Harvard Pilgrim Health Care *of New England*

Benefit Handbook

HMO

RHODE ISLAND

EFFECTIVE DATE: 01/01/2024
FORM #LG-COC-1-2024-HPHCNE

INTRODUCTION

Welcome to the HMO (the Plan). Thank you for choosing us to help meet your health care needs.

When we use the words "we," "us," and "our" in this Handbook, we are referring to Harvard Pilgrim Health Care of New England (HPHC-NE). When we use the words "you" or "your" we are referring to Members as defined in the Glossary.

Your health care under the Plan is provided or arranged through our network of Primary Care Providers (PCPs), specialists and other providers. You must choose a PCP for yourself and each of your family members when you enroll in the Plan.

When you enroll, you receive the covered health care services described in this Handbook, your Schedules of Benefits, and the Prescription Drug Brochure (if your Plan includes outpatient pharmacy coverage). These services must be provided or arranged by your PCP, except as described in section *I.D.1. Your PCP Manages Your Health Care*.

In accordance with federal law (45 CFR § 148.180) and state law (RIGL 27-19-44), HPHC-NE does not:

- adjust Premiums based on genetic information;
- request or require genetic testing; or
- collect genetic information from an individual prior to, or in connection with enrollment in a plan, or at any time for underwriting purposes.

You can take advantage of a wide range of helpful online tools and resources for Members. For instance, **your secure online account** offers a secure place to help manage your health care. You can check your benefit documents, review claim histories, change PCPs, compare hospitals and much more! Through **your secure online account**, you can estimate health care costs for services from Plan Providers before receiving the services. You can compare cost estimates between Plan Providers. This allows you to better manage your out-of-pocket costs. For details on how to register **your secure online account**, log on to **www.harvardpilgrim.org**.

Call the Member Services Department at **1-888-333-4742** if you have any questions. Member Services staff is also available to help you with questions about the following:

- Choosing a PCP
- Your Benefit Handbook
- Your benefits
- Your enrollment
- Your claims
- Pharmacy management procedures
- Provider Information
- Requesting a Provider Directory
- Requesting a Member Kit
- Requesting ID cards

- Registering a complaint

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

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

We value your input. We appreciate hearing from you with any comments or suggestions. This will help us further improve our quality of service.

Harvard Pilgrim Health Care
Member Services Department
1 Wellness Way
Canton, MA 02021–1166
Phone: 1-888-333-4742
www.harvardpilgrim.org

Mental Health Parity Statement

The Plan provides benefit parity for mental health and substance use disorder treatment services. This means that coverage of benefits for mental health and substance use disorders is generally comparable to, and not more restrictive than, the benefits for coverage of physical health. For example:

- Member Cost Sharing and Out-of-Pocket Maximums are not more restrictive for mental health and substance use disorder treatment than for medical treatment.
- Limitations on Covered Benefits are not more restrictive for mental health and substance use disorder treatment than for medical treatment.
- Other kinds of limitations, such as requirements for Medical Necessity determinations or Prior Approval, are applied comparably to both mental health and substance use disorder treatment and medical treatment.

Medical Necessity Guidelines. We use evidence based clinical review criteria to evaluate if certain services or procedures are Medically Necessary for a Member's care. Members or their providers may obtain a copy of the Medical Necessity Guidelines that apply to a service or procedure for requested coverage. Call the Member Services Department at **1-888-333-4742** to obtain medical Necessity Guisdelines; or go to **www.harvardpilgrim.org**.

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

Language Assistance Services

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

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

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

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

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

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

العربية (Arabic)

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

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

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

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

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

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

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

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

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

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

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

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of 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 under the HMO (the Plan).

A. HOW TO USE THIS BENEFIT HANDBOOK

1. Why This Benefit Handbook Is Important

The following legal documents, together called the Evidence of Coverage (EOC), describe the services covered by the Plan and other coverage terms and conditions:

- the Benefit Handbook
- the Schedules of Benefits
- the Prescription Drug Brochure (if your Plan includes outpatient pharmacy coverage)

Also incorporated by reference is an Employer Agreement issued to your employer; it includes information on Dependent eligibility. For eligibility questions, contact your employer.

The Benefit Handbook describes how your membership works. 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 EOC online using **your secure online account** at **www.harvardpilgrim.org**.

2. Words With Special Meaning

This Handbook has words with special meaning. These words are capitalized and defined in *II. Glossary*.

3. How To Find What You Need To Know

See the Table of Contents to find information you need. Below is a description of some important Handbook sections.

The most important information is first. For example, this section explains important coverage requirements. You can avoid coverage denials by understanding Plan rules.

Medical benefits details are provided in section *III. Covered Benefits*. They are listed in the same order as in your Schedule of Benefits. Review section *III. Covered Benefits* and your Schedule of Benefits to understand your benefits completely.

B. HOW TO USE YOUR PROVIDER DIRECTORY

The Provider Directory identifies the Plan's PCPs, specialists, hospitals and other providers you must use for most services. It lists providers by state, town, specialty, and languages spoken. View the Provider Directory online at **www.harvardpilgrim.org**. You can also get a free paper copy of the Provider Directory by calling the Member Services Department at **1-888-333-4742**.

The online Provider Directory lets you search for providers by: .

- name
- gender
- specialty
- hospital affiliation
- languages spoken

- office location(s)

You can also find information about whether a provider is accepting new patients. The online Directory is updated often according to state and Federal laws. It is more current than the paper directory.

Please Note: Plan Providers participate by contractual arrangements; these can be terminated either by a provider or by us. A provider may leave the network due to retirement, relocation or other reasons. This means we cannot guarantee that a Provider you choose will remain in our network throughout your membership. We will make every effort to notify you at least 30 days in advance if your PCP is leaving the network. We will help you find a new Plan Provider. Under certain circumstances you may be eligible for transition services if your provider leaves the network (please see section *I.F. SERVICES PROVIDED BY A DISENROLLED OR NON-PLAN PROVIDER* for details).

C. MEMBER OBLIGATIONS

1. Choose a Primary Care Provider (PCP)

You must choose a Primary Care Provider (PCP) for yourself and each covered person in your family when you enroll in the Plan. You may choose a different PCP for each family member. We will assign a PCP to you if you do not choose a PCP when you first enroll, or you select a PCP who is not available.

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)

PCPs are listed in the Provider Directory. To confirm if a PCP is available, go to our website at **www.harvardpilgrim.org**; or call the Member Services Department.

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

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

2. Obtain Referrals to Specialists

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

If you need a specialist, you must contact your PCP for a Referral before the appointment. Referrals to Plan Providers must be in writing. 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.

3. Show Your Identification Card

Show your identification (ID) card every time you request health services. If you do not show your ID card, the Provider may not know you have insurance. You can order a new ID card online by using **your secure online account** at **www.harvardpilgrim.org**; or call the Member Services Department.

4. Share Costs

You must share the cost of Covered Benefits provided under the Plan. Your Member Cost Sharing may include the following:

- Copayments
- Coinsurance
- Deductibles

Your Plan also has an Out-of-Pocket Maximum. This limits the amount of Member Cost Sharing you are required to pay. Your specific Member Cost Sharing amounts are listed in your Schedule of Benefits. See section *I.E. MEMBER COST SHARING*.

5. 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. See section *IV. Exclusions* for information. Also, some services covered by the Plan are limited. These limits help maintain reasonable premium rates for all Members. See your Schedule of Benefits for any specific limits that apply to your Plan.

D. HOW TO OBTAIN CARE

IMPORTANT POINTS TO REMEMBER

1) You and each Member of your family must choose a PCP.
2) In order to receive Covered Benefits you must use Plan Providers, except as noted below.
3) If you need care from a specialist, you must call your PCP for a Referral. For exceptions, see section *I.D.7. Services That Do Not Require a Referral*.
4) In a Medical Emergency, 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.
- Care when you are temporarily traveling outside of the state where you live as described below.
- Mental health care. See section *III. Covered Benefits, Mental Health and Substance Use Disorder Treatment*.
- Special services that do not require a Referral; see section *I.D.7. 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 to find out who is available for 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. Change your PCP online by using **your secure online account** at **www.harvardpilgrim.org**; or by calling the Member Services Department. The change is effective immediately. If you choose a new PCP, all Referrals from your prior PCP become invalid. Your new PCP must 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 need to go for coverage. An exception is if a different hospital is Medically Necessary for your care.

For specialty care, your PCP will refer you to a Plan Provider affiliated with the hospital your PCP uses. This helps your PCP coordinate and maintain the quality of your care. Ask your PCP about the Referral networks that he or she uses.

If the services you need are not available through your PCP's referral network, your PCP may refer you to any Plan Provider. We will assist you if you or your PCP has a hard time finding a Plan Provider to provide the services you need. For help finding a medical, mental health, or substance use disorder treatment provider, call the Member Services Department at **1-888-333-4742**. If no Plan Provider has the expertise to meet your

medical needs, we will help you find the right Non-Plan Provider. In these cases, Prior Approval is required 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 finds that the Referral is appropriate;
2) The specialty care provider: (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 information.

Some specialty services may be obtained without asking your PCP. For information see section *I.D.7. Services That Do Not Require a Referral*.

3. Using Plan Providers

You must get Covered Benefits from a Plan Provider to be eligible for coverage. Covered Benefits from a provider who is not a Plan Provider will be covered if one of the following exceptions applies:

1) The service was received in a Medical Emergency. (See section *I.D.5. Medical Emergency Services* for information.)
2) The service was received while you were outside of the state where you live and coverage is available under the benefit for temporary travel. See section *I.D.6. Coverage for Services When You Are Temporarily Traveling Outside of the State Where You Live* for information.
3) No Plan Provider has the professional expertise needed to provide the Medically Necessary Covered Benefit. In this case, services by a Non-Plan Provider must be authorized in advance by us, unless 1) or 2) above applies.
4) Your physician is disenrolled as a Plan Provider or you are a new Member of the Plan, and an exception stated in section *I.F. SERVICES PROVIDED BY A DISENROLLED OR NON-PLAN PROVIDER* applies.

See the Provider Directory to find out if a provider is in the Plan network. The Provider Directory is available online at **www.harvardpilgrim.org**; or by calling our Member Services Department at **1-888-333-4742**.

4. Centers of Excellence

Certain specialized services are only covered when received from designated Plan Providers with special training, experience, facilities or protocols for the service. We call these Plan Providers "Centers of Excellence." Centers of Excellence are chosen by us based on the findings of recognized specialty organizations or government agencies such as Medicare.

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

- Weight loss surgery (bariatric surgery)

Important Notice: No coverage is provided for the service listed above unless received from a designated Center of Excellence. To confirm a Provider's status, see the Provider Directory at **www.harvardpilgrim.org**.

The list of services that you must get at a designated Center of Excellence may change upon 30 days' notice. Services may be added to the list if we decide that quality of care is significantly improved by receiving care at a Center of Excellence. Services may be removed from the list if we decide that there are no longer any significant advantages in quality of care to be gained by receiving care at a Center of Excellence.

5. Medical Emergency Services

In a Medical Emergency, including for substance use disorder or mental health condition, go to the nearest emergency facility; or call 911 or other local emergency number. A Referral from your PCP is not needed. Your Schedule of Benefits lists your emergency room Member Cost Sharing. 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 phone number is also on

your ID card. If an attending emergency physician provides notice to the Plan that you are in the hospital, no further notice is required. Your PCP will help to arrange for any follow-up care you may need. See the *II. Glossary* for more information on Medical Emergency Services.

6. Coverage for Services When You Are Temporarily Traveling Outside of the State Where You Live
The Plan covers urgently needed Covered Benefits for sickness or injury when you travel temporarily outside of the state where you live. You do not have to call your PCP before getting care. However, the following services are not covered:

- Care you could have foreseen before traveling outside of the state where you live;
- Routine examinations and preventive care, including immunizations;
- Follow-up care that can wait until your return.

If you are hospitalized, you must call the Plan at **1-888-333-4742** within 48 hours, or as soon as you can. This phone number is on your ID card. If we or your PCP receive notice of hospitalization from an attending emergency physician, no further notice is required. Your PCP will help to arrange for any follow-up care you may need.

You must file a claim whenever you get services from a Non-Plan Provider. For information, see section *V. Reimbursement and Claims Procedures*. Member Cost Sharing listed in your Schedule of Benefits will apply.

7. Services That Do Not Require a Referral
In most cases you need a Referral from your PCP to get covered care from any other Plan Provider. However, you do not need a Referral for the services listed below when a Plan Provider provides these services. Plan Providers are listed in the Provider Directory. Please keep your PCP informed of such care so your medical records are up-to-date. This keeps your PCP aware of your entire medical situation.

i. Family Planning Services:

- Contraceptive monitoring
- Family planning consults, including pregnancy testing
- Tubal ligation (if a covered benefit - Check your Schedule of Benefits to see if your Plan covers this benefit.)
- Voluntary termination of pregnancy (if a covered benefit - Check your Schedule of Benefits to see if your Plan covers this benefit.)

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

- Routine outpatient prenatal and postpartum care
- Consults 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 OB, GYN, certified nurse midwife or family practitioner:

- Annual GYN exam, including routine pelvic and clinical breast exam
- Cervical cryosurgery
- Colposcopy with biopsy
- Excision of labial lesions
- Follow-up care provided by an OB or GYN for conditions identified during maternity care, annual GYN visit or an evaluation for acute or emergency GYN 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 - Check your Schedule of Benefits to see if your Plan covers this benefit.)
- Pediatric dental services (if a covered benefit - Check your Schedule of Benefits to see if your Plan covers this benefit.)

v. Other Services:

- Acupuncture treatment for injury or illness (if a covered benefit - Check your Schedule of Benefits to see if your Plan covers this benefit.)
- Chiropractic care
- Nutritional counseling
- Routine eye examination (if a covered benefit - Check your Schedule of Benefits to see if your Plan covers this benefit.)
- Urgent Care services

E. MEMBER COST SHARING

Below we describe Member Cost Sharing that may apply under the Plan. See your Schedule of Benefits for the Member Cost Sharing details specific to your Plan. Your Plan may have two types of office visit cost sharing: a lower cost sharing known as "Level 1" and a higher cost sharing known as "Level 2." Member Cost Sharing may include Copayments, Coinsurance, or Deductible amounts, as described in this section.

1. Copayment

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

Your Plan may have other Copayment amounts. See your Schedule of Benefits for information about Copayments under your Plan.

2. Deductible

A Deductible is a specific dollar amount. A Deductible is:

- payable by a Member for Covered Services received each Plan Year or Calendar Year;
- paid before any benefits subject to the Deductible are paid by the Plan; and
- incurred on the date of service.

A family Deductible is met when any combination of Members in a covered family incur expenses for services subject to the Deductible. Your Plan may have different Deductibles for different Covered Benefits. Any Deductible that applies to your Plan is listed in your Schedule of Benefits.

If your Plan has a Deductible, it will have 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 Plan Year or Calendar Year. If you are a Member with Family Coverage, the Deductible can be met for the rest of the Plan Year or Calendar Year in one of two ways:

a. If a Member of a covered family meets an individual Deductible, then that Member has no further Deductible Member Cost Sharing for Covered Benefits.

b. If any number of Members in a covered family together meet the family Deductible, then all Members of the covered family have no further Deductible Member Cost Sharing for Covered Benefits. No one family member may pay more than the individual Deductible amount toward the family Deductible.

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

A Member may change to Family Coverage from Individual Coverage or to Individual Coverage from Family Coverage within a Plan Year or Calendar Year. If this happens, 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. The previously incurred Deductible amount might be greater than the new Deductible limit. If it is, the Member or family will only be responsible for applicable Copayment or Coinsurance amounts listed in his/her Schedule of Benefits.

3. Coinsurance

After the appropriate Deductible amount is met, you may be responsible for paying a Coinsurance amount. This amount is a percentage of the Allowed Amount or the Recognized Amount, if applicable. When using Plan Providers, the Allowed Amount is based on the contracted rate between HPHC-NE and the Provider. 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 payable by a Member or a family in a Plan Year or Calendar Year. Once the Out-of-Pocket Maximum is reached, no further Copayment, Deductible or Coinsurance amounts are paid by the Member. HPHC-NE pays 100% of the Allowed Amount for the rest of the Plan Year or Calendar Year. When a family Out-of-Pocket Maximum is met in a Plan Year or Calendar Year, it is considered met by all Members in a family for the rest of the Plan Year or Calendar Year.

Charges above the Allowed Amount never apply to the Out-of-Pocket Maximum.

If you have a family Plan, you have both an individual Out-of-Pocket Maximum and a family Out-of-Pocket Maximum. 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 further Member Cost Sharing for the rest of the Plan Year or Calendar Year.

b. If any number of Members in a covered family together meet the family Out-of-Pocket Maximum, then all Members of the covered family have no further Member Cost Sharing for the rest of the Plan Year or Calendar Year.

A Member may change to Family Coverage from Individual Coverage or to Individual Coverage from Family Coverage within a Plan Year or Calendar Year. If this happens, 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. The previously incurred Out-of-Pocket Maximum amount may be greater than the new Out-of-Pocket Maximum limit. If it is, the Member has no further cost sharing for that Plan Year or Calendar Year.

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

1. Disenrollment of Plan Provider

If your Provider is disenrolled as a Plan Provider, we will provide you written notice of this disenrollment. If your Provider is disenrolled for reasons unrelated to fraud or quality of care; you may be eligible to continue coverage for services provided by the disenrolled Plan Provider. Coverage may continue (i) from the disenrollment date or the date of the disenrollment member notice (whichever is later); and (ii) under the terms of this Handbook and your Schedule of Benefits, for the following services:

a. **Active Course of Treatment**

If you are undergoing an active course of treatment for an illness, injury or condition, we may authorize additional coverage through the active course of treatment or up to 1 year, (whichever is earlier). An active course of treatment includes when a member:

- has a "serious and complex condition;
- is currently undergoing a course of institutional or inpatient care;
- has a scheduled nonelective surgery including any related postoperative care; or
- is in the second or third trimester of what is documented as a non-high-risk pregnancy.

The term "serious and complex condition" is an acute illness that is serious enough to require 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**

If you are a Member and are pregnant, you may continue to receive coverage for services from your disenrolled provider. This coverage will continue through delivery and up to 6 weeks of postpartum visits immediately following childbirth or up to 1 year, (whichever is earlier).

c. **Terminal Illness**

A Member with a terminal illness may continue to receive coverage for services delivered by the disenrolled provider until the Member's death.

G. PRIOR APPROVAL

Prior Approval is required before receiving certain services. Your Plan Provider will get Prior Approval for you. your Plan Provider fails to get Prior Approval when required, you will **not** be liable for the costs.

Please Note: You do not need to get Prior Approval for services received in a Medical Emergency.

Check Section *III. Covered Benefits* to see which benefits require Prior Approval. For a detailed list of services or for updates and revisions to the Prior Approval list, visit our website at **www.harvardpilgrim.org**. If you have questions about services requiring Prior Approval, contact Member Services at **1-888-333-4742**.

H. MEDICAL NECESSITY GUIDELINES

We use evidence based clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their providers can get a copy of the Medical Necessity Guidelines applicable to a service or procedure for requested coverage. You can get Medical Necessity Guidelines by calling the Member Services Department at **1-888-333-4742**; or go to **www.harvardpilgrim.org**.

I. 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 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 that is not included as a Covered Benefit under this Handbook or your Schedule of Benefits.

In considering these types of special services, you should understand exactly what services will be provided and whether they are worth the fee you must pay. For example, the Plan does not require participating providers to be available by phone 24-hours a day. However, the Plan does require PCPs to provide both an answering service that can be contacted 24-hours a day and prompt appointments when Medically Necessary.

J. BUNDLED PAYMENT ARRANGEMENTS

The Plan may participate in bundled payment arrangements with certain Providers. In these cases, 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 payment arrangement may be less than if the Covered Benefits were received without the bundled payment arrangement. See **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 us and their services. We may revise the list of Providers or services 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 (i) to encourage use of the most appropriate and cost-effective treatment; and (ii) 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 uses disorders
- high risk pregnancies and newborn care

The Plan may work with certain providers to set up care management programs. The Plan, or providers affiliated with the care management program, may identify and contact Members who may be candidates for these programs. The Plan or providers may also contact Members to: (i) help with enrollment; (ii) develop treatment plans; (iii) establish goals; or (iv) determine alternatives to a member's current treatment plan. 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.

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.

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. However, there are exceptions. These include: (i) care in a Medical Emergency and (ii) care while traveling outside of the state where you live.

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.

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:

The Allowed Amount is the lower of the Provider's charge or a rate determined as described below:

The Allowed Amount is determined based on 150% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.

When a rate is not published by CMS for the service, we use other industry standard methodologies to determine the Allowed Amount for the service as follows:

For services other than Pharmaceutical Products, we use a methodology called a relative value scale, which is based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by Optuminsight, Inc. If the Optuminsight, Inc. relative value scale becomes no longer available, a comparable scale will be used.

For Pharmaceutical Products, we use industry standard methodologies that are similar to the pricing methodology used by CMS and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.

When a rate is not published by CMS for the service and no industry standard methodology applies to the service, or the provider does not submit sufficient information on the claim to pay it under CMS published rates or an industry standard methodology, the Allowed Amount will be 50% of the provider's billed charge, except that the Allowed Amount for certain mental health and substance use disorder treatment will be 80% of the billed charge.

Pricing of the Allowed Amount will be conducted by UnitedHealthcare, Inc. United Healthcare, 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.

Anniversary Date The date agreed to by HPHC-NE and your Employer Group upon which the yearly Employer Group premium rate is adjusted and benefit changes normally become effective. This Benefit Handbook, the Schedules of Benefits, the Prescription Drug Brochure (if your Plan includes outpatient pharmacy coverage) and the Employer Group agreement will terminate unless renewed on the Anniversary Date.

FOR EXAMPLE: If your Anniversary Date is January 1st, this is the date when the Plan goes into effect and begins to pay for Covered Benefits.

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.

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 Plan Year or Calendar Year for physical therapy services, once you reach your 30 visit limit for that Plan Year or Calendar Year, no additional benefits for that service will be covered by the Plan.

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 either a Plan Year or Calendar Year basis. Please see your Schedule of Benefits to determine which type of year your Plan utilizes.

Centers of Excellence Certain specialized services are only covered when received from designated providers with special training, experience, facilities or protocols for the service. Centers of Excellence are selected by us based on the findings of recognized specialty organizations or government agencies such as Medicare.

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%.

Community Residence Any home or other living arrangement: (1) that is established, offered, maintained, conducted, managed, or operated by any person for a period of at least 24 hours; (2) where, on a 24-hour basis, direct supervision is provided for the purpose of providing rehabilitative treatment, Habilitation Services, psychological support, and/or social guidance for three or more persons with Mental Health or substance use disorders or persons with developmental disabilities or cognitive disabilities such as brain injury. Examples include, but are not limited to, group homes, halfway homes, and fully-supervised apartment programs. Semi-independent living programs, foster care, and parent de-institutionalization subsidy aid programs are not considered community residences under this Benefit Handbook.

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 they apply to, 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.

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

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

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

Deductible A specific dollar amount the Member pays for Covered Benefits received each Plan Year or Calendar Year before any benefits subject to the Deductible are paid 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.

Deductible Rollover A Deductible Rollover allows you to apply any Deductible amount you paid for Covered Benefits during the last three months of a Plan Year or Calendar Year toward the Deductible for the next Plan Year or Calendar Year. To be eligible for a Deductible Rollover, a Member must have had continuous coverage with us through the same employer Group at the time the prior Plan Year or Calendar Year charges were incurred. Deductible Rollover amounts may also apply to the Out-of-Pocket Maximum for the next Plan Year or Calendar Year. If your Plan has a Deductible Rollover, it will be listed in your Schedule of Benefits.

Dental Care Any service provided by a licensed dentist that involves 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, under this definition, surgery performed by an oral maxillofacial surgeon to correct positioning of the bones of the jaw (orthognathic surgery) is not considered Dental Care.

Dependent A Member of the Subscriber's family who: (1) meets the eligibility requirements for coverage through a Subscriber; and (2) is enrolled in the Plan.

Employer Group or Employer An organization that has contracted with us to provide health care coverage for its employees under the Plan.

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 Rhode Island, Maine, Massachusetts and New Hampshire and certain areas in Connecticut, New York and Vermont.

Evidence of Coverage (EOC) The legal documents, including the Benefit Handbook, Schedules of Benefits, and the Prescription Drug Brochure (if your Plan includes outpatient pharmacy coverage), that describe the services covered by the Plan and other terms and conditions of coverage.

Experimental, Unproven, or Investigational Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests, and except as required by RIGL §§ 27-18-80, 27-55-2, 27-18-74, and 27-18-62, 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. To determine if a service has been recognized as safe or effective in accordance with generally accepted evidence-based medical standards, primary reliance will be placed on 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: (i) 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 (ii) 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.

Family Coverage Coverage for a Member and one or more Dependents.

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

Harvard Pilgrim Health Care of New England (HPHC-NE) Harvard Pilgrim Health Care of New England is a Massachusetts corporation that is licensed as a Health Maintenance Organization (HMO) in the state of Rhode Island. HPHC-NE provides or arranges for health care benefits to Members through a network of Primary Care Providers, specialists and other providers.

Individual Coverage Coverage for a Subscriber only. No coverage for Dependents is provided.

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 (i) a family member or friend is trained to administer the drug; and (ii) ongoing supervision by skilled medical personnel is required.

Medical Emergency A medical condition, whether physical or mental (including a condition due to 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: (1) placing the health of the Member or another person in serious jeopardy; or (2) serious impairment to body function; or (3) serious dysfunction of any body organ or part; or (4) for a pregnant woman who is having contractions, inadequate time to make a safe transfer to another hospital before delivery or that transfer may pose a threat to the woman or unborn child's health or safety.

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.

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:
  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 by the Secretary.

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 get 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 **1-888-333-4742**.

Member Any Subscriber or Dependent covered under the Plan.

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

There may be two types of office visit cost sharing that apply to your Plan: a lower cost sharing known as "Level 1" and a higher cost sharing known as "Level 2."

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

Non-Plan Provider Providers of health care services that are not under contract with us to provide care to Members.

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.

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 Benefits in a Plan Year or Calendar Year. The Out-of-Pocket Maximum is specified in your Schedule of Benefits.

Please Note: Charges above the Allowed Amount never apply to the Out-of-Pocket Maximum.

✔ FOR EXAMPLE: If your plan has an individual Out-of-Pocket Maximum of $1,000, this is the most Member Cost Sharing you will pay for out-of-pocket costs for that Plan Year or Calendar Year. As an example, the Out-of-Pocket Maximum can be reached by the following: $500 in Deductible expenses, $400 in Coinsurance expenses and $100 in Copayment expenses.

Physical Functional Impairment A condition in which the normal or proper action of a body part is damaged, and affects the ability to participate in Activities of Daily Living. Physical Functional Impairments include, but are not limited to, problems with ambulation, communication, respiration, swallowing, vision, or skin integrity.

A physical condition may impact an individual's emotional well-being or mental health. However such impact is not considered in determining whether or not a Physical Functional Impairment exists. Only the physical consequences of a condition are considered.

Plan This package of health care benefits offered by Harvard Pilgrim Health Care.

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 physicians, podiatrists, psychologists, psychiatrists, nurse practitioners, advanced practice registered nurses, physician's assistants, psychiatric social workers, certified psychiatric nurses, psychotherapists, licensed independent clinical social workers, licensed nurse mental health clinical specialist, board-certified behavior analysts (BCBAs), board-certified assistant behavioral analysts (BCaBAs), nurse midwives, nurse anesthetists, acupuncturists, licensed mental health counselors, level I

licensed alcohol and drug counselors, optometrists, and doulas (to the extent licensure or certification is required). Plan Providers are listed in the Provider Directory.

Plan Year The one-year period for which benefits are purchased and administered. Benefits for which limited yearly coverage is provided renew at the beginning of the Plan Year. Benefits for which limited coverage is provided every two years renew at the beginning of every second Plan Year. Generally, the Plan Year begins on the Plan's Anniversary Date. Benefits under your Plan are administered on either a Plan Year or Calendar Year basis. Please see your Schedule of Benefits for which type of year your Plan utilizes.

✔ FOR EXAMPLE: A Plan Year could begin on April 1st and end on March 31st or begin on January 1st and end on December 31st.

Premium A payment made to us for health coverage under the Plan.

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

Prior Approval (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.

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**.

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: (1) Applicable state law, (2) an All Payer Model Agreement if adopted, or (3) 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.

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.

✔ 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.

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.

Service Area The geographic area where Plan Providers are available to manage a Member's care.

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

Subscriber The person who meets the Subscriber eligibility requirements described in this Benefit Handbook and is enrolled in the Plan.

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.

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 from a Plan Provider or facility; 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.

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.

Urgent Care Health care services (medical, mental health, substance use or other care condition), that a prudent layperson believes requires treatment within twenty-four (24) after onset of the condition. This does not include conditions considered to be emergencies as defined in "Medical Emergency" earlier in this section.

III. Covered Benefits

This Section contains detailed information on the benefits covered under your Plan.

- If your Plan includes outpatient pharmacy coverage, see your Prescription Drug Brochure for coverage details.
- Your Schedule of Benefits lists Member Cost Sharing information and any benefit limitations that apply to your Plan.
- Benefits are administered on a Plan Year or Calendar Year basis. See your Schedule of Benefits for which type of year your Plan utilizes

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.

Benefit	Description
1 . Acupuncture Treatment for Injury or Illness	
	The Plan may cover acupuncture treatment for illness or injury, including, electro-acupuncture, that is provided for the treatment of neuromusculoskeletal pain in accordance with Rhode Island law. **Please Note:** Not all Plans cover this benefit. Check your Schedule of Benefits to see if your Plan covers this benefit.
2 . Ambulance and Medical Transport	
	Emergency Ambulance Transport Your Plan covers ambulance transport (ground, sea and air (helicopter or fixed wing)) to the nearest hospital that can provide you with Medically Necessary care. This includes transport for a medical or mental health/substance use disorder emergency. **Non-Emergency Medical Transport** You're also covered for non-emergency medical transport, including non–emergency ambulance, 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 transportation. Your Plan Provider will seek Prior Approval for you.

Benefit	Description
3 . Autism Spectrum Disorders Treatment	
	Coverage is provided for the diagnosis and treatment of Autism Spectrum Disorders to the extent required by Rhode Island law. Coverage includes: • 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. • Prescription drug coverage (if your Plan includes outpatient pharmacy coverage). 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 by Rhode Island law 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.
4 . Chemotherapy and Radiation Therapy	
	The Plan covers outpatient chemotherapy administration and radiation therapy at a hospital or other outpatient medical facility. Covered Benefits include the facility charge, the charge for related supplies and equipment, and physician services for anesthesiologists, pathologists and radiologists. **Prior Approval Required:** Prior Approval is required for radiation oncology. Your Plan Provider will seek Prior Approval for you.
5 . Chiropractic Care, including Spinal Manipulation	
	The Plan covers musculoskeletal adjustment or manipulation.
6 . Clinical Trials for the Treatment of Cancer or Other Life-Threatening Diseases	
	The Plan covers services for Members enrolled in a qualified clinical trial for the treatment, prevention or detection of any form of cancer or other life-threatening disease. Coverage is provided in accordance with the terms and conditions under Rhode Island G.L. §27-18-74 and federal law. All of the requirements for coverage under the Plan apply to coverage under this benefit. Coverage is provided under this benefit for services that are Medically Necessary for the treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the Plan. No coverage is provided for the investigational product or service itself that is the subject of the clinical trial.
7 . COVID-19 Services	
	The Plan covers the following services for COVID-19 in accordance with Rhode Island law §27-18-86 (2022): • Administration of the COVID-19 vaccine • Testing for COVID-19 There is no Member Cost Sharing for the services above.

Benefit	Description
8 . 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. **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: • 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 **Extraction of Teeth Impacted in Bone:** The Plan may cover extraction of teeth impacted in bone. Only the following services are covered: • Extraction of teeth impacted in bone • Pre-operative and post-operative care, immediately following the procedures • Anesthesia • Bitewing x-rays **Prior Approval Required:** Prior Approval is required for extraction of teeth impacted in bone. Your Plan Provider will seek Prior Approval for you. **Please Note:** Not all Plans cover this benefit. Check your Schedule of Benefits to see if your Plan covers this benefit. **Pediatric Dental Care** The Plan may cover two preventive dental exams per Plan Year or Calendar Year for children up to the age limit listed in your Schedule of Benefits. If covered under your Plan, following are the only covered services: • Cleaning • Fluoride treatment • Teaching plaque control • Bitewing x-rays **Please Note:** Not all Plans cover this benefit. Check your Schedule of Benefits to see if your Plan covers this benefit.

Benefit	Description
9 . 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 and be provided by a Plan Provider. Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care. The following items are also covered: **Diabetes Equipment:** • Blood glucose monitors • 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 **Pharmacy Supplies:** • Certain blood glucose monitors • Certain insulin pumps (including supplies) and infusion devices • Blood glucose strips • Flash glucose monitors (including supplies) • Insulin, insulin needles and syringes • Lancets • Oral agents for controlling blood sugar • Urine and ketone test strips For coverage of pharmacy items listed above, you must have the Plan's outpatient pharmacy benefit and get a prescription from your Plan Provider. Present your prescription at a participating pharmacy. Member Cost Sharing for up to a 30-day supply of insulin will not exceed $40 in accordance with state law. You can find participating pharmacies by logging into **your secure online account** at **www.harvardpilgrim.org** or by calling the Member Services Department at **1-888-333-4742**. **Prior Approval Required:** Prior Approval is required for insulin pumps and continuous glucose monitoring systems. Your Plan Provider will seek Prior Approval for you.

Benefit	Description
10 . Dialysis	
	The Plan covers dialysis on an inpatient, outpatient or at home basis. When federal law permits Medicare to be the primary payer, you must apply for Medicare and also pay any Medicare premium. When Medicare is primary (or would be primary if the Member were timely enrolled) under federal law, the Plan will cover only those costs that exceed what would be payable by Medicare. Coverage for dialysis in the home includes non-durable medical supplies, and drugs and equipment necessary for dialysis. We must approve dialysis services if you are temporarily traveling outside of the state where you live. We will cover dialysis services for up to 30 days of travel per Plan Year or 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 any service provided in the home. Your Plan Provider will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**
11 . Drug Coverage	
	You have limited coverage for drugs received during inpatient and outpatient treatment and also for certain medical supplies you purchase at a pharmacy under this Benefit Handbook. This coverage is described in Subsection 1, below. You may also have coverage for outpatient prescription drugs purchased at a pharmacy under the Plan's outpatient prescription drug coverage. Subsection 2, below, explains more about this coverage. **1) Coverage under your Medical Plan** Your medical plan covers the following: a. Drugs Received During Inpatient Care. The drug is administered to you while you are an inpatient at a hospital, Skilled Nursing Facility or other medical facility at which Covered Benefits are provided to you on an inpatient basis. b. Drugs Received During Outpatient or Home Care. These drugs are known as "Medical Drugs." A Medical Drug is administered to you either: (1) in a doctor's office or other outpatient medical facility; or (2) at home while 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: (1) a family member or friend is trained to administer the drug; and (2) ongoing supervision by skilled medical personnel is required. An example of a drug that cannot be self-administered is a drug that must be administered intravenously. Examples of drugs that can be self-administered are drugs that can be taken in pill form and drugs that are typically self-injected by the patient. c. Drugs and supplies required by law. Coverage is provided for: • certain diabetes supplies. See "Diabetes Services and Supplies" above for details on that benefit.

Benefit	Description
Drug Coverage (Continued)	
	• certain prescribed self administered anticancer medications used to kill or slow the growth of cancerous cells are covered with no Member Cost Sharing • intravenous Immunoglobulin (IVIg) therapy is covered for the treatment of Pediatric Autoimmune Neuropsychiatric Disorders and Pediatric Acute-Onset Neuropsychiatric Syndromes under this benefit. • long-term antibiotic therapy for a Member diagnosed with Lyme disease as required by law. Please note: the plan will provide coverage for a long-term antibiotic drug, including an experimental drug, for an off-label use in the treatment of Lyme disease if the drug has been approved by the United States Food and Drug Administration. • treatment of pre-exposure prophylaxis (PrEP)for the prevention of HIV and post-exposure prophylaxis (PEP to prevent HIV infection) in accordance with Rhode Island law. No coverage is provided for: (1) drugs that have not been approved by the United States Food and Drug Administration; or (2) drugs the Plan excludes or limits. This includes but is not limited to, drugs for cosmetic purposes. **Prior Approval Required:** Prior Approval is required for select Medical Drugs. Your Plan Provider will seek Prior Approval for you. **2) Outpatient Prescription Drug Coverage** In addition to the coverage provided under your medical plan, you may also have the Plan's outpatient prescription drug benefit. This benefit provides coverage for most prescription drugs purchased at an outpatient pharmacy. If you have outpatient prescription drug coverage, your Member Cost Sharing for prescription drugs purchased at a pharmacy will be listed on your Prescription Drug Schedule of Benefits and your ID card. Please see the Prescription Drug Brochure for details on this benefit.
12 . Durable Medical Equipment (DME)	
	The Plan covers DME when Medically Necessary and ordered by a Plan Provider. We will rent or buy all equipment. The cost of the repair and maintenance of covered equipment is also covered. In order to be covered, all equipment must be: • Able to withstand repeated use; • Not generally useful in the absence of disease or injury; • Normally used in the treatment of an illness or injury or for the rehabilitation of an abnormal body part; 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

Benefit	Description
Durable Medical Equipment (DME) (Continued)	
	• Certain types of braces • Crutches • Hospital beds • Oxygen and oxygen equipment • Prefabricated orthoses (e.g., knee, ankle or wrist) • Respiratory equipment • Walkers • Wheelchairs and power wheelchairs Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan. **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.
13 . Early Intervention Services	
	The Plan covers early intervention services provided for Members until three years of age. Covered Benefits include: • Assistive technology services and devices • Evaluation and case management • Nursing care • Nutrition • Physical, occupational and speech and language therapy • Service plan development and review • Psychological counseling • Screening and assessment of the need for services
14 . Emergency Room Care	
	If you have a Medical Emergency, you are covered for care in a hospital emergency room. Please remember the following: • If you need follow-up care after you are treated in an emergency room, you must call your PCP. Your PCP will provide or arrange for the care you need. • If you are hospitalized, you must call the Plan at **1-888-333-4742** within 48 hours or as soon as you can. This phone number can also be found on your ID card. If notice of hospitalization is given to the Plan or PCP by an attending emergency physician no further notice is required.
15 . 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. • Professional services relating to the injection of birth control drugs and the insertion or removal of birth control implants or devices.

Benefit	Description
Family Planning Services (Continued)	
	Please Note: An exclusion for Family Planning Services may apply when coverage is provided by a church or church-controlled organization, as allowed by law. Ask your Employer Group if this exclusion applies to your Plan.
16 . Fertility Services	
	This fertility benefit applies to Members who do not meet the definition of infertility (see Infertility Services and Treatment). This benefit is included to support inclusive family building for same sex couples, transgender and non-binary individuals, and individuals without a partner. The Plan may cover the following diagnostic services for fertility: • Consultation • Evaluation • Laboratory tests, including blood tests, sperm testing and ultrasound related to covered fertility treatments listed below. The Plan may cover fertility treatment when determined to be Medically Necessary. Only the following treatments are covered: • Intrauterine Insemination (IUI) • Donor sperm • Donor egg procedures, including related egg and inseminated egg procurement, processing and cryopreservation up to a maximum of 24 months • In Vitro Fertilization (IVF) • Reciprocal In Vitro Fertilization (IVF) Note: No coverage is provided for reciprocal IVF services for non-Members. See "*Infertility Services and Treatment*" below for information on other services related to Assistive Reproductive Technology procedures covered under the Plan. **Important Notice:** We use clinical criteria to evaluate whether the use of fertility services is Medically Necessary. If you are planning to receive fertility services, we recommend that you review the current Medical Necessity Guidelines online at **www.harvardpilgrim.org**. To get a copy, please call the Member Services Department at **1-888-333-4742**. **Prior Approval Required:** Prior Approval is required for coverage under this benefit. Your Plan Provider will seek Prior Approval for you. **Please Note:** Not all Plans cover this benefit. Check your Schedule of Benefits to see if your Plan covers this benefit.

Benefit	Description
17 . Gender Affirming Services	
	The Plan covers gender affirming services to the extent Medically Necessary and in accordance with clinical guidelines. To develop clinical guidelines and determine Medical Necessity, HPHC consults up-to-date medical standards set forth by nationally recognized medical experts in the transgender field. This includes but is not limited to those issued by the World Professional Association for Transgender Health (WPATH). When a Member meets Medical Necessity Guidelines, coverage includes: • Surgery • Related physician and behavioral health visits • Outpatient prescription drugs Procedures required in preparation for, as a component of, as a follow-up to, or as a revision to a covered treatment are also covered. **Important Notice:** We use clinical criteria/guidelines to evaluate whether gender affirming services are Medically Necessary. If you are planning to receive gender affirming services, please review the current Medical Necessity Guidelines that identify covered services under this benefit. To get a copy, please call the Member Services Department at **1-888-333-4742** or go to our website at **www.harvardpilgrim.org**. Benefits for gender affirming services are in addition to other benefits provided under the Plan. HPHC does not consider gender affirming services to be reconstructive surgery to correct a Physical Functional Impairment or Cosmetic Services. Coverage for reconstructive surgery or Cosmetic Services is limited to the services described under the Reconstructive Surgery benefit in this Benefit Handbook. **Prior Approval Required:** Prior Approval is required for coverage under this benefit. Your Plan Provider will seek Prior Approval for you.
18 . Hearing Aids	
	The Plan covers hearing aids up to the limit listed in your Schedule of Benefits, if applicable. 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 any applicable limit listed in your Schedule of Benefits, you will be responsible for the additional cost. No back-up hearing aids that serve a duplicate purpose are covered. Covered services and supplies related to your hearing aid are not subject to the dollar limit listed in your Schedule of Benefits. Covered Benefits include the following: • One hearing aid per hearing impaired ear • Except for batteries, any necessary parts, attachments or accessories, including ear moldings; and • Services provided by a licensed audiologist, hearing instrument specialist or licensed physician that are necessary to assess, select, fit, adjust or service the hearing aid. **Prior Approval Required:** Prior Approval is required for cochlear implants. Your Plan Provider will seek Prior Approval for you.

Benefit	Description
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) • Laboratory tests, x-rays, and E.K.G. evaluations • Medical and surgical supplies • Medical social services • Nutritional counseling • Prescription drugs and medication • Occupational therapy • Palliative care • Physical therapy • Services of a home health aide • Skilled nursing care • Speech therapy For information related to Medically Necessary coverage of Private Duty Nursing, see the benefit "Private Duty Nursing in The Home" later in this section. When physical, occupational and speech therapies are received as part of home health care, they are not subject to the outpatient rehabilitation benefit limit listed in your schedule of benefits. **Prior Approval Required:** Prior Approval is required for coverage under this benefit. Your Plan Provider will seek Prior Approval for you.
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 respite care is covered for the purpose of relieving the primary caregiver and may be provided up to 5 days every 3 months not to exceed 14 days per Plan Year or Calendar Year. Inpatient care is also covered in an acute hospital or extended care facility. Care must be 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

Benefit	Description
Hospice Services (Continued)	
	• Occupational therapy • Physical therapy • Speech therapy • Respiratory therapy • Respite care • Social services **Prior Approval Required:** Prior Approval is required for hospice care. Your Plan Provider will seek Prior Approval for you.
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 • 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.
22 . House Calls	
	The Plan covers house calls. Covered Benefits in the home or residence include preventive services, diagnostic treatment, and follow-up care as appropriate. A licensed or certified medical or behavioral health Provider must provide this care.

Benefit	Description
23 . Hematopoietic Stem Cell and Human Organ Transplant Services	
	The Plan covers hematopoietic stem cell and human organ transplant services. The following services are covered when the recipient is a Member of the Plan: • Care for the recipient • Donor search costs through established organ donor registries • Donor costs that are not covered by the donor's health plan If a Member is a donor for a recipient who is not a Member, then the Plan will cover the donor costs for the Member, when they are not covered by the recipient's health plan. **Prior Approval Required:** Prior Approval is required for any planned inpatient admission. Your Plan Provider will seek Prior Approval for you.
24 . Infertility Services and Treatment	
	The Plan covers infertility services and treatment in accordance with Rhode Island law. Services and treatment include standard fertility preservation services for Members not in an active infertility treatment when a Medically Necessary medical treatment may directly or indirectly cause iatrogenic infertility. Infertility is defined as the condition of a Member who has been unable to conceive or produce conception during a period of one year. Attempts at conception to satisfy the diagnosis of infertility may be done naturally or through artificial insemination. For purposes of meeting the criteria for infertility, if a person conceives but is unable to carry that pregnancy to live birth, the period of time attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the one year. Standard fertility-preservation services means procedures consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other reputable professional medical organizations. Iatrogenic infertility means fertility is impaired by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes. The Plan covers the following: • Consultation • Evaluation • Laboratory tests • Preimplantation genetic testing (PGT) When the Member meets Medical Necessity Guidelines, the Plan covers the following infertility treatment: • Therapeutic artificial insemination (AI), including related sperm procurement and banking • Assisted hatching (AH) • Donor egg procedures, including related egg and inseminated egg procurement, processing and banking • Gamete intrafallopian transfer (GIFT) • Intra-cytoplasmic sperm injection (ICSI) • Intra-uterine insemination (IUI) • In-vitro fertilization and embryo transfer (IVF)

Benefit	Description
Infertility Services and Treatment (Continued)	
	• Zygote intrafallopian transfer (ZIFT) • Microsurgical epididiymal sperm aspiration (MESA) • Testicular sperm extraction (TESE) • Frozen embryo transfer (FET) • Donor oocyte (DO/IVF) • Donor embryo/frozen embryo transfer (DE/FET) • Cryopreservation* of embryos/blastocyts • Cryopreservation* of sperm • Cryopreservation* of oocytes *Cryopreservation is limited to 24 months unless: (1) a Member is in active infertility treatment; or (2) a Member is not in active infertility treatment; but is having a Medically Necessary medical treatment that may directly or indirectly cause iatrogenic infertility; (fertility impaired by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes). **Important Notice:** We use evidence based clinical criteria to evaluate if the use of infertility treatment is Medically Necessary. Infertility treatments evolve and new treatments may be developed. If you are planning to receive infertility treatment we recommend that you review the current Medical Necessity Guidelines online at **www.harvardpilgrim.org**. For a copy, call the Member Services Department at **1-888-333-4742**. **Prior Approval Required:** Prior Approval is required for all services for the treatment of infertility. Your Plan Provider will seek Prior Approval for you.
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. Examples of radiology services include x-rays and ultrasounds. 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: • Diagnostic screenings and tests, including but not limited to, allergy testing and lead screenings and diagnostic evaluations for lead poisoning in accordance with Rhode Island law. • Prostate Specific Antigen (PSA) testing (no Member Cost Sharing applies) • Genetic testing, including biomarker testing in accordance with Rhode Island law. • 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. Testing must be performed at a facility accredited by the American Association of Blood Banks or its successors. • Screening and diagnostic mammograms, including 3–D tomosynthesis screenings.

Benefit	Description
Laboratory, Radiology and Other Diagnostic Services (Continued)	
	• Breast cancer screening procedures for a Member with dense breast tissue. Services include, but are not limited to, MRI, ultrasound, or molecular breast imaging, in accordance with American College of Radiology guidelines. **Prior Approval Required:** Prior Approval is required for biomarker testing, 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.
26 . Low Protein Foods	
	The Plan covers food products modified to be low-protein ordered for the treatment of inherited diseases of amino acids and organic acid to the extent required by Rhode Island law.
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. Please see section *VII.F. ADDING A DEPENDENT* for more enrollment information. • Routine outpatient postpartum care for the mother up to six weeks after delivery. Under this Maternity benefit, you may choose to receive certain services from a doula. A "doula" or "perinatal doula" is a trained non-medical professional; a doula provides physical, emotional, and informational support to pregnant individuals and their partners before, during, and after pregnancy. Doulas are not medical professionals. They do not deliver babies, provide medical diagnosis, treatment, or advice. They do not administer medications. Doula services are covered per pregnancy as follows (no PCP referral or prior approval required), when provided by a certified doula who is contracted with us. To locate a certified doula in our network, please call Member Services at **1-888-333-4742**. The Plan covers the following doula services: • Up to two (2) visits before birth (in-person or via telemedicine) • Attendance during labor and delivery After delivery, Covered Benefits (in-person or via telemedicine) include: • One (1) home visit by a registered nurse, certified nurse midwife, or other Provider, or • two (2) home visits by a certified doula. Additional home visits may be included when Medically Necessary. Examples of Covered Benefits include, but are not limited to, parent education, assistance

Benefit	Description
Maternity Care (Continued)	
	and training in breast or bottle feeding, and the performance of any clinical tests, as appropriate. **Please Note:** Duplicative Covered Benefits within a doula's area of professional competence will not be reimbursed. If a doula provides a Covered Service, that same service will not also be covered when received from another Provider. If another Provider provides a Covered Benefit, that same service will not also be covered when received from a doula. As an example, if you receive lactation services from a doula, we do not cover those services from another Provider such as a registered nurse or lactation consultant. **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.
28 . Medical Formulas	
	The Plan covers the following to the extent required by Rhode Island law: • 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. The Plan also covers the following: • 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 coverage under this benefit. Your Plan Provider will seek Prior Approval for you.
29 . Mental Health and Substance Use Disorder Treatment	
	The Plan covers Mental Health and Substance Use Disorder treatment. 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. Services will be covered to the extent Medically Necessary. To be covered by the Plan, all mental health and substance use disorder treatment must be provided by Plan Providers. The only exceptions apply to: (1) care required in a Medical Emergency; and (2) care when you are temporarily outside of the state where you live. Please see section *I. How the Plan Works* for more information. **Mental Health and Substance Use Disorder Treatment** Subject to the Member Cost Sharing stated in your Schedule of Benefits, the Plan provides coverage for the following Medically Necessary mental health and substance use disorder treatment services: a) **Inpatient Services** The plan covers Medically Necessary inpatient Mental Health and Substance Use Disorder treatment services. Services may be provided in an acute care hospital or a Community Residence, as applicable. b) **Intermediate Care Services** The following intermediate care services are covered when Medically Necessary: • Acute residential treatment services

Benefit	Description
Mental Health and Substance Use Disorder Treatment (Continued)	
	• Partial hospitalization Programs • Intensive outpatient Programs • Home and community Based Adult intensive services (AIS) and Child and Family Intensive Treatment (CFIT). AIS/CFIT programs offer services primarily based in the home and community for qualifying adults and children with moderate-to-severe mental health conditions. These programs consist at a minimum of ongoing emergency/crisis evaluations, psychiatric assessment, medication evaluation and management, case management, psychiatric nursing services, and individual, group, and family therapy. c) **Outpatient Services** The following outpatient services are covered when Medically Necessary: • Care by a licensed mental health professional (including online counseling through secure digital messaging) • Crisis intervention services • Substance use disorder treatment • Detoxification services • Medication management • Medication-assisted treatment, including methadone maintenance • Psychological testing We will provide coverage for Medically Necessary Outpatient or intermediate behavioral health services provided by licensed behavioral health Providers while the Member is in a tuition-based program, subject to plan rules, including any network requirements or Member Cost Sharing. **Prior Approval Required:** Prior Approval is required for certain Mental Health and Substance use Disorder treatment services. Your Plan Provider will seek Prior Approval for you.
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 . Orthoses	
	The Plan covers custom fabricated or support orthoses when ordered by a Plan Provider, as required by Rhode Island law. **Note:** See "Durable Medical Equipment" for information about prefabricated orthoses that may be covered. In order to be covered, all orthoses 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 orthosis. No back-up items or items that serve a duplicate purpose are covered.

Benefit	Description
32 . 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
33 . 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.
34 . 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 annual gynecological visit • Immunizations (including travel vaccinations), 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 • School, camp, sports and premarital examinations • Health education and nutritional counseling • Palliative care • Sickness and injury care • Vision and Hearing screenings • Medication management • Chemotherapy • Radiation therapy

Benefit	Description
35 . Private Duty Nursing Services in The Home	
	The Plan covers Medically Necessary private duty nursing services in the home for a member who is homebound*; coverage is provided when the patient requires continuous skilled nursing observation and intervention. Services must be ordered by a physician, and performed by a licensed nurse (RN or LPN) who is part of a certified home health care agency. *To be considered homebound, you do not have to be bedridden. However, your condition should be such that there exists a normal inability to leave the home and, consequently, leaving the home would require a considerable and taxing effort. If you leave the home, you may be considered homebound if those absences are infrequent or for relatively short periods of time, or to get medical treatment. **Prior Approval Required:** Prior Approval is required for coverage under this benefit. Your Plan Provider will seek Prior Approval for you.
36 . Prosthetic Devices	
	The Plan covers prosthetic devices when ordered by a Plan Provider. The cost of repair and maintenance of a covered device is also covered. 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:** Prior Approval is required for prosthetic arms and legs. Your Plan Provider will seek Prior Approval for you.
37 . 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;

Benefit	Description
Reconstructive Surgery (Continued)	
	– Reconstruction of the breast on which the mastectomy was performed; and – Surgery and reconstruction of the other breast to produce a symmetrical appearance. **Please Note:** Inpatient hospital care for mastectomies is covered for: (1) a minimum of 48 hours following a surgical procedure known as a mastectomy; and (2) a minimum of 24 hours following an axillary node dissection. Any decision to shorten this minimum coverage shall be made by the attending Provider in consultation with and upon agreement by the Member. Coverage shall also include a minimum of one home visit by a Provider or registered nurse. Benefits include coverage for procedures that must be done in stages. However, membership must be effective on all dates that 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. **Important Notice:** We use clinical guidelines to evaluate if 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.harvardpilgrim.org**. To get a copy, please call the Member Services Department at **1-888-333-4742.** **Prior Approval Required:** Prior Approval is required for coverage under this benefit. Your Plan Provider will seek Prior Approval for you.
38 . Rehabilitation Hospital Care	
	The Plan covers care in a facility licensed to provide rehabilitative care on an inpatient basis (including chronic care hospitals). Coverage is provided when you need daily Rehabilitation Services that must be provided in an inpatient setting. Rehabilitation Services include cardiac rehabilitation therapy, physical therapy, pulmonary rehabilitation therapy, occupational therapy and speech therapy. The Benefit Limit is listed in the Schedule of Benefits. **Prior Approval Required:** Prior Approval is required for coverage under this benefit. Your Plan Provider will seek Prior Approval for you.
39 . Rehabilitation and Habilitation Services – Outpatient	
	The Plan covers the following outpatient Rehabilitation and Habilitation Services: • Cardiac rehabilitation therapy • Occupational therapy • Physical therapy • Pulmonary rehabilitation therapy • Speech therapy Outpatient Rehabilitation and Habilitation Services are covered up to the Benefit Limit listed in the Schedule of Benefits. Services are covered only: • If, in the opinion of your Plan Provider, there is likely to be significant improvement in your condition within the period of time benefits are covered; and • When needed to improve your ability to perform Activities of Daily Living.

Benefit	Description
Rehabilitation and Habilitation Services – Outpatient (Continued)	
	Activities of Daily Living do not include special functions needed for occupational purposes or sports. If you are in an approved course of pulmonary rehabilitation, physical and occupational therapies are covered to the extent that they are a Medically Necessary component of the pulmonary rehabilitation. Services must be approved by the Plan. Rehabilitation and Habilitation Services are also covered under your inpatient hospital and home health benefits. When such therapies are part of an approved home care treatment plan they are available as described in section III. Covered Benefits, *Home Health Care*. **Please Note:** Outpatient physical, occupational, and speech therapies for children up to the age of 3 are covered to the extent Medically Necessary. The benefit limit stated in the Schedule of Benefits does not apply.
40 . 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
41 . Skilled Nursing Facility Care	
	The Plan covers care in a health care facility licensed to provide skilled nursing care on an inpatient basis. Coverage is provided only when you need daily skilled nursing care that must be provided in an inpatient setting. The Benefit Limit is listed in the Schedule of Benefits. **Prior Approval Required:** Prior Approval is required for coverage under this benefit. Your Plan Provider will seek Prior Approval for you.
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:** Prior Approval is required for coverage under this benefit. Your Plan Provider will seek Prior Approval for you.

Benefit	Description
43 . Telemedicine Virtual Visit Services	
	The Plan covers Medically Necessary telemedicine services for the purpose of diagnosis, consultation, or treatment in the same manner as an in-person visit. Telemedicine services substitute for an in-person visit with a plan Provider when Medically Necessary and clinically appropriate. Visits are available for both medical and mental health and substance use disorder treatment. Telemedicine includes the delivery of clinical healthcare services by use of real time, two-way synchronous audio, video, telephone-audio-only communications or electronic media or other telecommunications technology. This includes, but is not limited to: • on-line adaptive interviews • remote patient monitoring devices • audiovisual communications • the application of secure video conferencing or store and forward technology to provide or support healthcare delivery
44 . Temporomandibular Joint Dysfunction Services	
	The Plan covers medical treatment of Temporomandibular Joint Dysfunction (TMD). Only the following services are covered: • A physician consult • Physical therapy, (subject to the visit limit for outpatient physical therapy listed in the Schedule of Benefits) • Surgery • X-rays **Important Notice:** No Dental Care is covered for the treatment of Temporomandibular Joint Dysfunction (TMD). **Prior Approval Required:** Prior Approval is required for surgery under this benefit. Your Plan Provider will seek Prior Approval for you.
45 . Travel Reimbursement Benefit	
	The Plan will reimburse you for travel expenses related to Covered Benefits that are restricted by law in the state where you reside. Examples may include voluntary termination of pregnancy and gender affirming surgery for minors. 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 services, car rental, tolls, and parking expenses 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 and will not count toward a daily travel maximum if one has been established by your employer.

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. You must also provide proof of membership and proof of payment. See section *V. Reimbursement and Claims Procedures* for information on how to submit for reimbursement. To obtain a reimbursement form, please contact the Member Services Department at **1-888-333-4742** or go 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 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. They are often located in stores, supermarkets or pharmacies. To see a list of convenience care clinics covered by the Plan, please refer to your Provider Directory. 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. This includes mental health and substance use disorder services. Urgent care centers are independently owned and operated centers. They 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. Search under "urgent care." (3) **Hospital urgent care centers:** Some hospitals provide treatment for urgent care services as part of the hospital's outpatient services. This includes mental health and substance use disorder services. A hospital urgent care center may be located within a hospital. Or it may be located at a satellite location separate from the hospital. These urgent care centers are owned and operated by the hospital; they are considered a department of the hospital. They are staffed by doctors, nurse practitioners, and physician assistants. They provide treatment for illnesses and injuries that require urgent attention but are not life threatening. These services are considered outpatient hospital services. That means when you look in the Provider Directory only the hospitals are listed. These services may require higher Member Cost Sharing than urgent care services received at independent urgent care centers.

Benefit	Description
Urgent Care Services (Continued)	
	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 due to 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 • Care for sudden extreme anxiety • Treatment for minor illnesses and infections, including earaches • Treatment for minor sprains or strains You do not need to get a Referral from your PCP to be covered for Urgent Care. Whenever possible, you should contact your PCP before you get Urgent Care. Your PCP may be able to provide the services you need 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 think 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	
	Routine Eye: The Plan may cover routine eye examinations. **Please Note:** Not all Plans cover this benefit. Check your Schedule of Benefits to see if your Plan covers this benefit. **Vision Hardware for Special Conditions:** The Plan provides coverage for contact lenses or eyeglasses needed for the following conditions: • Keratoconus. The following coverage is provided per Plan Year or Calendar Year: (1) one pair of contact lenses; (2) lenses replacement limited to 3 per affected eye due to a change in the Member's condition. • Post cataract surgery with an intraocular lens implant (pseudophakes). The following coverage is provided per Plan Year or Calendar Year: (1) up to $140 per surgery toward the purchase of eyeglass frames and lenses; (2) up to $140 for lenses replacement due to a change in the Member's prescription of .50 diopters or more within 90 days of the surgery. • Post cataract surgery without lens implant (aphakes). The following coverage is provided per Plan Year or Calendar Year: (1) one pair of eyeglass lenses or contact lenses; (2) up to $50 toward the purchase of eyeglass frames; (3) lenses replacement due to a change in the Member's condition; (4) lenses replacement limited to 3 per affected eye due to wear, damage, or loss.

Benefit	Description
Vision Services (Continued)	
	• Post retinal detachment surgery. For a Member who wore eyeglasses or contact lenses prior to retinal detachment surgery: the Plan covers the full cost of one lens per affected eye up to one Plan Year or Calendar Year after the date of surgery. For Members who have not previously worn eyeglasses or contact lenses: the Plan covers either (i) a pair of eyeglass lenses and up to $50 toward the purchase of the frames; or (ii) a pair of contact lenses.
48 . Voluntary Sterilization	
	The Plan may cover voluntary sterilization, including tubal ligation and vasectomy. **Please Note:** Not all Plans cover this benefit. Check your Schedule of Benefits to see if your Plan covers this benefit.
49 . Voluntary Termination of Pregnancy	
	The Plan may cover voluntary termination of pregnancy. **Please Note:** Not all Plans cover this benefit. Check your Schedule of Benefits to see if your Plan covers this benefit.
50 . Wigs and Scalp Hair Prostheses	
	The Plan covers wigs and scalp hair prostheses up to the benefit limit listed in your Schedule of Benefits when needed for hair loss due to treatment for: (1) any form of cancer or leukemia; (2) a certain pathologic condition such as alopecia areata, alopecia totalis, alopecia medicamentosa; or (3) permanent loss of scalp hair due to injury.

If you reside and work in New Hampshire, you may be eligible for New Hampshire mandated benefits. Please contact Member Services for more details.

If you live outside of Rhode Island, your coverage may include benefits required by laws of your state. Please contact Member Services for more details.

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, except when specifically listed as a Covered Benefit. Check your Schedule of benefits to see if your Plan covers this benefit. 2. Acupuncture services that are outside the scope of standard acupuncture care. 3. Alternative, holistic or naturopathic services, and all procedures, laboratories and nutritional supplements associated with such treatments. 4. Aromatherapy, treatment with crystals and alternative medicine. 5. Any of the following types of programs (including tuition-based programs): • health resorts, spas • recreational programs, camps, outdoor skills programs, and wilderness programs (therapeutic outdoor programs) • therapeutic or educational boarding schools • educational programs for children in residential care • self-help programs • life skills programs • relaxation or lifestyle programs 6. Massage therapy. 7. Myotherapy.
2 . Dental Services	
	1. Dental Care; except the specific dental services listed as Covered Benefits in this Benefit Handbook and your Schedule of Benefits. 2. Extraction of teeth, except when specifically listed as a Covered Benefit. Check your Schedule of Benefits to see if your Plan covers this benefit. 3. Pediatric dental care, except when specifically listed as a Covered Benefit. Check your Schedule of Benefits to see if your Plan covers this benefit. 4. Temporomandibular Joint Dysfunction (TMD) care, except for the specific medical treatments listed as Covered Benefits in this Benefit Handbook.
3 . Durable Medical Equipment, Orthoses 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.

Exclusion	Description
4 . Experimental, Unproven or Investigational Services	
	1. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.
5 . Foot Care	
	1. Non-custom and prefabricated foot orthotics, fittings and arch supports, except for therapeutic/molded shoes and shoe inserts for a Member diagnosed with severe diabetic foot disease or other systemic illnesses that compromise the blood supply to the foot. 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. **Note:** A systemic circulatory disease is defined as a metabolic, neurological, or peripheral vascular disease resulting in decreased sensation or severe circulatory compromise in the patient's legs or feet; this includes but is not limited to diabetes.
6 . Maternity Services	
	1. Planned home births. 2. Routine pre-natal and post-partum care when you are traveling outside the Service Area. 3. The following doula services or expenses: • Travel expenses and mileage; • Any childcare services or services for children other than the newborn; • Housekeeping assistance; and • Doula services provided in connection with home births.
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. Sensory integrative praxis tests. 3. 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 Children, Youth and Families; or (2) provided by the Department of Behavioral Healthcare. 4. Services or supplies for the diagnosis or treatment of mental health and substance use disorders that, in the reasonable judgment of the Plan, are any of the following: • Not consistent with prevailing national standards of clinical practice for the treatment of such conditions. • Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome. • Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.

Exclusion	Description
Mental Health and Substance Use Disorder Treatment (Continued)	
	5. 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 review for 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 toward symptom reduction and functional recovery related to specific mental health disorders. • tuition based programs that offer educational, vocational, recreational, or personal developmental activities.
8 . Physical Appearance	
	1. Cosmetic services, including drugs, devices, treatments and procedures; except for: • cosmetic services that are incidental to the correction of a Physical Functional Impairment • restorative surgery to repair or restore appearance damaged by an accidental injury • post-mastectomy care • gender affirming procedures and related services 2. Electrolysis or laser hair removal, except for what is Medically Necessary as part of gender affirming services. 3. Hair removal or restoration, including, but not limited to transplantation or drug therapy. 4. Liposuction, except for what is Medically Necessary as part of gender affirming services, or removal of fat deposits considered undesirable. 5. Skin abrasion procedures performed as a treatment for acne. 6. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). 7. 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 reduction/enhancement • panniculectomy • removal of redundant skin • silicone injections (e.g. for breast enlargement), except for what is Medically Necessary as part of gender affirming services or another Covered Benefit 8. Treatment for skin wrinkles and skin tags or any treatment to improve the appearance of the skin.

Exclusion	Description
Physical Appearance (Continued)	
	9. Treatment for spider veins. 10. 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 • 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. Note: Your employer may participate in other wellness and health improvement incentive programs we offer. Please review all your Plan documents for any incentive amounts 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 • foods of any kind (including high protein foods and low carbohydrate foods) 5. Physical examinations and testing for insurance, licensing or employment. 6. Services for Members who are donors for non-Members, except as described under Human Organ Transplant Services. 7. Testing for central auditory processing. 8. Group diabetes training, educational programs or camps.
10 . Providers	
	1. Charges for services which were provided after the date on which your membership ends. 2. Charges for any products or services, including, but not limited to, the following when related to any care that is not a Covered Benefit under this Handbook: • Professional fees • medical equipment • drugs • hospital or other facility charges that are related to any care that is not a Covered Service under this Handbook 3. Charges for missed appointments.

Exclusion	Description
Providers (Continued)	
	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. 7. Provider's charge to file a claim or to transcribe or copy your medical records. 8. Services or supplies provided by: • anyone related to you by blood, marriage or adoption • anyone who ordinarily lives with you
11 . Reproduction	
	1. Any form of Surrogacy or services for a gestational carrier other than covered maternity services. 2. Birth control drugs, implants and devices. This exclusion may apply when coverage is provided by a church or church controlled organization, as allowed by law. Check your Schedule of Benefits to see if your Plan covers this benefit. 3. Infertility drugs if a Member is not in a Plan authorized cycle of infertility treatment. 4. Any reproductive related services or drugs for members who are not medically infertile, except when specifically listed as a Covered Benefit. 5. Infertility treatment for Members who are not medically infertile, except as otherwise listed in this Benefit Handbook. 6. Intrauterine insemination (IUI) services provided in the home. 7. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). 8. Sperm collection, freezing and storage except as described in section *III. Covered Benefits*. 9. Sperm identification when not Medically Necessary (e.g., gender identification). 10. The following fees: wait list fees, non-medical costs, shipping and handling charges etc. 11. Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit. Check your Schedule of Benefits to see if your Plan covers this benefit. 12. Voluntary termination of pregnancy, except when specifically listed as a Covered Benefit. Check your Schedule of Benefits to see if your Plan covers this benefit.
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.

Exclusion	Description
13 . Telemedicine Services	
	1. Telemedicine services involving e-mail, fax or an automated computer program used to diagnose and/or treat ocular or refractive conditions. 2. Provider fees for technical costs for the provision of telemedicine services.
14 . Types of Care	
	1. Recovery programs including rest or domiciliary care, sober houses, transitional support services, and therapeutic communities. 2. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. 3. Pain management programs or clinics. 4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. 5. Private duty nursing services as follows: • Services when the primary duties are limited to bathing, feeding, exercising, homemaking, giving oral medications or acting as a companion or sitter • Services provided by a member of your household or the cost of any care provided a Member's relatives (by blood, marriage, or adoption) • Services after the caregiver or patient has demonstrated the ability to carry out the plan of care • Services that are provided outside the home (for example, school, nursing facility or assisted living facility) • Services that duplicate or overlap services (for example, when a person is receiving hospice care services or for the same hours of a skilled nursing home care visit) • Services for observation only • Services of a nurse's aide • Services for a person without an available caregiver in the home (twenty-four hour private duty nursing is not covered) • Maintenance care when the condition has stabilized (including routine ostomy care or tube feeding administration, or if the anticipated need is indefinite • Respite care (for example, care during a caregiver's vacation) or private duty nursing so that the caregiver may attend work or school 6. Sports medicine clinics. 7. 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 phone 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 exams, except when specifically listed as a Covered Benefit. Check your Schedule of Benefits to see if your Plan covers this benefit.
16 . All Other Exclusions	
	1. Any service or supply furnished in connection with a non-Covered Benefit. 2. 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. 3. 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). 4. Any service or supply (with the exception of contact lenses) purchased from the internet. 5. Beauty or barber service. 6. Diabetes equipment replacements when solely due to manufacturer warranty expiration. 7. Donated or banked breast milk. 8. Externally powered exoskeleton assistive devices and orthoses. 9. Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law and prescribed for Members who meet HPHC policies for enteral tube feedings. 10. Guest services. 11. Medical equipment, devices or supplies except as listed in this Benefit Handbook. 12. 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. 13. Reimbursement for travel expenses, except as listed in this Benefit Handbook. 14. The following travel expenses associated with the travel reimbursement benefit : • Alcohol and tobacco • Childcare expenses • Entertainment • Expenses for anyone other than you and your companion

Exclusion	Description
All Other Exclusions (Continued)	
	• First class, business class and other luxury transportation services • Lodging other than a hotel or motel • Lost wages • Meals • Personal care and hygiene items • Telephone calls • Tips and gratuities 15. Services for non-Members. 16. Services for which no charge would be made in the absence of insurance. 17. Services for which no coverage is provided in this EOC. 18. 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. 19. Services that are not Medically Necessary. 20. Services your PCP or a Plan Provider has not provided, arranged or approved except as described in the *Handbook* sections *"Your PCP Manages Your Health Care"* and *"Using Plan Providers"*. 21. Taxes or governmental assessments on services or supplies. 22. 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. 23. Transportation by wheelchair vans. 24. Voice modification surgery, except when Medically Necessary for gender affirming services. 25. The following products and services: • Air conditioners, air purifiers and filters, dehumidifiers and humidifiers • Car seats. • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners • Electric scooters • Exercise equipment • Home modifications including but not limited to elevators, handrails and ramps • Hot tubs, Jacuzzis, saunas or whirlpools • Mattresses • Medical alert systems • Motorized beds • Pillows • Power-operated vehicles • Stair lifts and stair glides • Strollers

Exclusion	Description
All Other Exclusions (Continued)	
	• 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 receive services from a non-Plan Provider. This should happen only when you get care:

- In a Medical Emergency; or
- When you are temporarily traveling outside of the state where you live.

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 Member Cost Sharing that applies if the service was provided by a Plan Provider. HPHC 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 beyond the applicable Member Cost Sharing based on the Recognized Amount. You are not responsible, and a Non-Plan Provider cannot bill you, for:

- Amounts beyond your Member Cost Sharing, based on the Recognized Amount, for non-emergency ancillary Covered Benefits received at certain In-network facilities from a Non-Plan Provider.
- Amounts beyond 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 beyond your Member Cost Sharing, based on the Recognized Amount, for Covered Benefits that are Medical Emergency Services provided by a Non-Plan Provider.
- Amounts beyond your 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, please call our Member Services Department at **1-888-333-4742**.

B. REIMBURSEMENT FOR BILLS YOU PAY

If you pay a Plan Provider for a Covered Benefit, we will reimburse you less the Member Cost Sharing that applies. Claim reimbursements must be submitted to the following addresses:

Pharmacy Claims:

OptumRx
Manual Claims
P.O. Box 650334
Dallas, TX 75265–0334

All Other Claims:

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

To be reimbursed for a bill you paid, you must submit an HPHC medical reimbursement form. Note: for pharmacy items see below. The form must include 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 medical reimbursement form must include all 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 provided
- The CPT code (or a brief description of the illness or injury) for which payment is requested
- 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, call our Member Services Department at **1-888-333-4742**.

A medical reimbursement form can be obtained online at **www.harvardpilgrim.org** or call the Member Services Department at **1-888-333-4742**.

1. International Claims

For reimbursement of services received while outside of the United States, you must submit an HPHC medical reimbursement claim form. You must include an itemized bill and proof of payment. We may require you to provide more documentation, including, but not limited to:

- records from financial institutions clearly showing you paid for the services that are the subject of the claim
- the source of funds used for payment
- an English translated description of the services received

2. Pharmacy Claims

To get reimbursement for pharmacy bills you paid, you must submit a Prescription Claim Form. You can get this form online at **www.harvardpilgrim.org**; or call the Member Services Department at **1-888-333-4742**.

Along with this form, you must send a drug store receipt that shows the items you are asking to be reimbursed..

The following information must be on the Prescription Claim Form:

- The Member's name and Plan ID number
- The name of the drug or medical supply
- The quantity
- The number of days supply of the medication provided
- The date the prescription was filled
- The prescribing provider's name
- The pharmacy name and address
- The amount you paid

If you have a question regarding your reimbursement, you should contact the Member Services Department at **1-888-333-4742**.

C. TIME LIMITS ON FILING CLAIMS

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

Benefits may be denied if claims are not filed in a timely manner as stated below..

Clean, electronic claims will be reviewed within 30 days of receipt. Complete, written claims will be reviewed within 40 days of receipt. Claims related to Surprise Bills will be reviewed within 30 days. If a claim cannot be paid within that time, HPHC will notify the provider in writing:

a. of any additional information or documentation necessary for payment; or

b. that the claim is denied, in whole or in part, and the reasons for denial.

D. PAYMENT LIMITS

We limit the amount we will pay for services that are not received from Plan Providers. The most we 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.

E. MISCELLANEOUS CLAIMS PROVISIONS

Generally, benefits will be paid to: (1) the Member who received the services for which a claim is made; or (2) directly to the health care provider whose charge is the basis for the claim.

Any payment by HPHC-NE in accordance with the terms of this Handbook will discharge HPHC-NE from all further liability to the extent of such payment.

VI. Appeals and Complaints

This section explains our procedures for processing appeals and complaints. It also explains your options if an appeal is denied.

A. ABOUT OUR APPEAL AND COMPLAINT PROCEDURES

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

- An appeal may be filed when a Member is denied coverage. This includes either: (i) the denial of a health service a Member requested; or (ii) the denial of payment for a health service that a Member received.
- A complaint may be filed when a Member has a concern or issue with any action we take or our services. Please note: an appeal is submitted for a denial of coverage for health services, not a complaint.

Please file appeals and complaints at the addresses or phone numbers listed in this section.

1. Member Representation

A Member's authorized representative may file an appeal or complaint. He/she may participate in any part of the appeal or complaint process. Any notice described in this section will be provided to the Member or, upon request, the Member's representative.

A Member's representative may be any person appointed in writing to represent the Member in a specific appeal or complaint such as:

- a guardian
- a conservator
- an agent under a power of attorney
- a health care agent under a health care proxy
- a family member

We may require documentation that a representative meets one of the above criteria.

2. Membership Required for Coverage

To be eligible for coverage, a Member must be enrolled under the Plan on the date a service is received. An appeal decision approving coverage is not valid for services received after membership ends. However, payment may be made after membership ends for services received while someone is still a Member under the Plan.

B. HOW TO FILE AN APPEAL

An appeal may be filed in person, by mail, by fax, by phone and electronically through the secure online portal.

Please submit appeals to:

HPHC-NE Appeals and Grievances Department
1 Wellness Way
Canton, MA 02021
Telephone: 1-888-333-4742
Fax: 1-617-509-3085
www.harvardpilgrim.org

C. THE APPEAL PROCESS

Our internal appeal process is available whenever a Member is denied coverage. This includes either: (i) the denial of a health service based on Medical Necessity; or (ii) the denial of payment for a non-Covered Benefit.

1. How to File an Appeal
Appeals may be filed in person, by mail, by fax or by phone at the addresses or phone numbers listed in section *VI.B. HOW TO FILE AN APPEAL*. After an appeal is filed, we will appoint an Appeals and Grievances Analyst. This Analyst is responsible for the appeal during the appeal process.

Note: If you need help, contact Rhode Island's health insurance consumer assistance program:

RIREACH
300 Jefferson Blvd, Suite 300
Warwick, RI 02888
Telephone: 1–401–207–0101
www.ripin.org

2. Time Limit for Filing Appeals
You have 180 days from the date you were notified of the denial of a Covered Benefit (or claim payment) to file an internal appeal.

3. Documentation of Oral Appeals
If an appeal is filed by phone, a Member Services Representative will write a summary of the appeal and send it to the Appeals and Grievances Department.

4. Acknowledgment of Appeals
We will acknowledge your appeal in a written letter. This letter will include the name, address and phone number of the Appeals and Grievances Analyst managing your appeal. Your Appeals and Grievances Analyst is available to answer any questions you have about your appeal or the appeal process. The time limit for the appeal may be extended to 45 days if: (1) the Member has requested an extension to submit more information; or (2) we inform the Member that more information is needed to make a decision.

5. Release of Medical Records
An appeal may require the review of medical information. A signed and dated authorization from the Member or the Member's authorized representative is required to release or obtain protected health information. This form must be signed and dated by the member or the Member's authorized representative. When signed by an authorized representative, appropriate proof of authorization to release or obtain protected health information must be provided. If an authorization to release or obtain protected health information is not provided when the appeal is filed, the Appeals and Grievances Analyst will promptly send a blank form to the Member or the Member's representative. If the signed and dated authorization form is not received within 30 days of the date the appeal is received, we may issue a decision based on the information already in the file.

6. Time Limit for Processing Appeals
Members will be provided with a written appeal decision within 30 days of the date the appeal was received. The time limit may be extended to 45 days if: (1) the Member has requested an extension in order to submit more information; or (2) we inform the Member that more information is needed to make a decision.

7. The Appeal Process
Upon receipt of an appeal, we will review, investigate and decide the appeal within the applicable time limit. The time limit may be extended by mutual agreement.

The Appeals and Grievances Analyst will investigate the appeal and determine if more information is required from the Member. This information may include: (i) medical records; (ii) statements from doctors; and (iii) bills and receipts for services the Member received. The Member may also provide us with any written comments, documents, records or other information related to the claim. If we need more information to decide an appeal, the Appeals and Grievances Analyst will contact the Member to request the information needed.

Appeals may involve a medical necessity determination. A health care professional will review the appeal. This reviewer will be in active practice in the same or similar specialty as the medical specialty that typically treats the condition that is the subject of the appeal. The health care professional conducting the review will not have either (i) participated in any prior decision on the Member's appeal; or (ii) be the subordinate of such a person.

We will make a decision following the investigation and review of the appeal. We will consider the following review criteria when making the decision:

- the benefits and the terms and conditions of coverage stated in this Handbook and Schedule of Benefits
- the views of medical professionals who have cared for the Member
- the views of any specialist who has reviewed the appeal
- any relevant records or other documents provided by the Member
- any other relevant information available to us

Our appeal decision will be sent to the Member in writing. The decision will identify: (1) the specific information considered in the appeal; (2) an explanation of the basis for the decision; and (3) reference to the plan provisions used to make the decision. If the decision is to deny coverage based on a Medical Necessity determination, the decision will include:

- the specific information the decision was based on
- the Member's presenting symptoms or condition, diagnosis and treatment interventions
- the specific reasons the medical evidence does not meet the relevant medical review criteria
- identification of any alternative treatment option covered by us
- the applicable clinical practice and review criteria information used to make the decision

The decision will also include the steps to request external review by an independent review organization (IRO). IROs are designated by the Rhode Island Office of the Health Insurance Commissioner. The option to request external review is described in section *VI.E. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED*.

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

Note: Prior to issuing any adverse benefit determination, the review process will comply with Rhode Island law 27–18.9–7(b)(3).

D. THE EXPEDITED APPEAL PROCESS

1. Expedited Appeals Process

We will provide an expedited review if your appeal involves services that:

- if delayed, could seriously jeopardize your life or health or ability to regain maximum function;

  are ongoing and about to terminate.

  involve emergent health care services defined as the following:
  - services provided for the sudden onset of a medical, mental health, substance use disorder, or other health care condition; and
  - such condition manifests itself by acute symptoms of a severity (e.g., severe pain}; and
  - the absence of immediate medical attention could reasonably be expected by a prudent layperson to result in placing your health in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any body organ or part)
- are ongoing and about to terminate.

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

We will make an expedited appeal decision within 72 hours from receipt of the appeal. Our decision will be sent to the Member in writing.

If you are filing an expedited appeal with HPHC, you may file a request at the same time for expedited external review with an independent review organization (IRO). You do not have to wait until HPHC completes your

expedited appeal to file for an expedited external review. See the section *VI.E. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED*, "External Review" for information on how to file for external review.

2. Continuation of Services Pending Expedited Appeal

If an expedited appeal is filed concerning an ongoing service about to end, the coverage will be continued until our internal expedited appeal process is completed if:

- We authorized the service when the service began;
- The service was not ended or reduced due to a benefit limit under this Handbook or Schedule of Benefits;
- The person making the appeal continues to be a duly enrolled Member under this Handbook; and
- The appeal is filed on a timely basis, based on the course of treatment.

E. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED

If you disagree with the appeal decision, you may have options for further review. These may include: (1) external review by an independent review organization (IRO) appointed by the Rhode Island Office of the Health Insurance Commissioner (OHIC); or (2) legal action. Below is a summary of these options.

1. External Review

Any Member who wishes to contest a final appeal decision involving a medical necessity determination may request external review of the decision by an IRO. IROs are under contract with the Rhode Island Office of the Health Insurance Commissioner (OHIC). Assignment of IROs to perform these external reviews is on a rotational basis as directed by OHIC. To obtain external review, a written request must be filed with us within 4 months of receipt of the written notice of our appeal decision. There is no filing fee and no minimum dollar claim amount required to request an external appeal.

If you need to submit more information to us, you have at least five (5) business days for standard appeals or 24 hours for expedited appeals. . HPHC-NE considers all medical exigencies when handling an external review. We will process the request as quickly as possible. We will forward the complete review file to the IRO no later than five (5) business days for standard appeals and two (2) business days of receipt of your written request. The review file will include the criteria we used to make our decision. The IRO's external review shall be based on the following:

- the review criteria used by the Plan to make the internal appeal determination;
- the Medical Necessity for the care, treatment or service for which coverage was denied; and
- the appropriateness of the service delivery for which coverage was denied.

The IRO shall notify you and your Provider of record of its external appeal decision to uphold or overturn the appeal:

- no more than 10 calendar days from receipt of all of the information necessary to complete the review for standard appeals (within 72 hours from receipt of the request for expedited appeals); and
- not greater than forty-five (45) calendar days after receipt of the request for external review.

The decision of the IRO is binding. However, any person who is not satisfied with the IRO's final decision is entitled to judicial review in a court of competent jurisdiction.

If the IRO overturns the Plan's appeal decision, we will send you a written notice within five (5) business days of receipt of the written decision from the IRO. This notice will:

- acknowledge the decision of the IRO;
- advise you of any additional steps you need to take to receive the requested coverage or services;
- advise you of the date when we or our delegate will issue payment or authorize services; and
- include the name and phone number of the person at HPHC-NE who will help you with final resolution of the appeal.

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

2. Legal Action

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

F. THE FORMAL COMPLAINT PROCEDURE

Complaints may be filed in person, by mail, by fax or by phone at the addresses or phone numbers listed earlier in this section. An Appeals and Grievances Analyst will investigate each complaint and respond in writing.

1. Documentation of Oral Complaints

If a complaint is filed by phone, a Member Services Representative will write a summary of the complaint and send it to the Appeals and Grievances Department.

2. Acknowledgment of Complaints

We will acknowledge written complaints in writing. In our letter, we will include the name, address and phone number of the Appeals and Grievances Analyst who will manage your complaint. Your Appeals and Grievances Analyst is available to answer questions you have about your complaint or the process.

3. Release of Medical Records

Any complaint that requires review of medical information must include a signed authorization to release or obtain protected health information. This form must be signed and dated by the Member or the Member's authorized representative. When signed by an authorized representative, appropriate proof of authorization to release or obtain protected health information must be provided. If this authorization is not provided when the complaint is filed, a Member Services Representative will send a blank form to the Member or the Member's representative. If a signed authorization to release or obtain protected health information is not received within 30 days of the date the complaint is received, we may respond to the complaint without the missing information.

4. Time Limit for Responding to Complaints

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

VII. Eligibility

Important Notice: Your membership in the Plan is effective on the date of enrollment by your Employer Group. We may not have current information on membership status. Your employer may notify us of enrollment changes retroactively. As a result, the information we have regarding membership status may not be current. Only your Employer Group can confirm membership status.

This section describes eligibility requirements under the Plan. Eligibility of Dependents and effective dates of coverage are determined by the Employer Group.

A. MEMBER ELIGIBILITY

1. Residence Requirement

To be eligible for Plan coverage, you must live, and maintain a permanent residence, within the Enrollment Area at least nine months of a year.

If you have any questions about these requirements, you may call the Member Services Department.

2. Subscriber Eligibility

To be a Subscriber under this Plan, you must:

- Be an employee of an Employer Group, in accordance with employee eligibility guidelines agreed to by the Employer Group and us; and
- Be enrolled through an Employer Group that is up-to-date in premium payments for coverage.

We have the right to examine an Employer Group's records, including payroll records, to verify eligibility and premium payments.

3. Dependent Eligibility

Unless an employer has elected different types of coverage for Dependents, a Dependent must meet one of the coverage requirements listed below to be eligible for the Plan. Please note that to the extent allowed by law, employers may elect: (i) different coverage for Dependents; and (ii) different ages for the termination of Dependents. Please consult your Employer Group's Benefits Office for specific Dependent eligibility requirements that apply to your Plan.

To be eligible as a Dependent, an individual must be one of the following:

1) The legal spouse of the Subscriber. A legal spouse means the same-sex or opposite-sex spouse of the Subscriber who has entered into a legally valid marriage or civil union in a jurisdiction where such marriage or civil union is legal. We recognize same-sex spouses and partners in a civil union subject to the Employer's eligibility policies.
2) The former spouse of the Subscriber. Eligibility may continue until one of the following, whichever comes first: (1) the Subscriber or the former spouse remarries; or (2) until the divorce judgment between them no longer requires the Subscriber to provide health coverage to the former spouse.

   Please Note: After the Subscriber remarries, a former spouse may continue coverage through an individual contract, if providing such coverage is: (1) required by the divorce judgment; and (2) the applicable premium for such coverage is paid to us. There is no coverage for the former spouse after he or she remarries.
3) A child (including an adopted child) of the Subscriber or spouse of the Subscriber until the end of the month in which the child turns 26.
4) A child (including an adopted child) of the Subscriber or spouse of the Subscriber, age 26 years or older who meets each of the following requirements: (a) is currently Disabled; and (b) remains financially dependent on the Subscriber. The term "Disabled" means unable to engage in any substantial gainful activity by reason of a specific medically determinable physical or mental impairment which can be expected to last, or has lasted, for at least 12 months or result in death.

5) A child for whom the Subscriber or Subscriber's spouse is the court appointed legal guardian for the duration of the guardianship or up to age 26, whichever comes first. Proof of guardianship must be submitted to us prior to enrollment.

6) The unmarried child of an enrolled Dependent child of the Subscriber (or the Subscriber's enrolled spouse) until (1) the child's parent is no longer an eligible Dependent; or (2) the child reaches age 19; whichever occurs first. There is no coverage under this paragraph unless the enrolled Dependent parent has legal custody of the child.

We may require reasonable evidence of eligibility from time to time.

B. EXTENSION OF BENEFITS

If you are totally disabled on the date your Plan ends, you will continue to receive Covered Benefits for 12 months. All Covered Benefits must be:

- Medically Necessary;
- Provided while the total disability lasts; and
- Directly related to the condition that cause the Member to be totally disabled on that date.

All the terms, conditions and limitations of coverage under the Plan will apply during the extension of benefits. The extension of benefits will end on the earliest of: (1) the date the total disability ends; (2) the date you become eligible for coverage under another plan; or (3) 12 months after your extended benefits began.

C. EFFECTIVE DATE - NEW AND EXISTING DEPENDENTS

Please see your Employer Group's Benefit Administrator for information on enrollment and effective dates of coverage. Also see section *VII.I. SPECIAL ENROLLMENT RIGHTS.*

D. EFFECTIVE DATE - ADOPTIVE DEPENDENTS

An adoptive child who has been living with you, and for whom you have been receiving foster care payments, may be covered from the date the petition to adopt is filed. An adoptive child who has not been living with you may be covered from the date of placement in your home for purposes of adoption by a licensed adoption agency. Please see section *VII.I. SPECIAL ENROLLMENT RIGHTS* for additional rights upon adoption of a child.

E. CHANGE IN STATUS

You are responsible for informing your Employer Group and us of all changes that affect Member eligibility. These changes include: address changes; marriage of a Dependent; and death of a Member.

Please Note: We must have your current address on file in order to correctly process claims.

F. ADDING A DEPENDENT

To add a new Dependent to your Plan, contact your Employer's human resources or benefits department. If you have family coverage and want to add a newborn or newly adopted child, call our Member Services Department at **1-888-333-4742**

Dependents of eligible employees who meet the eligibility guidelines described in this Handbook and the Employer Agreement will be enrolled in the Plan: (1) using HPHC-NE enrollment forms; or (2) in a manner otherwise agreed to in writing by us and the Member's Employer Group.

We must receive proper notice from the Employer Group of any Member enrollment in, or termination from, the Plan. This is required no more than 60 days after such change is to be effective, unless otherwise required by law. Please see your Employer Group for information on Dependent eligibility and effective dates of coverage.

G. NEWBORN COVERAGE

A Member's newborn infant is eligible for coverage under the Plan from the moment of birth up to 31 days, in accordance with Rhode Island law. Coverage includes the Covered Benefits in this Handbook, including Medical Emergency Services. , The Subscriber must obtain coverage for the newborn within 60 days of the date of birth. Otherwise no coverage is provided after the 31 day period. Please see section *VII.F. ADDING A DEPENDENT* for information on enrollment procedures. See section *VII.I. SPECIAL ENROLLMENT RIGHTS* for additional rights upon birth of a child.

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

If your membership begins while you are in the hospital, coverage starts on the day membership is effective. To be covered, you must call both your PCP and the Plan and allow us to manage your care. This may include transfer to a Plan affiliated facility, if medically appropriate. All other terms and conditions of coverage under this Handbook will apply.

I. SPECIAL ENROLLMENT RIGHTS

An employee may decline enrollment for the employee and his or her Dependents (including his or her spouse) due to other health insurance coverage. In this case, the employee may be able to enroll, along with his/her Dependents, in this Plan if: (1) the employee or his or her Dependents lose eligibility for that other coverage; (2)or the employer stops contributing toward the employee's or Dependents' other coverage. Enrollment in this Plan must be requested within 30 days after (i) or (2), as applicable. . Also, if an employee has a new Dependent as a result of marriage, birth, adoption or placement for adoption, the employee may be able to enroll himself or herself and his or her Dependents. Enrollment must be requested within 30 days after the marriage, birth, adoption or placement for adoption.

Special enrollment rights may also apply to persons who lose coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for state premium assistance under Medicaid or CHIP. An employee or Dependent who loses coverage due to loss of Medicaid or CHIP eligibility may be able to enroll in this Plan. Enrollment must be requested within 60 days after Medicaid or CHIP coverage ends. An employee or Dependent who becomes eligible for group health plan premium assistance under Medicaid or CHIP may be able to enroll in this Plan. Enrollment must be requested within 60 days after the employee or Dependent is determined to be eligible for such premium assistance.

Note: In accordance with RI law, an eligible individual who is pregnant may enroll any time after the commencement of the pregnancy.

VIII. Termination and Transfer to Other Coverage

Important Notice: We may not have current information on membership status. Employer Groups may notify us of enrollment changes retroactively. As a result, the information we have may not be current. Only your Employer Group can confirm membership status.

A. TERMINATION BY THE SUBSCRIBER

You may end your membership under this Plan with your Employer Group's approval. We must receive a completed Enrollment/Change form from the Employer Group within 60 days of the date you want your membership to end.

B. TERMINATION FOR LOSS OF ELIGIBILITY

A Member's coverage will end under this Plan if the Employer Group contract the Member receives coverage under is terminated. A Member's coverage may also end for failing to meet any of the specified eligibility requirements. This includes a Member moving outside the Enrollment Area.

We will inform you in writing if coverage ends for loss of eligibility.

C. TERMINATION FOR NON-PAYMENT BY THE EMPLOYER GROUP

A Member's coverage will end under this Plan if the Employer Group contract the Member receives coverage under is terminated for non-payment.

We will notify you in writing, if your coverage is terminated due to your Employer Group failing to pay its premium. We will elect to follow one of two options in this event: 1) continue your coverage up to the date you receive notice of termination; or 2) offer temporary continued coverage and individual coverage if you meet state mandated eligibility criteria.

If your membership is terminated you may be eligible for continued enrollment under federal or state law. . See section *VIII.F. CONTINUATION OF EMPLOYER GROUP COVERAGE REQUIRED BY LAW* for information.

D. MEMBERSHIP TERMINATION FOR CAUSE

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

- Misrepresentation of a material fact on a membership application;
- Committing or trying to commit fraud to obtain benefits the Member is not eligible for under this Handbook;
- Obtaining or trying to obtain benefits under this Handbook for a person who is not a Member; or
- Committing acts of physical or verbal abuse unrelated to the Member's physical or mental condition that pose a threat to providers, the Plan or other Members..

Membership termination for providing false information shall be effective immediately upon notice to a Member. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Any person who knowingly presents: (i) a false or fraudulent claim for payment of a loss or benefit; or (ii) false information in an insurance application, is guilty of a crime. Such person may be subject to fines and confinement in prison. Termination of membership for the other causes will be effective 30 days after notice. Premium paid for periods after the effective date of termination will be refunded.

E. MEMBERSHIP TERMINATION OR RESCISSION FOR MISREPRESENTATION OR FRAUD

We may terminate your coverage for misrepresentation or fraud. If your coverage is terminated for these reasons, we may not allow you to re-enroll for coverage with us under any other plan. This includes, for example, non-group, another employer's plan or dependent coverage..

1. Acts of Misrepresentation or Fraud

Examples of misrepresentation or fraud include:

- false or misleading information on your application;
- enrolling someone as your spouse when they are not your spouse;
- receiving benefits that you are not eligible for;
- keeping payments made by HPHC-NE that were meant as payment to a Provider;
- abuse of the benefits under this plan, including the resale or transfer of supplies, medication, or equipment provided to you as Covered Benefits;
- allowing someone else to use your Member ID; or
- submitting false paperwork, forms, or claims information.

2. Date of Termination

If we terminate your coverage for misrepresentation or fraud, your coverage will end as of your Effective Date or a later date chosen by us. Rescission is a cancellation or discontinuance of coverage that has retroactive effect. It includes a cancellation or discontinuance that voids benefits paid. During the first two years of coverage, we reserve the right to rescind your coverage and deny payment of claims retroactive to your Effective Date for any false or misleading information on your application. In accordance with federal law: (1) we shall not rescind coverage except with 30 days prior notice to each enrolled participant who would be affected; and (2) we may not rescind your coverage except in cases of fraud or intentional misrepresentation of material fact.

F. CONTINUATION OF EMPLOYER GROUP COVERAGE REQUIRED BY LAW

1. Rhode Island Law

If your employment is terminated due to one of the following, the benefits under this Plan may be continued as provided under Rhode Island General Laws, Chapter 27-19.1: (1)involuntary layoff or death; or (2) as a result of the workplace ceasing to exist; or (3) the permanent reduction in size of the workforce. The period of this continuation will be for up to eighteen (18) months from your termination date. The continuation period cannot exceed the shorter of:

- the period that represents the period of your continuous employment preceding termination with your employer; or
- the time from your termination date until the date that you or any other covered Member under your plan becomes employed by another employer and eligible for benefits under another group plan.

We must receive the applicable Premium in order to continue coverage under this provision.

2. Federal Law

If you lose Employer Group eligibility and the Employer Group has 20 or more employees, you may be eligible for continuation of group coverage under the Federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA). Please contact the Employer Group for information if health coverage ends due to:1) separation from employment; 2) reduction of work hours; or 3) loss of dependency status. Continuation of coverage may not be extended beyond the applicable time allowed under federal law. The size of your Employer Group will determine whether you select your continuation of coverage rights under state or federal law.

G. INDIVIDUAL COVERAGE

If your employer plan ends and you live in Rhode Island, you may be eligible to enroll in coverage under an Individual plan offered through the Rhode Island Health Benefits Exchange (Health Source R.I.) For information, contact Health Source R.I. by phone at **1-855-840-HSRI** or on**www.healthsourceri.com**.

In addition, we offer individual health plans for Massachusetts, Maine and New Hampshire residents. Coverage purchased on an individual basis may differ from the coverage under your previous Plan. Individuals may enroll only in a plan offered in their state of residence and must meet all eligibility guidelines. Your state of residence will have specific rules about eligibility and coverage.

1. Massachusetts Residents:
For individual coverage questions please call us at **1-866-229-8821** - weekdays 8:30 a.m. -5:00 p.m.

2. Maine Residents:
For individual coverage questions please call us at **1-855-354-4742**- weekdays 8:30 a.m. - 5:00 p.m.

3. New Hampshire Residents:
For individual coverage questions please call us at **1-844-213-1591** - weekdays 8:30 a.m. -5:00 p.m.

H. MEMBERS ELIGIBLE FOR MEDICARE

If your membership ends because you are eligible for Medicare and your situation permits Medicare to be the primary payer for Medicare-covered services, you may apply for coverage under an HPHC plan for Medicare enrollees. You may contact HPHC's Member Services Department for more information.

IX. When You Have Other Coverage

This section explains how benefits under the Plan will be paid when another company or individual is also responsible for payment for health services a Member has received. This can happen when there is other insurance available to pay for health services, in addition to that provided by the Plan. It can also happen when a third party is legally responsible for an injury or illness suffered by a Member.

Nothing in this section should be interpreted as (i) providing coverage for any service or supply that is not expressly covered under this EOC; or (ii) increasing the level of coverage provided.

A. BENEFITS IN THE EVENT OF OTHER INSURANCE

Benefits under this EOC 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, if applicable, for any service that is covered at least in part by any of the plans involved. If benefits are provided in the form of services, or if a provider of services is paid under a capitation arrangement, the reasonable value of these services will be used as the basis for coordination. No duplication in coverage of services will occur among plans. For prescription drug claims, we will coordinate benefits pursuant to our secondary payor allowed amount in all cases.

When a Member is 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.

For Health Benefit Plans that contain provisions for the coordination of benefits, the following rules will determine which Health Benefit Plans are primary or secondary:

1. Employee/Dependent

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

2. Dependent Children

i. Dependent Child Whose Parents Are Not Separated or Divorced

The order of benefits is determined as follows:

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

ii. Dependent Child/Separated or Divorced Parents

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

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

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

3. Active Employee or Retired or Laid-Off Employee
The benefits of a plan that covers the person as an active employee or as a dependent of an active employee are determined before those of the plan that covers the person as an individual who is retired or laid off or as a dependent of an individual who is retired or laid off.

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

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

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

B. PAYMENT WHEN HPHC COVERAGE IS PRIMARY OR SECONDARY

When HPHC-NE is primary, HPHC-NE is responsible for processing and paying claims for Covered Benefits first. Coverage will be provided to the full extent of benefits available under this EOC.

When HPHC-NE is secondary, HPHC-NE is responsible for processing claims for Covered Benefits after the primary plan has issued a benefit determination. HPHC-NE will first review the primary plan's benefit determination. HPHC-NE will then pay or provide Covered Benefits as the secondary payor. HPHC-NE's benefits will be reduced so that the total amount paid by all plans for a Covered Benefit will not exceed the amount payable under this Handbook. As permitted under Rhode Island law for prescription drug claims, the benefits of your Plan will be reduced so that they and the benefits payable under the other plans do not total more than the Allowable Expenses of your Plan. HPHC-NE may recover any payments made for services in excess of HPHC-NE's liability as the secondary plan, either before or after payment by the primary plan.

C. WORKERS' COMPENSATION/GOVERNMENT PROGRAMS

If you have a work-related illness or injury, you and your employer must ensure that all medical claims related to the illness or injury are billed to your employer's workers' compensation insurer. We will not provide coverage for any injury or illness for which it determines that the Member is entitled to benefits pursuant to: (1) any worker's compensation statute or equivalent employer liability; or (2) indemnification law. This is the case whether or not the employer has obtained workers' compensation coverage as required by law.

We may pay for costs of health care services or medications for any work-related illness or injury. If we do this, then we have the right to recover those costs from you, the person, or company legally obligated to pay for such services, or from the Provider. If your Provider bills services or medications to us for any work-related illness or injury, please contact us at **1–888–333–4742**.

D. SUBROGATION AND REIMBURSEMENT

Subrogation is a means by which HPHC-NE and other health plans recover expenses of services where a third party is legally responsible for a Member's injury or illness.

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

of care by another party. HPHC-NE's recovery will be made from any recovery the Member receives from an insurance company or any third party.

HPHC-NE's right to recover 100% of the value of services paid for or provided by HPHC-NE is not subject to reduction for a pro rata share of any attorney's fees incurred by the Member in seeking recovery from other persons or organizations.

HPHC-NE's right to 100% recovery shall apply even if a recovery the Member receives for the illness or injury is designated or described as being for injuries other than health care expenses. The subrogation and recovery provisions in this section apply whether or not the Member recovering money is a minor.

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

Nothing in this Handbook shall be construed to limit HPHC-NE's right to utilize any remedy provided by law to enforce its rights to subrogation under this Handbook.

E. SUBROGATION AGENT

We may contract with a third party to administer subrogation recoveries. In such case, that subcontractor will act as our agent.

F. MEDICAL PAYMENT POLICIES

For Members who are entitled to coverage under the medical payment benefit of a boat, homeowners, hotel, restaurant, or other insurance policy, or the first $2,000 of Personal Injury Protection (PIP) coverage (or $8,000 for self-funded plans governed by ERISA), such coverage shall become primary to the coverage under this Benefit Handbook for services rendered in connection with a covered loss under that policy. For Members who are entitled to coverage under (1) a medical payment policy, or (2) Personal Injury Protection (PIP) coverage in excess of $2,000 (or $8,000 for self-funded plans governed by ERISA), such coverage shall become secondary to the coverage under this Benefit Handbook for services rendered in connection with a covered loss under that policy, where, and only to the extent, the law requires the coverage under this Benefit Handbook to be primary. The benefits under this Benefit Handbook shall not duplicate any benefits to which the Member is entitled under any medical payment policy or benefit. All sums payable for services provided under this Benefit Handbook to Members that are covered under any medical payment policy or benefit are payable to HPHC-NE.

G. MEMBER COOPERATION

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

H. CONSTRUCTIVE TRUST

By accepting benefits from HPHC-NE, you hereby agree that if you receive any payment from any responsible party as a result of an injury, illness, or condition, you will serve as a constructive trustee over the funds that constitute such payment. This is the case whether the payment of such benefits is made to you directly or made on your behalf, for example to a Provider. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to HPHC-NE.

I. HPHC'S RIGHTS

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

J. MEDICARE ELIGIBILITY

When a Subscriber or an enrolled Dependent reaches age 65, that person may become entitled to Medicare based on his or her age. That person may also become entitled to Medicare under age 65 due to disability or end stage renal disease. HPHC will pay benefits before Medicare:

- for you or your enrolled spouse, if you or your spouse is age 65 or older, if you are actively working and if your Employer has 20 or more employees;
- for you or your enrolled Dependent, for the first 30 months you or your Dependent is eligible for Medicare due to end stage renal disease; or
- for you or your enrolled Dependent, if you are actively working, you or your Dependent is eligible for Medicare under age 65 due to disability, and your Employer has 100 or more employees.

HPHC may pay benefits after Medicare (including if you are eligible but not enrolled):

- if you are age 65 or older and are not actively working;
- if you are age 65 or older and your Employer has fewer than 20 employees;
- after the first 30 months you are eligible for Medicare due to end stage renal disease; or
- if you are eligible for Medicare under age 65 due to disability but are not actively working or are actively working for an Employer with fewer than 100 employees.

Note: In any of the circumstances described above, you will receive coverage for Covered Benefits that Medicare does not cover. When Medicare is primary (or would be primary if the Member were timely enrolled), HPHC will pay for services only to the extent payments would exceed what would be payable by Medicare. If you are eligible for Medicare, but do not have it because you failed to apply for Medicare or dropped Medicare, the Plan will estimate the amount that would be payable by Medicare and pay secondary benefits accordingly. The Plan will not pay any amounts that would have been paid by Medicare if you had properly applied for it. This applies to both Parts A and B of Medicare.

X. Plan Provisions and Responsibilities

A. IF YOU DISAGREE WITH RECOMMENDED TREATMENT

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

B. LIMITATION ON LEGAL ACTIONS

Any legal action against HPHC for failing to provide Covered Benefits must be brought within three years of the initial denial of any benefit.

You cannot bring an action at law or in equity to recover on this Group Contract prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of this Group Contract.

C. ACCESS TO INFORMATION

You agree that, except where restricted by law, we may have access to: (1) all health records and medical data from health care providers providing services covered under this Handbook; and (2) information concerning health coverage or claims from all providers of motor vehicle insurance, medical payment policies, home-owners' insurance and all types of Health Benefit Plans. We will comply with all laws restricting access to special types of medical information including, but not limited to, HIV test data, and substance use disorder rehabilitation and mental health and substance use disorder treatment records.

You can get a copy of the Notice of Privacy Practices on the Harvard Pilgrim website, **www.harvardpilgrim.org**; or call the Member Services Department at **1-888-333-4742**.

D. SAFEGUARDING CONFIDENTIALITY

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

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

E. NOTICE

Any Member mailings, including but not limited to, notices, plan documents, invoices, and Activity Statements will be sent to the last address on file with HPHC-NE. The Member is responsible for notifying HPHC-NE of an address change to ensure mailed materials are sent to the right address. HPHC-NE is not responsible for mailed materials sent to the incorrect address if a Member has not updated his/her address with HPHC-NE prior to the materials being mailed out. Notice to HPHC-NE, other than a request for Member appeal, should be sent to:

HPHC-NE Member Services Department
1 Wellness Way
Canton, MA 02021

For the addresses and phone numbers for filing appeals, please see section *VI. Appeals and Complaints*.

F. MODIFICATION OF THIS EVIDENCE OF COVERAGE (EOC)

This EOC may be amended with the prior written agreement of your employer, except for: (a) changes mandated under state or federal law; or (b) changes due to a labor management collective bargaining agreement. Amendments do not require the consent of Members.

This EOC is the entire contract between you and the Plan. The responsibilities of HPHC-NE to the Member are only as stated in those documents. They can only be modified in writing by an authorized officer of the Plan. No other action by us, including deliberate non-enforcement of any benefit limit, shall be deemed to waive or alter any part of these documents.

G. OUR RELATIONSHIP WITH PLAN PROVIDERS

Our relationship with Plan Providers is governed by separate agreements. They are independent contractors. Such Providers may not modify this EOC or create any obligation for HPHC-NE. We are not liable for statements about this Handbook by them, their employees or agents. We may change our arrangements with service Providers, including the addition or removal of Providers, without notice to Members.

H. WELLNESS INCENTIVES

As a Member of the Plan, you may be able to receive incentives for participation in wellness and health improvement programs. HPHC-NE may provide incentives, including reimbursement for certain fees that you pay when participating in fitness or weight loss programs, or other wellness incentive programs. The award of incentives does not depend on the outcome of the wellness or health improvement program. Please visit our website at **www.harvardpilgrim.org** for information. You may also see your Plan documents for the amount of incentives, if any, available under your Plan. For tax information, please consult with your employer or tax advisor.

I. IN THE EVENT OF A MAJOR DISASTER

We 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) or the disability of service providers. If we cannot provide or arrange services due to a major disaster, we are not responsible for the costs or outcome of this inability.

J. EVALUATION OF NEW TECHNOLOGY

We have a dedicated team of staff that evaluates new technologies, as well as ones with new applications, including

- new diagnostics
- testing
- interventional treatment
- therapeutics
- medical/behavioral therapies
- surgical procedures
- medical devices
- drugs

The team manages the evidence-based evaluation process from initial inquiry to final policy recommendation. This process determines whether it is an accepted standard of care or if the status is Experimental, Investigational or Unproven. The team researches the safety and effectiveness of these new technologies by reviewing published

peer reviewed medical reports and literature, consulting with expert practitioners, and benchmarking. The team presents its recommendations to internal policy committees responsible for making decisions regarding coverage of the new technology under the Plan. The evaluation process includes:

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

K. GOVERNING LAW

This Evidence of Coverage is governed by Rhode Island law.

L. UTILIZATION REVIEW PROCEDURES

We use the following utilization review procedures: (i) to evaluate medical necessity of selected health care services using clinical criteria; and (ii) to facilitate clinically appropriate, cost-effective management of your care. This process applies to guidelines for both physical and mental health services.

- **Prospective Utilization Review (Prior Approval).** We review selected elective inpatient admissions, surgical day care, outpatient/ambulatory procedures, and some Medical Drugs prior to the provision of such services to determine whether proposed services meet Medical Necessity Guidelines for coverage. Prospective utilization review determinations will be made within two working days of obtaining all necessary information. For a determination to approve an admission, procedure or service, we will give notice via the HPHC provider portal within 24 hours of the decision. We will send written confirmation to you and the provider within two working days. For a determination to deny or reduce benefits ("an adverse determination"), we will notify the provider rendering the service by phone within 24 hours of the decision. We will send a written or electronic confirmation of the phone notification to you and the provider within one working day thereafter.
- **Concurrent Utilization Review.** We review ongoing admissions for selected services at hospitals, including acute care hospitals, rehabilitation hospitals, skilled nursing facilities, skilled home health providers and behavioral health and substance use disorder treatment facilities. We do this to assure that the services being provided meet Medical Necessity Guidelines for coverage. Concurrent review decisions will be made within one working day of obtaining all necessary information. For either a determination to approve additional services or an adverse determination, we will notify the provider rendering the service by phone within 24 hours of the decision. We will send a written or electronic confirmation of the phone notification to you and the provider within one working day. For ongoing services, coverage will be continued without liability to you until you have been notified of an adverse determination.

  Active case management and discharge planning is incorporated as part of the concurrent review process and may also be provided upon the request of your Provider.
- **Retrospective Utilization Review.** Retrospective utilization review may be used in circumstance where services were provided before authorization was obtained. This will include the review of emergency medical admissions for appropriateness of level of care. Retrospective review decisions will be made within 30 days of receipt of the request. If needed, we may request an extension for an additional 15 calendar days when required by special circumstances, and when we give you notice within the first 30 calendar day period of the need for an extension.

If you wish to determine the status or outcome of a clinical review decision you may call the Member Services Department toll free at **1-888-333-4742**.

In the event of an adverse determination involving clinical review, your treating provider may discuss your case with a physician reviewer or may seek reconsideration from us. The reconsideration will take place within one working day of your provider's request. If the adverse determination is not reversed on reconsideration you may appeal. Your appeal rights are described in section *VI. Appeals and Complaints*. Your right to appeal does not depend on whether or not your provider sought reconsideration.

M. QUALITY ASSURANCE PROGRAMS

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

- **Verification of Provider Credentials** - HPHC credentials our contracted providers by obtaining, verifying and assessing the qualifications to provide care or services by obtaining evidence of licensure, education, training and other experience and/or qualifications.
- **Verification of Facility Credentials** - HPHC credentials our contracted providers by reviewing licensures and applicable certifications based on facility type.
- **Quality of Care Complaints** – HPHC follows a systematic process to investigate, resolve and monitor Member complaints regarding medical care received by a contracted provider.
- **Evidence Based Practice** – HPHC compiles Medical Necessity Guidelines, based upon the most current evidence-based standards, to assist clinicians by providing an analytical framework for the evaluation and treatment of common health conditions.
- **Performance monitoring** – HPHC participates in collecting data to measure outcomes related to the Health Care Effectiveness Data and Information Set (HEDIS) 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 for our members. The Quality Program is documented, tracked and evaluated against milestones and target objectives. The full program description and review is available on our website at **https://www.harvardpilgrim.org/public/about-us/quality**.

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

We use a standardized process to evaluate inquiries and requests for coverage (i) received from internal and/or external sources; and/or (ii) identified through authorization or payment inquiries. The evaluation process includes:

- Determining the FDA approval status of the device/product/drug in question,
- Reviewing relevant clinical literature, and
- Consulting actively practicing specialty care providers to determine current standards of practice.

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

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

We use Medical Necessity Guidelines to make fair and consistent utilization management decisions. Medical Necessity Guidelines are (i) developed in accordance with standards established by The National Committee for Quality Assurance (NCQA); and (ii) reviewed (and revised, if needed) at least annually (or more often if needed) to include current standards of practice. This process applies to clinical criteria for both physical and mental health services.

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

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

P. NON-ASSIGNMENT OF BENEFITS

You may not assign or transfer your rights to benefits, monies, claims or causes of action provided under this Plan to any person, health care provider, company or other organization without the written consent from Harvard Pilgrim. In addition, you may not assign any benefits, monies, claims, or causes of action that results from a denial of benefits without the written consent from Harvard Pilgrim.

Q. NEW TO MARKET DRUGS

New prescription 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 the Plan's Medical Policy Department and New Technology Assessment Committee or Pharmacy Services Department along with the Pharmacy and Therapeutics Committee. This occurs 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.

R. PAYMENT RECOVERY

If we determine that benefit payments under the Plan were made in error, we reserve the right to: (1) seek recovery of such payments from the Provider or Member to whom the payments were made; and (2) offset subsequent benefit payments to a Provider (regardless of payment source) or Member by the amount of any such overpayment.

XI. MEMBER RIGHTS & RESPONSIBILITIES

Members have a right to receive information about HPHC-NE, its services, its practitioners and providers, and Members' rights and responsibilities.

Members have a right to be treated with respect and recognition of their dignity and right to privacy.

Members have a right to participate with practitioners in decision-making regarding their health care.

Members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

Members have a right to voice complaints or appeals about HPHC-NE or the care provided.

Members have a right to make recommendations regarding the organization's members' rights and responsibilities policies.

Members have a responsibility to provide, to the extent possible, information that HPHC-NE and its practitioners and providers need in order to care for them.

Members have a responsibility to follow the plans and instructions for care that they have agreed on with their practitioners.

Members have a responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

Harvard Pilgrim Health Care of New England, Inc.
1 Wellness Way
Canton, MA 02021–1166
1–888–333–4742
www.harvardpilgrim.org