Access to Network Providers – PPO
NHCAR Ins. 2701.09(g)(7) and (9)

(7) The health carrier's method of informing covered persons of the requirements and procedures for gaining access to network providers, including but not limited to the following:

a. The process for choosing and changing network providers.

- Please see the Benefit Handbook excerpt, pages 2-4.

b. The process for providing and approving emergency, urgent, and specialty care.

- Please see the Benefit Handbook excerpt, page 4.

c. The identity of all of the plan's participating providers and facilities, including a specification of those participating providers, if any, that are accessible only at a reduced benefit level.

- Please see the online Provider Directory at www.harvardpilgrim.org.

d. Whether and when referral options are restricted to less than all providers in the network who are qualified to provide covered specialty services.

- Referrals are not required under the PPO product.

(9) The health carrier's process for enabling covered persons to change primary care providers.

- Selection of a primary care provider is not required under the PPO product.

This information is provided as part of Harvard Pilgrim's 2017 Health Care Access Report as required by the State of New Hampshire's network adequacy requirements. For more information specific to your plan, please refer to your Benefit Handbook, available on HPHConnect.

Harvard Pilgrim Health Care

HPHC Insurance Company

Benefit Handbook

THE PPO PLAN
NEW HAMPSHIRE
EMPLOYER GROUP PLAN

Coverage under this Plan is under the jurisdiction of the New Hampshire Insurance Commissioner.

IMPORTANT INFORMATION: This policy reflects the known requirements for compliance under The Affordable Care Act as passed on March 23, 2010. As additional guidance is forthcoming from the US Department of Health and Human Services and the New Hampshire Insurance Department, those changes will be incorporated into your health insurance policy.

EFFECTIVE DATE: 01/01/2017
FORM #1100_08

I. How the Plan Works

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

In Massachusetts, Maine, Rhode Island and New Hampshire there are certain specialized services that must be received from designated Plan Providers, referred to as "Centers of Excellence" to receive In-Network coverage. Please see section *I.D.4. Centers of Excellence – Massachusetts, Maine, New Hampshire, Connecticut or Rhode Island* for further information.

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

A. HOW TO USE THIS BENEFIT HANDBOOK

1. Why This Benefit Handbook Is Important

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

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

- How to obtain benefits with the lowest out-of-pocket expense
- Covered Benefits
- Exclusions
- The requirements for In-Network and Out-of-Network coverage

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

2. Words With Special Meaning

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

3. How To Find What You Need To Know

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

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

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

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

B. HOW TO USE YOUR PROVIDER DIRECTORY

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

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

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

to participate in the network for the duration of your membership.

C. MEMBER OBLIGATIONS

1. Show Your Identification Card

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

2. Share Costs

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

- Copayments
- Coinsurance
- Deductibles

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

3. Obtain Prior Approval

You are required to notify us or obtain Prior Approval before receiving certain Covered Benefits. For In-Network medical benefits a Plan Provider will do this for you. Please see section *I.G. NOTIFICATION AND PRIOR APPROVAL* for more information on these requirements.

To provide notification or obtain Prior Approval for Out-of-Network medical services you should call: **1–800–708–4414**.

To obtain Prior Approval for Out-of-Network mental health and drug and alcohol rehabilitation services you should call the Behavioral Health Access Center at **1–800–777–4742**.

You do not need to provide advance notification or obtain Prior Approval if services are needed in a Medical Emergency.

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

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

D. HOW TO OBTAIN CARE

IMPORTANT POINTS TO REMEMBER

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

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

1. How Your In-Network Benefits Work

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

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

Members are responsible for advising Providers of their membership in the Plan by showing them their identification card before receiving services.

Please Note: In Massachusetts, Maine,Rhode Island, Rhode Island, and New Hampshire there are certain specialized services that must be received from designated Plan Providers, referred to as "Centers of Excellence" to receive In-Network coverage. Please see section *I.D.4. Centers of Excellence – Massachusetts, Maine, New Hampshire, Connecticut or Rhode Island* for further information.

2. How Your Out-of-Network Benefits Work

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

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

To request Prior Approval, please call:

- **1-800-708-4414** for Medical Services
- **1-888-777-4742** for Mental Health and Drug and Alcohol Rehabilitation Services

Payments to Plan Providers are usually based on a contracted rate between us and the Plan Provider. Since we have no contract with Non-Plan Providers, there is no limit on what such providers can charge. You are responsible for any amount charged by a Non-Plan Provider in excess of the Allowed Amount for the service.

3. Selecting a Plan Provider

To obtain In-Network benefits you must receive services from a Plan Provider. Your out-of-pocket costs will almost always be lower if you use your In-Network benefits by using a Plan Provider. Plan Providers include a large number of specialists and health care institutions in New Hampshire and surrounding states. In addition, HPHC offers a large national network of Plan Providers across the United States. You may use the Provider Directory to find Plan Providers. The Provider Directory identifies the Plan's participating specialists, hospitals and other providers. It lists providers by state and town, specialty, and languages spoken. You may view the Provider Directory online at our web site, **www.harvardpilgrim.org**. You can also get a copy of the Provider Directory, free of charge, by calling the Member Services Department at **1–888–333–4742**.

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

4. Centers of Excellence – Massachusetts, Maine, New Hampshire, Connecticut or Rhode Island

Plan Providers with special training, experience, facilities or protocols for certain specialized services are designated as "Centers of Excellence."

Centers of Excellence are selected by us based on the findings of recognized specialty organizations or government agencies such as Medicare. Centers of Excellence are located in Massachusetts, Maine, Connecticut, Rhode Island and New Hampshire. The following specialized service should be obtained through a designated Center of Excellence:

- Weight loss surgery (bariatric surgery)

A list of Centers of Excellence may be found in the Provider Directory. The Provider Directory is available online at **www.harvardpilgrim.org** or by calling our Member Services Department at **1–888–333–4742**.

We may revise the list of services that must be received from a Center of Excellence upon 30 days' notice to Members. Services or procedures may be added to the list when we identify services in which significant improvements in the quality of care may be obtained through the use of selected providers. Services or procedures may be removed from the list if we determine that significant advantages in quality of care will no longer be obtained through the use of a specialized panel of providers.

To receive In-Network benefits for the service listed above in Massachusetts, Maine, Connecticut, Rhode Island or New Hampshire, you must obtain care at a Plan Provider that has been designated as a Center of Excellence.

Important Notice: If you choose to receive care in Massachusetts, Maine, Connecticut, Rhode Island or New Hampshire for the above service at a facility other

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

To receive In-Network benefits for the service listed above outside of Massachusetts, Maine, Connecticut, Rhode Island or New Hampshire, you must obtain care at a hospital that is listed as a Plan Provider. Please check your Provider Directory for a list of participating hospitals. If you choose to receive care for the above service at a facility other than a Plan Provider, coverage will be at the Out-of-Network benefit level.

5. Covered Benefits from Our Affiliated National Network of Providers

HPHC offers a comprehensive network of Plan Providers located in Massachusetts, New Hampshire, Rhode Island, Vermont, Connecticut and Maine. In addition, HPHC's national provider network allows Members to obtain In-Network benefits outside of those states. As of the issuance of this Handbook, the national network includes nearly 650,000 physicians and over 5,500 hospitals. To locate one of these Providers, log onto our website at **www.harvardpilgrim.org** or call Member Services at **1–888-333-4742**.

6. How to get Care After Hours

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

7. Medical Emergency Services

In a Medical Emergency, including an emergency mental health condition, you should go to the nearest emergency facility or call 911 or other local emergency number. Your emergency room Member Cost Sharing is listed in your Schedule of Benefits. Please remember that if you are hospitalized, you must call the Plan at **1-888-333-4742** within 48 hours or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to the Plan by an attending emergency physician no further notice is required. If notification is not received when the Member's condition permits, the Member is responsible for the Penalty payment.

E. MENTAL HEALTH PROVIDER CONTINUATION

If the Plan replaced your prior health plan and a mental health provider was treating you under the prior plan, you may be eligible to continue seeing your previous health care provider at the In-Network benefit level. Such eligibility may continue for up to one year after the Plan replaced your prior health plan.

This service is available if you received mental health services under a health plan sponsored by your current employer and you either:

- Received mental health services for two, three, or five separate days during the 30-day, 90-day, or 12 month period, respectively, immediately prior to joining the Plan, or
- Were hospitalized for mental health purposes during the 12- month period immediately prior to joining the Plan

F. MEMBER COST SHARING

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

1. Copayment

If the Covered Benefit you are receiving is subject to a Copayment, the Copayment is payable at the time of the visit or when billed by the provider. Copayment amounts are specified in your Schedule of Benefits.

2. Deductible

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

Your Plan has both an individual Deductible and a family Deductible. However, please note that a family Deductible only applies if you have Family Coverage. Unless a family Deductible applies, you are responsible for the individual Deductible for Covered Benefits each Calendar Year. If you are a Member with Family

Coverage, the Deductible can be satisfied in one of two ways:

a. If a Member of a covered family meets an individual Deductible, then services for that Member that are subject to that Deductible are covered by the Plan for the remainder of the Calendar Year.

b. If any number of Members in a covered family collectively meet the family Deductible, then all Members of the covered family receive coverage for services subject to that Deductible for the remainder of the Calendar Year.

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

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

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

3. Coinsurance

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

4. Out-of-Pocket Maximum

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

Certain expenses do not apply to the Out-of-Pocket Maximum. Please see your Schedule of Benefits for the Member Cost Sharing amounts that do not apply to the Out-of-Pocket Maximum. In addition, Penalty amounts and charges above the Allowed Amount never apply to the Out-of-Pocket Maximum.

In most cases you have both an individual Out-of-Pocket Maximum and a family Out-of-Pocket Maximum. If you are a Member with Family Coverage, your Out-of-Pocket Maximum can be reached in one of two ways:

a. If a Member of a covered family meets an individual Out-of-Pocket Maximum, then that Member has no additional Member Cost Sharing for the remainder of the Calendar Year.

b. If any number of Members in a covered family collectively meet the family Out-of-Pocket Maximum, then all Members of the covered family have no additional Member Cost Sharing for the remainder of the Calendar Year.

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

5. Out-of-Network Charges in Excess of the Allowed Amount

On occasion, a Non-Plan Provider may charge amounts in excess of the Allowed Amount. In those instances, you will be financially responsible for the difference between what the Provider charges and the amount of the Allowed Amount payable by the Plan. This means that you will be responsible for paying the full amount above the Allowed Amount. Amounts charged by a Non-Plan Provider in excess

of the Allowed Amount do not count toward the Out-of-Pocket Maximum.

6. Penalty

The amount that a Member is responsible to pay for certain Out-of-Network services when notification or Prior Approval has not been received before obtaining the services. The Penalty charge is in addition to any Member Cost Sharing amounts. Penalty charges do not count towards any Out-of-Pocket Maximum. Please see section *I.G. NOTIFICATION AND PRIOR APPROVAL* for a detailed explanation of the Prior Approval Program.

7. Combined Payment Levels

Under some circumstances you may receive services from both a Plan Provider and a Non-Plan Provider when obtaining care. When this occurs, your entitlement to In-Network or Out-of-Network coverage always depends upon the participation status of the individual service Provider. For example, you may receive treatment in a Plan Provider's office and receive associated blood work from an non-plan laboratory. Since the payment level is dependent upon the participation status of the Provider, the Plan Provider would be paid at the In-Network coverage level and the laboratory would be paid at the Out-of-Network coverage level.

The benefit payment level that is applied to a hospital admission depends on the participation status of both the admitting physician and the hospital. If a Plan Provider admits you to a participating hospital, both the hospital and physician are paid at the In-Network coverage level. If an Out-of-Network physician admits you to a participating hospital, the hospital's charges are paid at the In-Network coverage level but the physician's charges are paid at the Out-of-Network coverage level. Likewise if a Plan Provider admits you to a non-plan hospital, the hospital's charges are paid at the Out-of-Network coverage level but the physician's charges are paid at the In-Network coverage level. All Out-of-Network payments by the Plan are limited to the Allowed Amount.

G. NOTIFICATION AND PRIOR APPROVAL

Members are required to notify HPHC before the start of any planned inpatient admission to a Non-Plan Medical Facility. A "Non-Plan Medical Facility" is any inpatient medical provider that is not under contract with us to provide care to members. Members are also required to obtain Prior Approval from HPHC before receiving certain services. This section explains when notification and Prior Approval are required and the procedures to follow to meet those requirements.

Please note that your doctor or hospital can provide notification or seek Prior Approval on your behalf. Also, you do not need to provide advance notification or obtain Prior Approval if services are needed in a Medical Emergency.

1. Notification of Planned Inpatient Admissions

You must notify HPHC in advance of any planned inpatient admission to a Non-Plan Medical Facility. This requirement applies to admissions to all types of inpatient medical and mental health and drug and alcohol rehabilitation facilities, including hospitals, Skilled Nursing Facilities (SNFs) and rehabilitation hospitals.

To provide notification for medical services, you should contact HPHC at **1-800-708-4414** at least five (5) business days in advance of the admission. To provide notification for mental health and drug and alcohol rehabilitation services, you should contact the Behavioral Health Access Center at **1–888–777–4742**. You do not need to provide advance notification to HPHC or the Behavioral Health Access Center if you are hospitalized in a Medical Emergency. In the event of a Medical Emergency admission, you or your physician must notify HPHC or the Behavioral Health Access Center, as applicable, within 48 hours or as soon as possible.

If either the hospital or admitting physician is a Non-Plan Provider, you are responsible for notifying HPHC. As noted above, providers may notify HPHC on your behalf.

2. When Prior Approval is Required

Prior Approval must be obtained for any of the services listed below.

1) **For Mental Health and Drug and Alcohol Rehabilitation Services**

   Prior Approval must be obtained before receiving certain mental health and drug and alcohol rehabilitation services from a Non-Plan Provider. To obtain Prior Approval for the mental health and drug and alcohol rehabilitation services listed below, you should call the Behavioral Health Access Center at **1-888-777-4742**. **Please refer to HPHC's Internet site at www.harvardpilgrim.org, or call Member Services for updates and revisions to the following list:**

   - **Intensive Outpatient Program Treatment** – Treatment programs at an outpatient

clinic or other facility generally lasting three or more hours a day on two or more days a week.

- **Partial Hospitalization and Day Treatment Programs**
- **Extended Outpatient Treatment Visits –** Outpatient visits of more than 50 minutes duration with or without medication management. Also included is any treatment routinely involving more than one outpatient visit in a day.
- **Outpatient Electro-Convulsive Treatment (ECT)**
- **Psychological Testing**
- **Applied Behavioral Analysis (ABA) for the treatment of Autism**

Please Note: You may also contact the Behavioral Health Access Center at **1-888-777-4742** for assistance in obtaining covered mental health services (including substance abuse treatment), even if Prior Approval is not required for the service you require.

2) **For Medical Services.**

You must obtain Prior Approval in advance of receiving any of the medical services listed below from a Non-Plan Provider. To obtain Prior Approval for medical services you or your Provider should call: **1-800-708-4414**. **Please refer to HPHC's Internet site at www.harvardpilgrim.org, or call Member Services for updates and revisions to the following list:**

- **Cosmetic, reconstructive and restorative procedures –** All Covered Benefits, including, but not limited to, blepharoplasty, breast reduction mammoplasty, including breast implant removal and gynecomastia surgery, panniculectomy, ptosis repair, rhinoplasty, and scar revision. (Please note that the Plan provides very limited coverage for Cosmetic Services. Please see "Reconstructive Surgery" in section *III. Covered Benefits* for details.)
- **Dental and Oral Surgery –** All Covered Benefits, including surgical treatment of temporomandibular joint dysfunction (TMD). (Please note that the Plan provides very limited coverage for Dental Care. Please see "Dental Services" in section *III. Covered Benefits* for details.)
- **Durable Medical Equipment —** Continuous glucose monitoring systems only.
- **Formulas and enteral nutrition –** Outpatient services only.
- **Home health care** – Includes home infusion and home hospice care.
- **Non—Emergency Air Ambulance Transportation —** Emergency air ambulance transportation is immediate transportation by air ambulance that is arranged by police, fire or other emergency rescue officials during a Medical Emergency. Emergency air ambulance services do not require Prior Approval. You must obtain Prior Approval for coverage of any other air ambulance transportation.
- **Occupational therapy** – Outpatient services only.
- **Physical therapy** – Outpatient services only.
- **Prosthetic devices** – Myoelectric and bionic arms and legs only
- **Pulmonary rehabilitation** – Outpatient services only.
- **Radiology – Advanced Radiology**- 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).
- **Select Medical Drugs** – including by not limited to, antibiotics for lyme disease; hyaluronate injections' immune globulin (IVIg); and immunobiologics (e.g. Remicade and Rituxin)
- **Speech and language therapy** – Outpatient services only.
- **Surgery (both inpatient and outpatient)** – Prior Approval is required for the following surgical procedures: bariatric surgery (weight loss surgery); cholecystectomy; knee or shoulder arthroscopy; repair bladder defect (urinary incontinence); implantable

neurostimulators; septoplasty; surgical treatment of obstructive sleep apnea, including uvulopalatopharyngoplasty (UPPP); sinus surgeries; hysterectomy; total hip replacement; total knee arthroplasty; and treatment of varicose veins.

Please refer to HPHC's Internet site, www.harvardpilgrim.org for updates and revisions to the above list.

3. How to Obtain Prior Approval

To seek Prior Approval for Out-of-Network medical services you should call: **1-800-708-4414**. To seek Prior Approval for mental health and drug and alcohol rehabilitation services received from a Non-Plan Provider you should call **1-888-777-4742**.

The following information must be given when seeking Prior Approval for medical services:

- The Member's name
- The Member's ID number
- The treating physician's name, address and telephone number
- The diagnosis for which care is ordered
- The treatment ordered and the date it is expected to be performed

For inpatient admission to a Non-Plan Provider the following additional information must be given:

- The name and address of the facility where care will be received
- The admitting physician's name, address and telephone number
- The admitting diagnoses and date of admission
- The name of any procedure to be performed and the date it is expected to be performed

4. The Effect of Notification and Prior Approval on Coverage

If you provide notification or obtain Prior Approval the Plan will pay up to the full benefit limit stated in this Benefit Handbook and your Schedule of Benefits.

If you do not provide notification or obtain Prior Approval when required, you will receive coverage for services later determined to be Medically Necessary, but you will be responsible for paying the Penalty amount stated in the Schedule of Benefits in addition to any applicable Member Cost Sharing.

If HPHC determines at any point that a service is not Medically Necessary, no coverage will be provided for the services at issue and you will be responsible for the entire cost of those services.

Neither notification nor Prior Approval entitle you to any benefits not otherwise payable under this Benefit Handbook or the Schedule of Benefits.

Please see section *X.L. UTILIZATION REVIEW PROCEDURES* for information on the time limits for Prior Approval decisions and reconsideration procedures for providers if coverage is denied. Please see Section *VI. Appeals and Complaints* for a description of your appeal rights if coverage for a service is denied by HPHC.

5. What Notification and the Prior Approval Program Do

The notification and Prior Approval Programs do different things depending upon the service in question. These may include:

- Assuring that the proposed service will be covered by the Plan and that benefits are being administered correctly.
- Consulting with Providers to provide information and promote the appropriate delivery of care.
- Evaluating whether a service is Medically Necessary, including whether it is, and continues to be, provided in an appropriate setting.

If the Prior Approval Program conducts a medical review of a service, you and your attending physician will be notified of the Plan's decision to approve or not to approve the care proposed. All decisions to deny a medical service will be reviewed by a physician (or, in the case of mental health and drug and alcohol rehabilitation services, a qualified clinician) in accordance with written clinical criteria. The relevant criteria will be made available to Providers and Members upon request.

If the Prior Approval Program denies a coverage request, it will send you a written notice that explains the decision, your Provider's right to obtain reconsideration of the decision, and your appeal rights.

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

1. Pregnancy

If you are a female Member in your second or third trimester of pregnancy and the Plan Provider you are seeing in connection with your pregnancy is involuntarily disenrolled, for reasons other than fraud or quality of care, you may continue to receive

In-Network coverage for services delivered by the disenrolled provider, under the terms of this Handbook and your Schedule of Benefits, for the period up to, and including, your first postpartum visit.

2. Terminal Illness

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

I. CLINICAL REVIEW CRITERIA

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our clinical review criteria applicable to a service or procedure for which coverage is requested. Clinical review criteria may be obtained by calling **1-888-888-4742 ext. 38723.**

J. PROVIDER FEES FOR SPECIAL SERVICES (CONCIERGE SERVICES)

Certain physician practices charge extra fees for special services or amenities, in addition to the benefits covered by the Plan. Examples of such special physician services might include: telephone access to a physician 24-hours a day; waiting room amenities; assistance with transportation to medical appointments; guaranteed same day or next day appointments when not Medically Necessary; or providing a physician to accompany a patient to an appointment with a specialist. Such services are not covered by the Plan. The Plan does not cover fees for any service that is not included as a Covered Benefit under this Handbook or your Schedule of Benefits.

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

K. BUNDLED PAYMENT ARRANGEMENTS

The Plan may participate in bundled service arrangements with certain Providers under which a specific service or treatment is paid for based on a fixed sum for all of the Covered Benefits you receive. Member Cost Sharing for Covered Benefits under a bundled service arrangement may be less than if the Covered Benefits were received without the bundled payment arrangement. Please refer to **www.harvardpilgrim.org** or call the Member Services Department at **1-888-333-4742** for a list of Providers who have bundled payment arrangements with Harvard Pilgrim and their corresponding services. We may revise the list of Providers or services who have bundled payment arrangements upon 30 days notice to Members.