

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

If you have an authorized representative submit an appeal on your behalf, the appeal must 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 please send your request to the following address:

HPHC Appeals and Grievances Department
1 Wellness Way
Canton, MA 02021
Telephone: 1-877-594-7196
Fax: 1-617-509-3085
www.harvardpilgrim.org

No appeal shall be deemed received until it has been received by HPHC at the appropriate address or telephone number listed above.

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

There are two types of appeal processes, the standard processes, the standard process which applies to most denied claims and denied prior authorization and expedited appeals process which applies to urgently needed services.

2. The Standard Appeal Process

The Appeals and Grievances Analyst will investigate the appeal. The analyst will let you know if additional information is needed. This information may include:

- medical records,
- statements from doctors, and

- bills and receipts for services you received.

You may also provide HPHC with any written comments, documents, records or other information related to the claim.

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

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

HPHC will review Pre-Service Appeals and send a written decision within 15 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. The Plan'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 the final decision under the appeal process. If the appeal decision is not fully in your favor, the decision will also include a description of other options for further review of your appeal. These are also described in section C, below.

If your appeal involves a decision on a medical issue, the Appeals and Grievances Analyst will obtain the opinion of a qualified physician or other appropriate medical specialist. This reviewer will be a health care professional who:

- was not involved in any prior decision on your appeal.
- is not the subordinate of any person who took part in a prior decision about your appeal.

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 related to the initial denial and your appeal.

3. The Expedited Appeal Process

HPHC, and Plan Sponsor when applicable, will provide you with an expedited review if your appeal involves medical services that, if not immediately provided could, in the opinion of a physician with knowledge of your medical condition:

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

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

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

HPHC will investigate and respond to your request as soon as possible but not later than 72 hours for both levels of appeals combined. We will notify you of the decision on your appeal by telephone and send you a written decision within two business days thereafter.

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

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

Important Notice: If you are filing an expedited appeal with HPHC, you may also file a request for expedited external review at the same time. You do not have to wait until HPHC completes your expedited appeal to file for expedited external review. Please see the section *VI.C.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 obtain further review of the appeal. These are described below.

1. Second Level Appeal Process

You or your authorized representative have the right to request a second level appeal to the Appeals Subcommittee of *UNITE HERE HEALTH*. All second level appeal requests must be in writing and postmarked within 45 days of the date of the first level appeal denial. For more information, please contact *UNITE HERE HEALTH* at **1-844-267-4325**.

2. External Review

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

An IRO provides you with the opportunity for a review of your appeal by an independent organization that is separate from HPHC 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 authorized 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 to *UNITE HERE HEALTH* at the following address:

The Appeals Subcommittee
UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504

You or your authorized 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 Member Services at **1-877-594-7196**.

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 (titled "The Expedited Appeal Process").

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

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

a. You must request external review within four 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.

b. Your appeal must involve a denial of coverage based on either: (1) a medical judgment; (2) a rescission of coverage; or (3) whether protections under the federal No Surprises Act apply. 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.

Note: Payment disputes are not eligible for external review, except when the appeal is filed to determine if Surprise Bill protections are applicable.

3. Legal Action

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

D. THE FORMAL COMPLAINT PROCESS

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

HPHC Member Service Department
Harvard Pilgrim Health Care, Inc.
1 Wellness Way
Canton, MA 02021
Telephone: 1-877-594-7196
Fax: 1–617–509–3085
www.harvardpilgrim.org

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

VII. Eligibility, Enrollment and Continuing Eligibility

To be eligible for coverage under the Select network, you must live within the Enrollment Area. If you live outside the Select Enrollment Area, your coverage will be under a separate network. If you live outside the service area or have any questions about the Enrollment Area, call the Member Services Department.

For information about eligibility, enrollment, and continuing eligibility under this plan, please contact *UNITE HERE HEALTH* at **1-857-305-5031**.

VIII. Termination and Transfer to Other Coverage

Important Notice: The Plan Sponsor may notify HPHC of enrollment changes retroactively. As a result, the information HPHC has may not be current. Only your Plan Sponsor can confirm membership status. Additionally, please refer to your SPD for complete details on Termination.

A. TERMINATION BY THE SUBSCRIBER

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

B. TERMINATION FOR LOSS OF ELIGIBILITY

Your Plan coverage will end if the Plan Sponsor's contract with HPHC is terminated. Your coverage may also end under this Plan if you do not meet any of the specified eligibility requirements. You will be notified if coverage ends for loss of eligibility. HPHC or the Plan Sponsor will inform you in writing.

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

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

C. TERMINATION FOR NON-PAYMENT BY THE PLAN SPONSOR

A Member's coverage will end under the Plan if the contract between HPHC and the Plan Sponsor through which the Member receives coverage is terminated for non-payment. HPHC or the Plan Sponsor will notify you in writing if your coverage ends due to the Plan Sponsor's non-payment.

If your membership is terminated, you may be eligible for continued enrollment under applicable law. See section *E. CONTINUATION OF COVERAGE REQUIRED BY LAW* for more information.

D. MEMBERSHIP TERMINATION FOR CAUSE

The Plan may end your coverage for any of the following causes:

- Misrepresenting a material fact on your Member application.
- Committing or attempting to commit fraud to obtain benefits that you are not eligible for under this Benefit Handbook.
- Getting or attempting to get benefits under this Benefit Handbook for a person who is not a Member; or
- Committing acts of physical or verbal abuse that pose a threat to providers, HPHC or other Members and which are unrelated to the Member's physical or mental condition.

Termination for providing false information will be effective immediately upon notice to you. It is a crime to knowingly provide false, incomplete or misleading information for the purpose of defrauding the company. Termination for the other causes will be effective fifteen days after notice.

E. CONTINUATION OF COVERAGE REQUIRED BY LAW

Under Federal law, if you lose Plan Sponsor eligibility and the Plan Sponsor has twenty or more employees, you may be able to continue group coverage under the Federal law. This law is known as the Consolidated Omnibus Budget Reconciliation Act (COBRA). Contact your Plan Sponsor for more information if health coverage ends due to:

- separation from employment;
- reduction of work hours; or
- loss of dependency status.

IX. When You Have Other Coverage

This section explains how Plan benefits will be paid when another company or individual must also pay for health services a Member has received. This can happen when:

- other insurance, in addition to this Plan, is available to pay for health services.
- a third party is legally responsible for a Member's injury or illness.

Nothing in this section should be interpreted as:

- providing coverage for any service or supply that is not expressly covered under this Benefit Handbook and Schedule of Benefits; or
- increasing the level of coverage provided.

A. BENEFITS IN THE EVENT OF OTHER INSURANCE

Benefits under this Handbook and Schedule of Benefits will be coordinated to the extent permitted by law with other plans covering health benefits, including:

- motor vehicle insurance,
- medical payment policies,
- governmental benefits (including Medicare), and
- all Health Benefit Plans.

The term "Health Benefit Plan" means:

- all group HMO and other group prepaid health plans,
- Medical or Hospital Service Corporation plans,
- commercial health insurance, and
- self-insured health plans.

There is no coordination of benefits with Medicaid plans or with hospital indemnity benefits amounting to less than $100 per day.

Coordination of benefits will be based on the Allowed Amount, or Recognized Amount. This applies 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, the reasonable value of these services will be used as the basis for coordination. This also applies if a provider of services is paid under a capitation arrangement.

No duplication in coverage of services will occur among plans.

A Member may be covered by two or more Health Benefit Plans. One will be "primary" and the other plan (or plans) will be "secondary." The benefits of the primary plan are determined:

- before those of secondary plan(s); and
- without considering the benefits of secondary plan(s).

The benefits of secondary plan(s):

- are determined after those of the primary plan; and
- may be reduced because of the primary plan's benefits.

Health Benefit Plans may contain provisions for the coordination of benefits. The rules below shall decide which Health Benefit Plans are primary or secondary:

1. Subscriber/Dependent

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

2. Dependent Children

i. Dependent Child Whose Parents Are Not Separated or Divorced

The order of benefits is determined as follows:

1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined first. The benefits of the plan of the parent whose birthday falls later in that year; are determined second.
2) Both parents may have the same birthday. The benefits of the plan that covered the parent longer are determined first. The benefits those of the plan that covered the other parent for a shorter period of time are determined second.
3) The other plan may not have the rule described in (1) above. It may instead have a rule based on the gender of the parent. As a result, the plans may not agree on the order of benefits. In this case, the other plan will determine the order of benefits.

ii. Dependent Child/Separated or Divorced Parents

A court order may specify one of the parents as responsible for the health care benefits of the child. Unless HPHC is aware of such a court order, the order of benefits is determined as follows:

1) First the plan of the parent with custody of the child;

2) Then, the plan of the spouse of the parent with custody of the child;

3) Finally, the plan of the parent not having custody of the child.

3. Active Subscriber or Retired or Laid-Off Subscriber
The benefits of a plan that covers the person as an active subscriber or as a dependent of an active subscriber are determined first. The benefits of the plan that covers the person as an individual who is retired or laid off or as a dependent of that person are determined second.

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

5. Longer/Shorter Length of Coverage
None of the above rules may determine the order of benefits. In this case, the benefits of the plan that covered theMember or Subscriber longer are determined first. The benefits of the plan that covered that person for the shorter time are determined second.

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

Important Note: Nothing in this Benefit Handbook shall be construed to limit HPHC's right to utilize any remedy provided by law to enforce its rights to coordination of benefits under this Benefit Handbook.

B. PROVIDER PAYMENT WHEN PLAN COVERAGE IS SECONDARY

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

C. WORKERS' COMPENSATION/GOVERNMENT PROGRAMS

HPHC may have information that shows the services provided to you are covered under:

- Workers' Compensation,
- employer's liability or other program of similar purpose, or
- by federal, state or other government agency.

In this case, payment may be held for such services until a determination is made whether payment will be made by such program. If payment is made for services for an illness or injury covered under another program of similar purpose, or by a federal, state or other government agency, the Plan will be entitled to recovery of its expenses. Recovery will be from the provider of services or the party or parties legally obligated to pay for such services.

D. SUBROGATION AND REIMBURSEMENT FROM RECOVERY

If you have an injury or illness legally caused or alleged to be caused by a third party, health plans have a right to be reimbursed by the third party for claims that are paid for the Covered Services you need. This is called subrogation.

Specifically:

- The Plan will be subrogated and succeed to all rights to recover against such third party (person or entity) for the value of the services paid for or provided by the Plan.
- The Plan will also have the right to be reimbursed from any recovery a Member obtains from such person or entity for the value of the services paid for or provided by the Plan.
- The Plan will have the right to seek such recovery from, among others:
  - the person or entity that caused or allegedly caused the injury or illness;
  - his/her liability carrier; or
  - your own auto insurance carrier, in cases of uninsured or underinsured motorist coverage.
- The Plan's right to reimbursement from any recovery shall apply even if the recovery the Member receives for the illness or injury is designated or described as being for injuries other than health care expenses or does not fully

compensate the Member for his or her damages, fees or costs.

- Neither the "make whole rule" nor the "common fund doctrine" apply to the Plan's rights of subrogation and/or reimbursement from recovery.
- The Plan's reimbursement will be made from any recovery the Member receives from an insurance company or any third party and the Plan's reimbursement from any such recovery will not be reduced by any attorney's fees, costs or expenses of any nature incurred by, or for, the Member in connection with the Member's receiving such recovery, and the Plan will have no liability for any such attorney's fees, costs or expenses.
- The Plan will have the right to take legal action, with or without your consent, against any party to secure reimbursement from the recovery for the value of services provided or paid for by the Plan for which such party is, or is alleged to be, liable.

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

E. MEDICAL PAYMENT POLICIES

A Member may be entitled to coverage under the medical payment benefit of a boat, homeowners, hotel, restaurant, or other insurance policy, or the first $2,000 of Personal Injury Protection (PIP) coverage (or $8,000 for self funded plans). Such coverage shall become primary to the coverage under this Benefit Handbook for services rendered in connection with a covered loss under that policy.

A Member may be entitled to coverage under (1) a medical payment policy, or (2) Personal Injury Protection (PIP) coverage in excess of $2,000 (or $8,000 for self funded plans). Such coverage shall become secondary to the coverage under this Benefit Handbook for services rendered in connection with a covered loss under that policy. This shall be where, and only to the extent, the law requires the coverage under this Benefit Handbook to be primary.

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

F. MEMBER COOPERATION

You agree to cooperate with the Plan in exercising its rights of subrogation and coordination of benefits. Such cooperation will include, but not be limited to:

- the provision of all information and documents requested by the Plan;
- the execution of any instruments deemed necessary by the Plan to protect its rights;
- the prompt assignment to the Plan of any monies received for services provided or paid for by the Plan; and
- the prompt notification to the Plan of any instances that may give rise to the Plan's rights.

You further agree to do nothing to prejudice or interfere with the Plan's rights to subrogation or coordination of benefits.

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

G. THE PLAN'S RIGHTS

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

H. MEMBERS ELIGIBLE FOR MEDICARE

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

For a Member who is eligible for Medicare by reason of End Stage Renal Disease, the Plan will be the primary payor for Covered Benefits during the "coordination period" specified by federal regulations at 42 CFR Section 411.162. Thereafter, Medicare will be the primary payor. When Medicare is primary (or would be primary if the Member were timely enrolled), the Plan will pay for services covered under Medicare Part

B only to the extent payments would exceed what would be payable by Medicare. The Plan will estimate the amount that would be payable by Medicare and pay secondary benefits accordingly. The Plan may apply the same terms when Medicare is primary by reason of age or disability (or would be primary if the Member were timely enrolled).

X. Plan Provisions and Responsibilities

A. IF YOU DISAGREE WITH RECOMMENDED TREATMENT

Plan Providers are responsible for determining treatment appropriate to your care. You:

- may disagree with the treatment recommended by Plan Providers for personal or religious reasons.
- may demand or seek a treatment that Plan Providers judge to be incompatible with proper medical care.
- have the right to refuse the recommendations of Plan Providers.

In this case, HPHC shall have no further obligation to provide coverage for the care in question. If you obtain care from Non-Plan Providers because of the disagreement, HPHC has no obligation for the cost or outcome of such care. You have the right to appeal benefit denials.

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

B. LIMITATION ON LEGAL ACTIONS

Members may bring a legal action against the Plan within a certain period of time as outlined in your Plan Sponsor's Summary Plan Description.

C. ACCESS TO INFORMATION

You agree that, except where restricted by law, HPHC and the Plan Sponsor may have access to:

- all health records and medical data from providers of Covered Benefits.
- information concerning health coverage or claims from all providers of:
    - motor vehicle insurance.
    - medical payment policies.
    - home-owners' insurance.
    - all types of health benefit plans.

HPHC and the Plan Sponsor will comply with all laws restricting access to special types of medical information including, but not limited to, data and records for:

- HIV tests,
- substance use disorder rehabilitation,
- mental health treatment, and
- substance use disorder treatment.

Information from a Member's medical record and information about a Member's physician patient and hospital patient relationships will be kept confidential and will not be disclosed without the Member's consent, except for:

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

D. SAFEGUARDING CONFIDENTIALITY

HPHC values your privacy rights. HPHC is committed to safeguarding protected health information (PHI) and personal information (PI). Our Privacy and Security policies include:

- how HPHC administers privacy and security programs;
- staff training; and
- how PHI and PI can be used and disclosed.

We may collect, use, and disclose financial and medical information about you when doing business with you or others. We follow our privacy policies and state and federal laws. Our business partners administer your health care coverage on our behalf. HPHC requires our partners to protect your information according to state and federal law.

For a copy of our Notice of Privacy Practices go to **www.harvardpilgrim.org** or call Member Services at **1-877-594-7196**.

E. NOTICE

Member mailings are sent to your last address that HPHC has on file. Mailings may include:

- notices;
- Plan documents;

- invoices; and
- Activity Statements.

See section *VI. Appeals and Complaints*. for the address and phone numbers to file an appeal.

F. MODIFICATION OF THIS HANDBOOK

The Benefit Handbook is the entire Plan as agreed to by HPHC and the Plan Sponsor. It can only be amended by HPHC and the Plan Sponsor as stated below. No other action by HPHC or the Plan Sponsor will waive or alter any part of the Benefit Handbook. This includes non-enforcement of any benefit..

HPHC may amend the Benefit Handbook. It may be amended by agreement, in writing, between HPHC and the Plan Sponsor or, if required by law, by HPHC upon written notice to the Plan Sponsor. Member consent is not required.

G. HPHC'S RELATIONSHIP WITH PLAN PROVIDERS

Separate agreements govern HPHC's relationship with Plan Providers. Plan Providers:

- are independent contractors.
- may not modify the Benefit Handbook.
- may not create any obligation for HPHC.

We are not liable for their statements about the Benefit Handbook. This includes their employees or agents.

Without notice to Members, HPHC may:

- change its arrangements with service providers; or
- add or remove providers from the Plan.

H. IN THE EVENT OF A MAJOR DISASTER

HPHC will try to provide or arrange for services in the case of a major disaster. This might include war, riot, epidemic, public emergency, or natural disaster. Other causes include:

- the partial or complete destruction of our facility(ies).
- the disability of service providers.

HPHC may not be able to provide or arrange services in a major disaster. HPHC is not responsible for the costs or outcome of this inability.

I. EVALUATION OF NEW TECHNOLOGY

HPHC has a dedicated team of staff that evaluates new:

- diagnostics;
- testing;
- interventional treatment;
- therapeutics;
- medical/behavioral therapies;
- surgical procedures;
- medical devices and drugs; and
- new applications of the above.

The team manages an evidence-based evaluation process. This process recommends a status of (i) an accepted standard of care; or (ii) Experimental, Unproven, or Investigational. The team researches the safety and effectiveness of these new technologies by:

- reviewing published peer reviewed medical reports and literature,
- consulting with expert practitioners, and
- benchmarking.

The team makes recommendations to internal policy committees. These committees make final policy decisions for new technology coverage. The policy evaluation process includes:

- determining the FDA approval status of the device/product/drug in question;
- reviewing relevant clinical literature; and
- consulting actively practicing specialists about current practice standards.

J. UTILIZATION REVIEW PROCEDURES

HPHC uses the following utilization review procedures to evaluate the Medical Necessity of certain health care services. HPHC uses clinical criteria to assure your care is clinically appropriate and cost effective., This applies to both physical and mental health services.

- **Prospective Utilization Review (Prior Approval).** HPHC reviews certain services before they are provided. This review determines if the proposed services meet Medical Necessity Guidelines. Services include, but are not limited to, the following:
  - elective inpatient admissions;
  - surgical day care;
  - outpatient/ambulatory procedures; and
  - Medical Drugs.

  Please call Member Services at **1-877-594-7196** to inquire if a specific service requires Prior Approval. When you use a Plan Provider, the provider is responsible for getting the approval from HPHC.

Prior Approval decisions are made within two working days of receiving all necessary information.

(1) For notice of a decision to approve an admission, procedure or service:
- we will send notice in the HPHC provider portal within 24 hours of the decision.
- will send written notice to you and the provider within two working days.

(2) For notice of a decision to deny or reduce benefits ("an adverse determination"):
- HPHC will call your provider within 24 hours of the decision.
- HPHC will send you and your provider written or electronic notice within one working day after the call.

Please Note: Prior Approval is not required to receive Acute Treatment Services or Clinical Stabilization Services from a Plan Provider. The terms "Acute Treatment Services" and "Clinical Stabilization Services" are defined in the Glossary at Section II of this Benefit Handbook.

- **Concurrent Utilization Review.** HPHC reviews ongoing admissions for certain services. These reviews are to assure that the services provided meet Medical Necessity Guidelines. These services may be at:
  - hospitals, including acute care hospitals;
  - rehabilitation hospitals;
  - skilled nursing facilities;
  - skilled home health providers; and
  - behavioral health and substance use disorder treatment facilities.

  Concurrent review decisions are made within one working day of receiving all necessary information.

  For either a decision to approve or to deny additional services, we will call your provider within 24 hours of the decision. HPHC will send you and your provider written or electronic notice within one working day. For ongoing services, coverage will continue without liability to you until you are notified of an adverse determination.

  Concurrent review includes active case management and discharge planning. Your provider may also request these services.

- **Retrospective Utilization Review.** HPHC may review services that were provided before Prior Approval was obtained. This includes review of emergency medical admissions for appropriate of level of care.

To find the status of a clinical review decision call Member Services at **1-877-594-7196**.

For an adverse determination involving clinical review, your provider may discuss your case with a physician reviewer. Your provider may also ask HPHC to reconsider our decision. HPHC will reconsider a decision within one working day of your provider's request. If the adverse determination is not reversed, you may appeal. Your appeal rights are described in section *VI. Appeals and Complaints*. Your right to appeal does not depend on making a request to reconsider our decision.

K. QUALITY ASSURANCE PROGRAMS

HPHC has quality controls in place guided by the National Committee for Quality Assurance (NCQA). Our Quality Assurance programs are designed to ensure consistently excellent health plan services. Key Quality Assurance programs include:

- **Verifying Provider Credentials** - HPHC obtains, verifies, and assesses Plan Provider qualifications to provide care or services. This involves gathering evidence of licensure, education, training and other experience and/or qualifications.
- **Verifying Facility Credentials** - HPHC reviews and confirms licensures and certifications based on facility type.
- **Quality of Care Complaints** – HPHC follows a process to investigate, resolve and monitor Member complaints about care provided by a Plan Provider.
- **Evidence Based Practice** – HPHC compiles Medical Necessity Guidelines. These guidelines are based on the most current evidence-based standards. They provide an analytical framework for clinicians to evaluate and treat common health conditions.
- **Performance monitoring** – HPHC collects data to measure outcomes. This data is related to the Health Care Effectiveness Data and Information Set (HEDIS). It is used to monitor health care quality across various domains of evidence-based care and practice.
- **Quality program evaluation** - Annually HPHC develops, plans and implements initiatives

to improve clinical service and quality. The Quality Program is documented, tracked and evaluated against milestones and objectives. See and review the full program description at **https://www.harvardpilgrim.org/public/about-us/quality**.

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

HPHC use a standard process to assess coverage questions and requests. These may come to us from internal or external sources. The process includes:

- Determining FDA approval status of the device, product, or drug in question;
- Reviewing relevant clinical literature; and
- Consulting with actively practicing specialists about current practice standards.

Decisions are developed into policy change recommendations. These are then sent to our management for review and final approval.

M. PROCESS TO DEVELOP MEDICAL NECESSITY GUIDELINES AND UTILIZATION REVIEW CRITERIA

HPHC uses Medical Necessity Guidelines to make fair and consistent utilization management decisions. Medical Necessity Guidelines are developed according to NCQA standards. Guidelines are reviewed (revised, if needed) at least annually. Review may occur more often to include updates in practice standards. This process applies to criteria for both physical and mental health services.

For example, HPHC uses the nationally recognized InterQual criteria to review elective surgical day procedures, and services provided in acute care hospitals. InterQual criteria are developed from current national standards of medical practice. Physicians and clinicians in academic medicine and all areas of active clinical practice provide input. InterQual criteria are reviewed and revised annually.

Medical Necessity Guidelines used to review other services. Physicians and other clinicians with relevant clinical expertise to provide input. The process includes review of relevant clinical literature and local practice standards.

N. NON-ASSIGNMENT OF BENEFITS

You may not assign or transfer your rights to benefits, monies, claims or causes of action provided under this Plan to:

- any person;
- health care provider;
- company; or
- other organization without written consent from HPHC.

You must have our written consent to assign any benefits, monies, claims, or causes of action that result from a benefits denial.

O. NEW TO MARKET DRUGS

Your coverage under this Benefit Handbook is limited to Medical Drugs. New Medical Drugs that are introduced into the market are reviewed by the Plan prior to coverage to ensure that the drug is safe and effective. New to market drugs will be reviewed by HPHC's Medical Policy Department and New Technology Assessment Committee or Pharmacy Services Department along with the Pharmacy and Therapeutics Committee within the first 180 days of their introduction to the market. If the new to market drug is covered by the Plan, Prior Authorization and coverage limitations may apply.

This Plan does not provide coverage for outpatient prescription drugs through HPHC. Please see your Summary Plan Description or call **Hospitality Rx** at **1-844-813-3860** for information on coverage of outpatient prescription drugs.

P. PAYMENT RECOVERY

We may determine that a mistake was made paying Plan benefits. We reserve the right to:

- recover such payments from the provider or Member.
- offset later benefit payments to a provider (regardless of payment source) or Member by any such overpayment amount.

XI. MEMBER RIGHTS & RESPONSIBILITIES

You have a right to receive information about:

- HPHC, its services.
- Plan practitioners and providers.
- Your rights and responsibilities.

You have a right:

- to privacy.
- to be treated with dignity and respect.
- to participate in decision-making regarding your health care.
- to a candid discussion of appropriate treatment options for your condition, regardless of cost or benefit coverage.
- to voice a complaint or appeal about HPHC or the care provided.
- to suggest changes to HPHC's members' rights and responsibilities policies.

You have a responsibility to:

- provide, to the extent possible, information that the Plan and Plan Providers need to manage your care.
- to follow your provider's plans and instructions for care.
- to understand your health problems.
- to participate in developing mutually agreed upon treatment goals to manage your health.

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