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

Welcome to The Harvard Pilgrim HDHP Plan for Harvard University (the Plan). Thank you for choosing us to help meet your health care needs. Your benefits are provided by your Plan Sponsor. Harvard Pilgrim Health Care, Inc. (Harvard Pilgrim or HPHC) administers the plan's benefits on behalf of your Plan Sponsor.

Your health care under the Plan is administered by HPHC through its affiliated network of Primary Care Providers, specialists and other Plan Providers. This is a self-insured health benefits plan for the Plan Sponsor’s employees and their dependents. The Plan Sponsor has assumed the financial responsibility for this Plan’s health care benefits. This type of funding, known as self-funding, allows the Plan Sponsor to self-insure the health care costs associated with its employees with its own resources. HPHC will perform benefits and claims administration, and case management services on behalf of the Plan Sponsor as outlined in this Benefit Handbook and your Schedule of Benefits. HPHC is not, however, the insurer of your coverage.

The Plan is designed to comply with the requirements of the Internal Revenue Service for a “High Deductible Health Plan.” Persons covered under a High Deductible Health Plan may be entitled to contribute to a Health Savings Account, often called an “HSA.” Depending on your personal circumstances, an HSA may be used to pay for health care services that are not covered by the Plan. An HSA may also provide you with generous tax advantages. It is important that you consult a qualified tax advisor for advice on whether you are eligible to contribute to an HSA and how an HSA may be used.

When we use the words “we,” “us,” and “our” in this Handbook, we are referring to HPHC. When we use the words “you” or “your” we are referring to Members as defined in the Glossary.

To use the Plan effectively, you will want to review this Handbook and the Schedule of Benefits, which describe your In-Network, and Out-of-Network benefits. This Plan has been designed to offer you the flexibility of obtaining Covered Benefits through the Plan’s network of Plan Providers or the Non-Plan Provider of your choice. Benefits are covered both In-Network and Out-of-Network. However, in most cases, your In-Network benefits provide you with a higher level of coverage with lower out of pocket costs.

All In-Network care must be provided by the Plan’s network of Plan Providers, except in a Medical Emergency.

If you choose to receive Covered Benefits from a Provider or at a facility, which is not a Plan Provider, your benefits will be covered at the Out-of-Network level.

Some benefits have limits on the amount of coverage provided in a Calendar Year. If a Covered Benefit has a benefit limit, your In-Network and Out-of-Network services are usually combined and count against each other to reach your benefit limit. Please see your Schedule of Benefits for detailed information regarding benefit limits on your coverage.

When you enroll, you receive the covered health care services described in this Handbook, the Schedule of Benefits and any riders or amendments to those documents.
As a Member, you can take advantage of a wide range of helpful online tools and resources at www.harvardpilgrim.org.

**Your secure online account** offers you a safe way to help manage your health care. You are able to check your Schedule of Benefits and Benefit Handbook, look up benefits, Copayments, claims history, and Deductible status, and view Prior Approval activities. You can also learn how your Plan covers preventive care and conditions such as asthma, diabetes, COPD and high blood pressure.

The cost transparency tool allows you to compare cost and quality on many types of health care services including surgical procedures and office visits. The cost transparency tool provides estimated costs only. Your Member Cost Sharing may be different.

To access information, tools and resources online, visit www.harvardpilgrim.org and select the Member Login button (first time users must create an account and then log in). To access the cost transparency tool once you’re logged in, click on the “Tools and Resources” link from your personalized Member dashboard and look for the Estimate My Cost link.

You may 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:

- Selecting Plan Providers
- Your Benefit Handbook
- Your In-Network and Out-of-Network 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 accommodate questions from non-English speaking Members, as we offer language 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**.

As we value your input, we would appreciate hearing from you with any comments or suggestions that will help us further improve the quality of service we bring you.

**Harvard Pilgrim Health Care, Inc.**  
Member Services Department  
1600 Crown Colony Drive  
Quincy, MA 02169  
1-888-333-4742  
www.harvardpilgrim.org
Clinical Review Criteria. HPHC uses clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our clinical review criteria applicable to a service or procedure for which coverage is requested. Clinical review criteria may be obtained by calling 1-888-888-4742 ext. 38723.

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).


Kreyòl Ayisyen (Creole) ATANSION: Si nou pa li Kreyòl Ayisyen, gen asisots pou sèvis ki disponib nan lang nou pou gratis.ROLE 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).

اللغة العربية (Arabic) إنذار: إذا كنت تتحدث اللغة العربية، خدمات المساعدة اللغوية متاحة للجهاز مجانًا. اتصل على 1-888-333-4742 (TTY: 711)

柬埔寨语 (Cambodian) ដំណោះស្រាយការជួយ នឹងមានជួយជាមួយសកម្មភាពជាតិ ដោយសារមានជួយនៃការអំពីការជួយ។ ១-៨៨៨-៣៣៣-៤៧២ (TTY: ៦១១)

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) चैनल दीजिएः अगर आप हिंदी बोलते हैं तो आपके सिखे भाषा की सहायता सुविधा में उपलब्ध है. जानकारी के लिए फोन करें, 1-888-333-4742 (TTY: 711)

ગુજરાતી (Gujarati) ચીનમાં આપણે: એ તમે ગુજરાતી બોલતા હોઈ તો આપણે માટે ભાષાકીય સહકાર તમારા માટે ઉપલબ્ધ છે. વિશેષ મહત્વથી માટે ફોન કરો, 1-888-333-4742 (TTY: 711)

မြန်မာစိုက် (Lao) ପରବର୍ତ୍ତ୍ତମାନରେ: ଯେକୌତ୍ୟର ଭାଷାଅପ୍ରାକୃତ, ତାହା ବଣ୍ଟିକୁରେକ ଭାଷାରକ, ଆସିଯିକ ଭାଷାରକ, ବ୍ୟକ୍ତିଗାର ଭାଷାରକ ହୋମ. ଫୋନ 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).


(Continued)
General Notice About Nondiscrimination and Accessibility Requirements

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

HPHC:

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

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

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7597 (TTY)

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


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XI. MEMBER RIGHTS & RESPONSIBILITIES
I. How the Plan Works

This section describes how to use your Benefit Handbook and how your coverage works under the The Harvard Pilgrim HDHP Plan for Harvard University (the Plan).

The Plan provides you with two levels of benefits known as In-Network coverage and Out-of-Network coverage. You receive In-Network coverage when you obtain Covered Benefits from Providers participating in the Plan. These Providers are referred to as “Plan Providers.” Plan Providers have agreed to accept our payment plus any Member Cost Sharing as payment in full.

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

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

A. HOW TO USE THIS BENEFIT HANDBOOK

1. Why This Benefit Handbook Is Important
This Benefit Handbook, the Schedule of Benefits and any applicable riders or amendments make up the agreement stating the terms of the Plan. If you have any questions about Dependent eligibility, we recommend that you see your Plan Sponsor for information.

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

- How to obtain benefits with the lowest out-of-pocket expense
- Covered Benefits
- Exclusions

- The requirements for In-Network and Out-of-Network coverage

You can view your Benefit Handbook, Schedule of Benefits and any applicable riders or amendments online by using your secure online account at www.harvardpilgrim.org.

2. Words With Special Meaning
Some words in this Handbook have a special meaning. These words are capitalized and are defined in the Glossary.

3. How To Find What You Need To Know
This Handbook’s Table of Contents will help you find the information you need. The following is a description of some of the important sections of the Handbook.

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

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

B. HOW TO USE YOUR PROVIDER DIRECTORY

In order to be eligible for In-Network coverage under the Plan, all services, except care in a Medical Emergency, must be received from Plan Providers. These are the physicians, Hospitals and other medical professionals who are under contract to care for Plan Members. You can find Plan Providers by using the Provider Directory.

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

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

The online Provider Directory provides links to several physician profiling sites including one maintained by the Commonwealth of Massachusetts Board of Registration in Medicine at www.massmedboard.org.

**Please Note:** Plan Providers participate through contractual arrangements that can be terminated either by a Provider or by HPHC. In addition, a Provider may leave the network because of retirement, relocation or other reasons. This means that we cannot guarantee that the Provider you choose will continue to participate in the network for the duration of your membership.

**C. MEMBER OBLIGATIONS**

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

2. **Share Costs**
   You are required to share the cost of Covered Benefits provided under the Plan. Your Member Cost Sharing may include one or more of the following:
   - Copayments
   - Coinsurance
   - Deductibles

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

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

   To provide notification or obtain Prior Approval for the following Out-of-Network services please call:

   - 1–800–708–4414 for medical services
   - 1–844–387–1435 for Medical Drugs
   - 1–888–777–4742 for mental health care (including the treatment of substance use disorders)

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

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

**D. HOW TO OBTAIN CARE**

### IMPORTANT POINTS TO REMEMBER

1) The Plan provides you with two levels of benefits known as In-Network benefits and Out-of-Network benefits.

2) In-Network benefits are available for Covered Benefits received from Plan Providers.

3) Plan Providers are Providers that are under contract with HPHC to provide services to Members.

4) Out-of-Network benefits are available for Covered Benefits received from Non-Plan Providers.

5) Some services require Prior Approval by the Plan.

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

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

**1. How Your In-Network Benefits Work**

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

Plan Providers are under contract to provide Covered Benefits to Members of the Plan. They are listed in the Plan Provider Directory. Although changes in Providers are relatively rare, Plan Providers may leave the network for a variety of reasons. Members should consult the Plan's on-line Provider Directory to verify a Provider's status as a Plan Provider. (You may view the on-line Provider Directory at www.harvardpilgrim.org.) A Member may also contact HPHC's Member Services Department at 1-888-333-4742 for information on Plan Providers. Members are responsible for advising Providers of their membership in the Plan by showing them their identification card before receiving services.

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

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

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

To request Prior Approval, please call:
- 1-800-708-4414 for medical services
- 1-844-387-1435 for Medical Drugs
- 1-888-777-4742 for mental health care
  (including the treatment of substance use disorders)

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

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

If you have difficulty finding a Plan Provider who can provide the services you need, we will assist you. For help finding a medical Provider, please call 1-888-333-4742. For help finding a mental health or substance use disorder Provider, please call 1-888-777-4742. If no Plan Provider has the expertise needed to meet your medical needs, we will assist you in finding an appropriate Non-Plan Provider.

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

4. Centers of Excellence
Plan Providers with special training, experience, facilities or protocols for certain specialized services are designated as "Centers of Excellence." Centers of Excellence are selected by us based on the findings of recognized specialty organizations or government agencies such as Medicare. Centers of Excellence are located in Massachusetts, Maine, Connecticut, Rhode Island and New Hampshire. The following specialized service should be obtained through a designated Center of Excellence:
In order to receive In-Network benefits for the following service in Massachusetts, Maine, New Hampshire or Rhode Island, you must obtain care at a Plan Provider that has been designated as a Center of Excellence:

- Weight loss surgery (bariatric surgery)

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

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

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

**Important Notice:** If you choose to receive care in Massachusetts, Maine, Connecticut, Rhode Island or New Hampshire for the above service at a facility other than a contracted Center of Excellence, coverage will be at the Out-of-Network benefit level.

To receive In-Network benefits for the service listed above outside of Massachusetts, Maine, Connecticut, Rhode Island or New Hampshire. Please check your provider directory for a list of participating hospitals.

If you chose to receive care for the above service at a facility other than a Plan Provider, coverage will be at the Out-of-Network benefit level.

**5. Covered Benefits from Our Affiliated National Network of Providers**

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

**6. How to get Care After Hours**

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

**7. Medical Emergency Services**

In a Medical Emergency, including an emergency related to a substance use disorder or mental health condition, you should go to the nearest emergency facility or call 911 or other local emergency number.

Your emergency room Member Cost Sharing is stated in your Schedule of Benefits. Please remember that if you are hospitalized, you must call HPHC at 1-888-333-4742 within 48 hours or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to the Plan or PCP by an attending emergency physician no further notice is required. If notification is not received when the Member’s condition permits, the Member is responsible for the Penalty Payment.

Follow up care outside the Plan’s network will be covered at the Out-of-Network benefit level.

**E. MEMBER COST SHARING**

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

**Please Note:** If you receive Covered Benefits at a location that is a Plan Provider but some or all of such Covered Benefits are provided by a Non-Plan Provider, you will be responsible for the Member Cost Sharing associated with Covered Benefits provided by Plan Providers, unless you had a reasonable opportunity to choose to obtain such Covered Benefits from a Plan Provider.

**1. Copayment**

A Copayment is a fixed dollar amount you must pay for certain Covered Benefits. If the Covered Benefit you are receiving is subject to a Copayment,
the Copayment is payable at the time of the visit or when billed by the Provider. Copayment amounts are specified in your Schedule of Benefits.

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

Your Plan Deductible may or may not apply to a list of preventive care services covered by the Plan. If the Deductible does not apply to the listed preventive care services, the Plan will cover those services even if you have not yet met the Deductible that applies to the other services covered by the Plan.

Your Plan has either an individual Deductible or a family Deductible.

Individual Deductible. The Individual Deductible applies when only a single individual is covered under the Plan.

Family Deductible. The Family Deductible applies when you have coverage for a Subscriber and one or more family members under the Plan.

If your Plan has a family Deductible, the Deductible may be met by all Members of the family combined. For example, a family of four would meet a $4,000 family Deductible if one covered family Member incurs $3,000 in covered medical expenses and another covered family Member incurs $1,000 in covered medical expenses during the Calendar Year. At that point, the family Deductible would be met for the entire family for that Calendar Year.

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

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

3. Coinsurance
Coinsurance is a percentage of the amount payable by the Plan, known as the “Allowed Amount.” After the appropriate Deductible amount is met, you may be responsible for paying a Coinsurance amount. When using Plan Providers, the Allowed Amount is based on the contracted rate between HPHC and the Provider. When using Non-Plan Providers, the amount the Plan pays is based on the Provider’s charge for the service up to the Allowed Amount for the service. In general higher Coinsurance amounts will apply to Out-of-Network services. Coinsurance amounts are stated 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 Member Cost Sharing (Copayments, Deductible or Coinsurance payments) for which a Member or a family is responsible in a Calendar Year.

Once the Out-of-Pocket Maximum has been reached, no further Copayment, Deductible or Coinsurance amounts will be payable by the Member for the services to which the Out-of-Pocket Maximum applies for the remainder of the Calendar Year. The Plan will pay 100% of the Allowed Amount for the remainder of the Calendar Year. Once a family Out-of-Pocket Maximum has been met in a Calendar Year, the Out-of-Pocket Maximum is deemed to have been met by all Members in a family for the remainder of the Calendar Year.

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

You have either an individual Out-of-Pocket Maximum or a family Out-of-Pocket Maximum.

Individual Out-of-Pocket Maximum. The Individual Out-of-Pocket Maximum applies when only a single individual is covered under the Plan.

Family Out-of-Pocket Maximum. The Family Out-of-Pocket Maximum applies when you have
coverage for a Subscriber and one or more family members under the Plan.

If your Plan has a family Out-of-Pocket Maximum, the Out-of-Pocket Maximum may be met by all Members of the family combined. For example, a family of four would meet a $10,000 family Out-of-Pocket Maximum if one covered family Member pays $5,000 in Member Cost Sharing, another family Member pays $3,000 in Member Cost Sharing and yet another covered family Member pays $2,000 in Member Cost Sharing during the Calendar Year. At that point, the family Out-of-Pocket Maximum would be met for the entire family for that Calendar Year.

Please see your Schedule of Benefits for the Out-of-Pocket Maximum amounts that apply to your Plan.

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

5. Out-of-Network Charges in Excess of the Allowed Amount
On occasion, a Non-Plan Provider may charge amounts in excess of the Allowed Amount. In those instances, you will be financially responsible for the difference between what the Provider charges and the Allowed Amount payable by the Plan. This means that you will be responsible for paying the full amount above the Allowed Amount. Amounts charged by a Non-Plan Provider in excess of the Allowed Amount do not count toward the Out-of-Pocket Maximum.

You may contact the Member Services Department at 1–888–333–4742 or call 711 for TTY service if you have questions about the maximum Allowed Amount that may be permitted by HPHC for a service.

6. Penalty
The amount that a Member is responsible to pay for certain Out-of-Network services when notification or Prior Approval has not been received before obtaining the services. The Penalty charge is in addition to any Member Cost Sharing amounts. Penalty charges do not count towards any Out-of-Pocket Maximum.

Please see section I.F. NOTIFICATION AND PRIOR APPROVAL for a detailed explanation of the Prior Approval program.

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

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

F. NOTIFICATION AND PRIOR APPROVAL

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

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

1. Notification of Planned Inpatient Admissions
You must notify HPHC in advance of any planned inpatient admission to a Non-Plan Medical Facility.
This requirement applies to admissions to all types of inpatient medical, mental health and substance use facilities.

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

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

2. When Prior Approval is Required

Prior Approval must be obtained for any of the services listed below. If you will receive these services from a Non-Plan Provider, you must seek Prior Approval. If you will receive these services from a Plan Provider, he or she will obtain Prior Approval for you.

1) For Mental Health Care (including the Treatment of Substance Use Disorders)

Prior Approval must be obtained before receiving certain mental health care (including the treatment of substance use disorders) from a Non-Plan Provider. To obtain Prior Approval for mental health care (including the treatment of substance use disorders) you should call the Behavioral Health Access Center at 1-888-777-4742.

Please Note: Prior Approval is not required to obtain substance use disorder treatment from a Plan Provider. In addition, when services are obtained from a Plan Provider, the Plan will not deny coverage for the first 14 days of (1) Acute Treatment Services or (2) Clinical Stabilization Services for the treatment of substance use disorder so long as the Plan receives notice from the Plan Provider within 48 hours of admission. The terms "Acute Treatment Services" and "Clinical Stabilization Services" are defined in the Glossary at section II of this Benefit Handbook. Services beyond the 14 day period may be subject to concurrent review as described in section X.J. UTILIZATION REVIEW PROCEDURES of this Handbook.

The following is a list of the mental health services that require Prior Approval when obtained from a Non-Plan Provider.

Please refer to HPHC’s Internet site at www.harvardpilgrim.org, or call Member Services for updates and revisions to this list:

- **Intensive Outpatient Program Treatment**
  - Treatment programs at an outpatient clinic or other facility generally lasting three or more hours a day on two or more days a week.

- **Partial Hospitalization and Day Treatment Programs**

- **Extended Outpatient Treatment Visits**
  - Outpatient visits of more than 50 minutes duration with or without medication management. Also included is any treatment routinely involving more than one outpatient visit in a day.

- **Outpatient Electro-Convulsive Treatment (ECT)**

- **Psychological Testing** – Outpatient visits of more than 50 minutes duration with or without medication management. Also included is any treatment routinely involving more than one outpatient visit in a day.

- **Applied Behavioral Analysis (ABA) for the treatment of Autism**

Please Note: You may also contact the Behavioral Health Access Center at 1-888-777-4742 for assistance in obtaining covered mental health care (including the treatment of substance use disorders), even if prior approval is not required for the service you require.

2) For Medical Services.

You must obtain Prior Approval in advance of receiving any of the medical services or Medical Drugs listed below from a Non-Plan Provider. To obtain Prior Approval for medical services or Medical Drugs you or your Provider should call:

- 1-800-708-4414 for medical services
- 1-844-387-1435 for Medical Drugs

Please refer to HPHC’s Internet site at www.harvardpilgrim.org, or call Member Services for updates and revisions to this list:

- Bronchial thermoplasty treatments — outpatient treatments only.
• **Cosmetic, reconstructive and restorative procedures** – All Covered Benefits, including, but not limited to, blepharoplasty, breast reduction mammoplasty, including breast implant removal and gynecomastia surgery, panniculectomy, ptosis repair, rhinoplasty, and scar revision.  (Please note that the Plan provides very limited coverage for Cosmetic Services. Please see “Reconstructive Surgery” in section III. Covered Benefits for details.)

The following information describes certain procedures as indicated above that require Prior Approval.

Blepharoplasty: Eyelid surgery where excess tissue such as skin and fat are removed (or repositioned) from upper and/or lower eyelids, and surrounding muscles and tendons may be reinforced. It can be both a functional and cosmetic surgery.

Gynecomastia Surgery: Surgical correction of over developed or enlarged breasts in men.

Panniculectomy: Surgical removal of a pannus/panniculus- loose subcutaneous fat in the lower abdominal area. A pannus/panniculus may be due to obesity, or result after pregnancy or massive weight loss.

Ptosis Repair: Repair of droopy eyelids. May be performed in conjunction with blepharoplasty.

Rhinoplasty: Surgery performed to change the size, shape or function of the nose.

• **Dental and Oral Surgery** – All Covered Benefits, including surgical treatment of temporomandibular joint dysfunction (TMD). (Please note that the Plan provides very limited coverage for Dental Care. Please see “Dental Services” in section III. Covered Benefits for details.)

• **Diabetes Equipment** — Continuous glucose monitoring systems only.

• **Formulas and enteral nutrition** – Outpatient services only.

• **Genetic testing** – Including, but not limited to, breast cancer (BRCA) testing.

• **Home health care** – Includes home infusion and home hospice care.

• **Infertility Services** – All services for the treatment of infertility.

• **Interventional pain management for back pain** – Including, but not limited to, epidural injections; facet joint injections and facet neurolysis.

• **Medical Drugs** – Including, but not limited to, antibiotics for lyme disease; hyalurionate injections; immune globulin (IV Ig); and immunobiologics (e.g., Remicade and Rituxin).

• **Non-emergency transportation** — Non-emergency transportation, including, but not limited to, transportation from an inpatient rehabilitation facility to a Member’s home. Please note Prior Approval is not required for transportation provided by a wheelchair van.

• **Prosthetic devices** – Upper and lower prosthetic arms and legs only.

• **Pulmonary rehabilitation** – Outpatient services only.

• **Radiology – advanced radiology** - Computerized axial tomography (CAT and CT and CTA scans); magnetic resonance imaging (MRI and MRA scans); nuclear cardiac studies; and positron emission tomography (PET scans).

• **Skilled Nursing Facility (SNF) and rehabilitation hospital care** – Includes all admissions to Skilled Nursing Facilities (SNFs) and inpatient rehabilitation facilities.

• **Surgery (both inpatient and outpatient)** – Prior Approval is required for the following surgical procedures: bariatric surgery (weight loss surgery); cholecystectomy; hip, knee and shoulder arthroplasties and arthroscopies including revisions; repair bladder defect (urinary incontinence); implantable neurostimulators; septoplasty; spine surgeries, including, but not limited to, artificial cervical disc, lumbar decompression, lumbar fusion (single and multiple level), lumbar microdiscectomy; surgical treatment of obstructive sleep apnea, including
The following information describes certain procedures as indicated above that require Prior Approval.

Gynecomastia: Overdevelopment of mammary glands/breast tissue in males.

Septoplasty: Surgery performed to correct/straighten the nasal septum (the partition between the two nasal cavities).

Uvulopalatopharyngoplasty (UPPP): Surgery to remove tissue in the throat. It may (or may not) involve removal of throat structures including the soft palate, tonsils, or adenoids.

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

3. How to Obtain Prior Approval
To seek Prior Approval for medical services, Medical Drugs or mental health (including treatment of substance use disorders) received from a Non-Plan Provider, you should call:

- 1-800-708-4414 for medical services
- 1-844-387-1435 for Medical Drugs
- 1-888-777-4742 for mental health care (including the treatment of substance use disorders)

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

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

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

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

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

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

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

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

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

5. What Notification and Prior Approval Do
The notification and Prior Approval programs do different things depending upon the service in question. These may include:

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

If the Prior Approval program conducts a medical review of a service, you and your attending physician will be notified of HPHC’s decision to approve or not to approve the care proposed. All decisions to deny a medical service will be reviewed by a physician (or, in the case of Medical Drugs or mental health care (including the treatment of substance use disorders), a qualified clinician) in accordance with written clinical criteria. The relevant criteria will be made available to Providers and Members upon request.
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If the Prior Approval program denies a coverage request, it will send you a written notice that explains the decision, your Provider’s right to obtain reconsideration of the decision, and your appeal rights.

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

1. Pregnancy
If you are a female Member in your second or third trimester of pregnancy and the Plan Provider you are seeing in connection with your pregnancy is involuntarily disenrolled, for reasons other than fraud or quality of care, you may continue to receive In-Network coverage for services delivered by the disenrolled Provider, under the terms of this Handbook and your Schedule of Benefits, for the period up to, and including, your first postpartum visit.

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

3. New Membership
If you are a new Member, we will provide In-Network coverage for services delivered by a physician or nurse practitioner who is not a Plan Provider, under the terms of this Handbook and your Schedule of Benefits, for up to 30 days from your effective date of coverage if:

- Your Employer only offers employees a choice of plans in which the physician or nurse practitioner is a Non-Plan Provider, and
- The physician or nurse practitioner is providing you with an ongoing course of treatment.

4. Conditions for Coverage of Services by a Disenrolled or Non-Plan Provider
Services received from a disenrolled or Non-Plan Provider as described in the paragraphs above, are only covered when the physician agrees to:

- Accept reimbursement from us at the rates applicable prior to notice of disenrollment (or, in the case of a new Member, our applicable rate) as payment in full and not to impose Member Cost Sharing with respect to the Member in an amount that would exceed the Member Cost Sharing that could have been imposed if the Provider had not been disenrolled;
- Adhere to the quality assurance standards of the Plan and to provide us with necessary medical information related to the care provided; and
- Adhere to our policies and procedures, including procedures regarding obtaining Prior Approval and providing Covered Benefits pursuant to a treatment plan, if any, approved by us.

H. CLINICAL REVIEW CRITERIA

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

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

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

J. BUNDLED PAYMENT ARRANGEMENTS

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

Acute Treatment Services 24-hour medically supervised addiction treatment for adults or adolescents provided in a medically managed or medically monitored inpatient facility, as defined by the Massachusetts Department of Public Health. Acute Treatment Services provide evaluation and withdrawal management and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups and discharge planning.

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 for In-Network benefits is the contracted rate the Plan has agreed to pay Plan Providers.

If services provided by a Non-Plan Provider are Covered Benefits under this Benefit Handbook, the Allowed Amount for such services depends upon where you receive the service, as explained below:

a. If you receive Out-of-Network services in the states of Massachusetts, New Hampshire, Vermont, Rhode Island, Connecticut or Maine, 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 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 you receive Out-of-Network services outside of the states of Massachusetts, New Hampshire, Vermont, Rhode Island, Connecticut or Maine, 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 services and substance use disorder services will be 80% of the billed charge.

Pricing of the Allowed Amount will be conducted by UnitedHealthcare, Inc. UnitedHealthcare, updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.

Anniversary Date The date agreed to by HPHC and your Plan Sponsor upon which the yearly benefit changes normally become effective. This Benefit Handbook, Schedule of Benefits and any applicable riders 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.

Behavioral Health Access Center The organization, designated by HPHC, that is responsible for arranging for the provision of services for Members in need of mental health care.
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(including the treatment of substance use disorders). You may contact the Behavioral Health Access Center by calling 1-888-777-4742. The Behavioral Health Access Center will assist you in finding an appropriate Plan Provider and arranging the services you require.

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. 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 stated in your Schedule of Benefits.

Centers of Excellence Plan Providers with special training, experience, facilities or protocols for certain services, selected by us based on the findings of recognized specialty organizations or government agencies such as Medicare. Certain specialized services are only covered as In-Network services in Massachusetts, Maine, Connecticut, Rhode Island or New Hampshire, when received from designated Centers of Excellence.

Clinical Stabilization Services 24-hour clinically managed post detoxification treatment for adults or adolescents, as defined by the Massachusetts Department of Public Health. Clinical Stabilization Services usually follow Acute Treatment Services for substance use disorders. Clinical Stabilization Services may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others and after care planning, for individuals beginning to engage in recovery from addiction.

Coinsurance A percentage of the Allowed Amount for certain Covered Benefits that must be paid by the Member. Coinsurance amounts are in addition to any Deductible and any applicable Copayment. Coinsurance amounts applicable to your Plan are 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.

Dental Care Any service provided by a licensed dentist involving the diagnosis or treatment of any disease, pain, injury, deformity or other condition of the human teeth, alveolar process, gums, jaw or associated structures of the mouth. However, surgery performed by an oral maxillofacial surgeon to correct positioning of the bones of the jaw (orthognathic surgery) is not considered Dental Care within the meaning of this definition.

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. Eligibility requirements are documented as part of the contract between the Plan Sponsor and HPHC. Please see your Plan Sponsor’s Benefits Office for details on the agreement between HPHC and your Plan Sponsor.

Experimental, Unproven, or Investigational Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests, will be deemed Experimental, Unproven, or Investigational by us under this Benefit Handbook for use in the diagnosis or treatment of a particular medical condition if any the following is true: a. The product or service is not recognized in accordance with generally accepted medical standards as being safe and effective for use in the evaluation or treatment of the condition in question. In determining whether a service has been recognized as safe or effective in accordance with generally accepted evidence-based medical standards, primary reliance will be placed upon data from published reports in authoritative

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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 that a service, procedure, device or drug is not safe and effective for the use in question. b. In the case of a drug, the drug has not been approved by the United States Food and Drug Administration (FDA). (This does not include off-label uses of FDA approved drugs).

**Family Coverage** Coverage for a Subscriber 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, Inc. (HPHC)** Harvard Pilgrim Health Care, Inc. is an insurance company that provides, arranges or administers health care benefits for Members through a network of Plan Providers. Under self insured plans such as this one, HPHC adjudicates and pays claims, and manages benefits on behalf of the Plan Sponsor.

**Health Savings Account or HSA** A tax-exempt trust or custodial account, similar to an individual retirement account (IRA), but established to pay qualified medical expenses. In order to establish a Health Savings Account an individual must: (1) be covered under a High Deductible Health Plan during the months in which contributions are made to the account; (2) not be covered by any other health plan that is not a High Deductible Health Plan (with certain limited exceptions established by law); (3) not be entitled to Medicare benefits; and (4) not be claimed as a dependent on another person’s tax return. Members should consult a qualified tax advisor before establishing a Health Savings Account.

**High Deductible Health Plan** A health care plan that meets the requirements of Section 223 of the Internal Revenue Code with respect to Deductibles and Out-of-Pocket Maximums. A person who is enrolled in a High Deductible Health Plan and meets other requirements stated in that law may establish a Health Savings Account (or HSA) for the purpose of paying qualified medical expenses.

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

**In-Network** The level of benefits or coverage a Member receives when Covered Benefits are obtained through a Plan Provider.

**Licensed Mental Health Professional** For services provided in Massachusetts, a Licensed Mental Health Professional is any one of the following: a licensed physician who specializes in the practice of psychiatry; a licensed psychologist; a licensed independent clinical social worker; a licensed nurse mental health clinical specialist; a level I licensed alcohol and drug counselor; a licensed marriage and family therapist; or a licensed mental health counselor. For services provided outside of Massachusetts, a Licensed Mental Health Professional is an independently licensed clinician with at least a masters degree in a clinical mental health discipline from an accredited educational institution and at least two years of clinical experience. The term “clinical mental health discipline” includes the following: psychiatry; psychology, clinical social work; marriage and family therapy; clinical counseling; developmental psychology; pastoral counseling; psychiatric nursing; developmental or educational psychology; counselor education; or any other discipline deemed acceptable by HPHC.

**Medical Drugs** A prescription drug that is administered to you either (1) in a doctor’s office or other outpatient medical facility, or (2) at home while you are receiving home health care services or receiving drugs administered by home infusion services. Medical Drugs cannot be self-administered. The words “cannot be self-administered” mean that the active participation of skilled medical personnel is always required to take the drug. When a Member is receiving drugs in the home, the words “cannot be self-administered” will also include circumstances in which a family member or friend is trained to administer the drug and ongoing supervision by skilled medical personnel is required.

**Medical Emergency** A medical condition, whether physical or mental (including a condition resulting from a substance use disorder), manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the Member or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part. With respect to a pregnant woman who is having contractions, Medical Emergency also means that there is inadequate time to effect a safe transfer to another hospital before delivery or that transfer may pose a threat to the health or safety of the woman or the unborn child.

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

Please remember that if you are hospitalized, you must call HPHC within 48 hours or as soon as you can. If the notice of hospitalization is given to HPHC by an attending emergency physician, no further notice is required.

**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.

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.

Non-Plan Provider A Provider not under contract with HPHC or its affiliates to provide care to Members. Payments for services received from Non-Plan Providers are limited to the Allowed Amount. When care is received from a Non-Plan Provider, Member’s are responsible for the applicable Deductible and Coinsurance plus any amounts in excess of the Allowed Amount. The Deductible and Coinsurance amounts are described in your Schedule of Benefits.

Out-of-Network The level of benefits or coverage a Member receives when Covered Benefits are obtained through a Non-Plan Provider.

Out-of-Pocket Maximum An Out-of-Pocket Maximum is a limit on the amount of Member Cost Sharing (Deductibles, Copayments and Coinsurance) that a Member must pay for certain Covered Benefits in a Calendar Year. Member Cost Sharing for some services may be excluded from the Out-of-Pocket Maximum. For example, Penalty amounts and charges above the Allowed Amount never apply to the Out-of-Pocket Maximum. If your Plan includes an Out-of-Pocket Maximum, your Schedule of Benefits will list the services that do not apply to the Out-of-Pocket Maximum.

Plan This package of health care benefits known as The Harvard Pilgrim PPO for Self-Insured Members that is administered by HPHC on behalf of your Plan Sponsor. HPHC or your Plan Sponsor may take any action on behalf of the Plan.

Plan Provider Providers of health care services who are under contract to provide In-Network services to Plan Members, and have agreed to charge Members only the applicable Copayments, Coinsurance and Deductible amounts for Covered Benefits. Plan Providers are listed in the Provider Directory.

Plan Sponsor The entity that has contracted with HPHC to provide health care services and supplies for its employees and their dependents under the Plan. The Plan Sponsor pays for the health care coverage provided under the Plan.

Prior Approval or Prior Approval Program (also known as Prior Approval) A program to (1) verify that certain Covered Benefits are and continue to be, Medically Necessary and provided in an appropriate and cost-effective manner or (2) to arrange for the payment of benefits. Prior Approval is required for certain Out-of-Network benefits. Before you receive services from a Non-Plan Provider, please refer to our Internet site, www.harvardpilgrim.org or contact the Member Services Department at 1-888-333-4742 for the complete listing of Out-of-Network services that require Prior Approval. To seek Prior Approval for medical services you should call: 1-800-708-4414.

To seek Prior Approval for medical services, Medical Drugs or mental health care (including the treatment of substance use disorders) received from a Non-Plan Provider, you should call:

- 1-800-708-4414 for medical services
- 1-844-387-1435 for Medical Drugs
- 1-888-777-4742 for mental health care (including the treatment of substance use disorders)

Please see section I.F. NOTIFICATION AND PRIOR APPROVAL for a detailed explanation of the Prior Approval Program.

Provider A Provider is defined as: a hospital or facility that is licensed to provide inpatient medical,
surgical, or rehabilitative services; a Skilled Nursing Facility; and medical professionals including but not limited to: physicians, psychologists, psychiatrists, podiatrists, nurse practitioners, advanced practice registered nurses, physician's assistants, psychiatric social workers, licensed nurse mental health clinical specialist, psychotherapists, psychologists, licensed independent clinical social workers, licensed mental health counselors, level I licensed alcohol and drug counselors, physicians with recognized expertise in specialty pediatrics (including mental health care), nurse midwives, nurse anesthetists, chiropractors, optometrists, speech-language pathologists and audiologists, and early intervention specialists who are credentialed and certified by the Massachusetts Department of Public Health. Dentists may also be Providers when providing services under this Plan. (Please note that coverage for dental services is very limited.) Plan Providers are listed in the Provider Directory.

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 online at www.harvardpilgrim.org.

Rehabilitation Services Rehabilitation Services are treatments for disease or injury that help restore or move an individual toward functional capabilities he/she had 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.

Schedule of Benefits A summary of the benefits selected by your Plan Sponsor and covered under your Plan are listed in the Schedule of Benefits. The Schedule of Benefits states the Copayments, Coinsurance or Deductible you must pay and any limitations on coverage.

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.

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

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

If a Covered Benefit has a benefit limit, your In-Network or Out-of-Network benefits are combined and count toward your benefit limit. For example, if the Covered Benefit is limited to ten visits per Calendar Year and you receive nine visits In-Network and one visit Out-of-Network, then you have reached your benefit limit. That benefit will not be covered again until the next Calendar Year.

#### Basic Requirements for Coverage

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

- It must be listed as a Covered Benefit in this section.
- It must be Medically Necessary.
- It must not be excluded in section IV. Exclusions.
- It must be received while an active Member of the Plan.
- In-Network services must be provided by a Plan Provider. The only exception is care needed in a Medical Emergency.
- Some Out-of-Network services require Prior Approval by the Plan. Please see section I.F. NOTIFICATION AND PRIOR APPROVAL for information on the Prior Approval Program.
- In Massachusetts, Maine, Connecticut, Rhode Island and New Hampshire, there are certain specialized services that must be received from designated Plan Providers, referred to as “Centers of Excellence,” to receive In-Network coverage. Please see section I.D.4. Centers of Excellence for a list of these services.

#### Prior Approval or Notification Required:

When you use your Out-of-Network benefits, some services require Prior Approval by the Plan. Before you receive services from a Non-Plan Provider, please refer to our Internet site, [www.harvardpilgrim.org](http://www.harvardpilgrim.org) or contact the Member Services Department at 1-888-333-4742 for the complete listing of Out-of-Network services that require Prior Approval. Please see section I.F. NOTIFICATION AND PRIOR APPROVAL for information on the Prior Approval Program.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Acupuncture Treatment for Injury or Illness</strong></td>
<td>The Plan covers acupuncture treatment for illness or injury, including, electro-acupuncture, that is provided for the treatment of neuromusculoskeletal pain.</td>
</tr>
<tr>
<td><strong>2. Ambulance Transport</strong></td>
<td><strong>Emergency Ambulance Transport</strong>&lt;br&gt; If you have a Medical Emergency (including an emergency related to a substance use disorder or mental health condition), your Plan covers ambulance transport to the nearest hospital that can provide you with Medically Necessary care. <strong>Non-Emergency Ambulance Transport</strong>&lt;br&gt; You’re also covered for non-emergency ambulance transport 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 Provider. <strong>Prior Approval or Notification Required:</strong> You must obtain Prior Approval for non-emergency transportation. Please note Prior Approval is not required.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Description</td>
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</tr>
<tr>
<td>Ambulance Transport (Continued)</td>
<td>for transportation provided by a wheelchair van. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: 1-800-708-4414. Please see section I.F. NOTIFICATION AND PRIOR APPROVAL for more information.</td>
</tr>
<tr>
<td>3. Autism Spectrum Disorders Treatment</td>
<td>Coverage is provided for the diagnosis and treatment of Autism Spectrum Disorders, as defined below. Covered Benefits include the following:</td>
</tr>
<tr>
<td></td>
<td>• 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.</td>
</tr>
<tr>
<td></td>
<td>• Professional services by Providers. This includes care by physicians, Licensed Mental Health Professionals, speech therapists, occupational therapists, and physical therapists.</td>
</tr>
<tr>
<td></td>
<td>• Rehabilitation and Habilitation Services, including, but not limited to, applied behavior analysis supervised by a board certified behavior analyst as defined by law.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Applied behavior analysis is defined as the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior. It includes the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.</td>
</tr>
<tr>
<td></td>
<td>There is no coverage for services related to autism spectrum disorders 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.</td>
</tr>
<tr>
<td>4. Cardiac Rehabilitation Therapy</td>
<td>The Plan covers cardiac rehabilitation. Coverage includes only Medically Necessary services for Members with established coronary artery disease or unusual and serious risk factors for such disease.</td>
</tr>
<tr>
<td>5. Chemotherapy and Radiation Therapy</td>
<td>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.</td>
</tr>
<tr>
<td>6. Clinical Trials for the Treatment of Cancer or Other Life-Threatening Diseases</td>
<td>The Plan covers services for Members enrolled in a qualified clinical trial of a treatment for any form of cancer or other life-threatening disease under the terms and conditions provided under federal law. All of the requirements for coverage under the Plan apply to coverage under this benefit. The following services are covered under this benefit: (1) all services that are Medically Necessary for treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the Plan; and (2) the reasonable cost of an investigational drug or device that has been approved for use in the clinical trial to the extent it is not paid for by its manufacturer, distributor or provider.</td>
</tr>
</tbody>
</table>
### 7. 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 covers 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 procedure
- Anesthesia
- X-rays

### 8. 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. Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care.

The following items are also covered:

**Diabetes Equipment:**

- Blood glucose monitors
- Dosage gauges
- Injectors
- Insulin pumps (including supplies) and infusion devices
- Lancet devices
- Therapeutic molded shoes and inserts
- Visual magnifying aids
- Voice synthesizers

**Prior Approval or Notification Required:** You must obtain Prior Approval for continuous glucose monitoring systems. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling:
### Benefit Description

#### Diabetes Services and Supplies (Continued)

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1-800-708-4414.</strong> Please see section <em>I.F. NOTIFICATION AND PRIOR APPROVAL</em> for more information.</td>
<td></td>
</tr>
<tr>
<td><strong>Pharmacy Supplies:</strong></td>
<td>For information on coverage of pharmacy items please contact your pharmacy administrator at 1–844–265–1224.</td>
</tr>
</tbody>
</table>

#### 9. 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), 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.

**Prior Approval or Notification Required:** You must notify HPHC in advance of any planned inpatient admission to a Non-Plan Medical Facility. Also, Prior Approval is required for any services provided in the home. If you use a Plan Provider, he or she will notify HPHC of your inpatient admission or seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414.** Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for more information.

#### 10. Drug Coverage

You have limited coverage for prescription drugs under the Plan, which is described below.

**Your Coverage under the Plan**

The Plan covers drugs administered to you by a medical professional in either of the following circumstances:

- 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; or
- 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 health care services or receiving drugs administered by home infusion services covered by the Plan.

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 home health care services, the words “cannot be self-administered” will include circumstances in which a family member or friend is trained to administer the drug and ongoing supervision by skilled medical personnel is required.

An example of a drug that cannot be self-administered is a drug that must be administered intravenously. Examples of drugs that can be self-administered are drugs that can be taken in pill form and drugs that are typically self-injected by the patient.

**Prior Approval or Notification Required:** You must obtain Prior Approval for select Medical Drugs. If you use a Plan Provider, he/she will seek Prior Approval...
Drug Coverage (Continued)

for you. The Prior Approval process is initiated by calling: 1-844-387-1435. Please see section I.F. NOTIFICATION AND PRIOR APPROVAL for more information.

The Plan also provides coverage for: (a) certain diabetes supplies and (b) syringes and needles you purchase at a pharmacy. Please see the benefits for “Diabetes Services and Supplies” and “Hypodermic Syringes and Needles” for the details of those benefits.

No coverage is provided under the Plan for: (1) drugs that have not been approved by the United States Food and Drug Administration; (2) drugs the Plan excludes or limits, including, but not limited to, drugs for cosmetic purposes or weight loss; and (3) any drug that is obtained at an outpatient pharmacy except (a) covered diabetes supplies and (b) syringes and needles, as explained above.

11 . Durable Medical Equipment (DME)

The Plan covers DME when Medically Necessary and ordered by a Provider. The Plan may rent or buy the equipment you need. The cost of the repair and maintenance of covered equipment is also covered.

In order to be covered, all equipment must be:

- Able to withstand repeated use;
- Not generally useful in the absence of disease or injury;
- Normally used in the treatment of an illness or injury or for the rehabilitation of an abnormal body part; and
- Suitable for home use.

Coverage is only available for:

- The least costly equipment adequate to allow you to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports; and
- One item of each type of equipment. No back-up items or items that serve a duplicate purpose are covered. For example, the Plan covers a manual or an electric wheelchair, not both.

Covered equipment and supplies include:

- Canes
- Certain types of braces
- Crutches
- Hospital beds
- Oxygen and oxygen equipment
- Respiratory equipment
- Walkers
- Wheelchairs

Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan.
<table>
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<tr>
<th>Benefit</th>
<th>Description</th>
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</table>
| **12. Early Intervention Services**          | The Plan covers early intervention services provided for Members until three years of age. Covered Benefits include:  
  - Nursing care  
  - Physical, speech, and occupational therapy  
  - Psychological counseling  
  - Screening and assessment of the need for services                                                                                                                                                                                                                     |
| **13. 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 get your care from a Plan Provider for coverage to be at the In-Network benefit payment level.  
  - If you are hospitalized, you must call HPHC at 1-888-333-4742 within 48 hours or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to the Plan by an attending emergency physician no further notice is required. |
| **14. 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.                                                                                                                                 |
| **15. Gender Reassignment Surgery**          | The Plan covers gender reassignment surgery as described below. Services are covered when your provider has determined that you are an appropriate candidate for gender reassignment surgery in accordance with HPHC clinical guidelines. To receive a copy of the HPHC guidelines please call the Member Services Department at 1–888–333–4742. Coverage includes surgery, related physician and behavioral health visits.  
  Benefits for gender reassignment surgery are in addition to the other benefits provided under the Plan. HPHC does not consider gender reassignment surgery to be reconstructive surgery to correct a Physical Functional Impairment or Cosmetic Services. Coverage for reconstructive surgery or Cosmetic Services is limited to the services described under the Reconstructive Surgery benefit in this Handbook.  
  Coverage for gender reassignment surgery is limited to the specific surgical procedures listed below. No other services are covered in connection with gender reassignment surgery:  
  **Male-to-female:**  
  - Initial augmentation mammoplasty  
  - Clitoroplasty  
  - Labiaplasty  
  - Orchiectomy |
<table>
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<tr>
<th>Benefit</th>
<th>Description</th>
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</table>
| **Gender Reassignment Surgery (Continued)** | • Penectomy  
• Vaginoplasty  
• Colovaginoplasty  
• Facial feminization surgery limited to forehead contouring, mandible contouring, chondrolaryngoplasty (trachea shave), and rhinoplasty |
| **Female-to-male:**                         | • Colpectomy  
• Hysterectomy  
• Bilateral mastectomy  
• Metoidioplasty  
• Salpingo-oophorectomy  
• Urethroplasty  
• Phalloplasty  
• Rhinoplasty  
• Scrotoplasty with placement of testicular prostheses |

Once initial gender reassignment surgery has been completed, the Plan does not cover any further cosmetic changes. In addition, no coverage is provided for reversal of gender reassignment surgery whether or not originally covered by the Plan.

Certain services covered under the benefit are provided by only a limited number of Providers in the country and may not currently be in the Plan’s network. However, the Plan will work with you and your physician to identify one or more providers who are appropriate to provide services under this benefit. Members with questions about coverage under this benefit should contact the Member Services Department at 1-888-333-4742.

For coverage of behavioral health services related to gender reassignment surgery, please see the section titled, “Mental Health Care (Including the Treatment of Substance Use Disorders)” in this Handbook.

**Prior Approval or Notification Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: 1-800-708-4414. Please see the section titled, “Prior Approval” for more information.

### 16. Hearing Aids

The Plan covers hearing aids up to the limit listed in your Schedule of Benefits. A hearing aid is defined as any instrument or device, excluding a surgical implant, designed, intended or offered for the purpose of improving a person’s hearing.

The Plan will pay the full cost of each medically necessary hearing aid up to the limit listed in your Schedule of Benefits, minus any applicable Member Cost Sharing. If you purchase a hearing aid that is more expensive than the limit listed in your Schedule of Benefits, you will be responsible for the additional cost. No back-up hearing aids that serve a duplicate purpose are covered. Covered services and supplies related to your hearing aid are not subject to the dollar limit listed in your Schedule of Benefits. Covered Benefits include the following:
### 17. 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 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 in a reasonable period of time.

When you qualify for home health care services as stated above, the Plan covers the following services when Medically Necessary:

- Durable medical equipment and supplies (must be a component of the home health care being provided)
- Medical and surgical supplies
- Medical social services
- Nutritional counseling
- Physical therapy
- Occupational therapy
- Services of a home health aide
- Skilled nursing care
- Speech therapy

**Prior Approval or Notification Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see the section titled, “Prior Approval” for more information.

### 18. 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 Calendar Year. Inpatient care is also covered in an acute hospital or extended care facility when it is Medically Necessary to control pain and manage acute and severe clinical problems that cannot be managed in a home setting. Covered Benefits include:

- Care to relieve pain
- Counseling
- Drugs that cannot be self-administered
- Durable medical equipment appliances
- Home health aide services
- Medical supplies
- Nursing care
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
</table>
| Hospice Services (Continued) | • Physician services  
• Occupational therapy  
• Physical therapy  
• Speech therapy  
• Respiratory therapy  
• Respite care  
• Social services |

**Prior Approval or Notification Required:** You must obtain Prior Approval for home hospice care. If you use a Plan Provider, he or she will seek Prior Approval for you. The Prior Approval process is initiated by calling: 1-800-708-4414. Please see section I.F. NOTIFICATION AND PRIOR APPROVAL for more information.

19. 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  
• Medications  
• Laboratory and x-ray services  
• Intensive care  
• Surgery, including related services  
• Anesthesia, including the services of a nurse-anesthetist  
• Radiation therapy  
• Physical therapy  
• Occupational therapy  
• Speech therapy

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

**Prior Approval or Notification Required:** You must notify HPHC in advance of any planned inpatient admission. If you use a Plan Provider, he/she will notify HPHC for you. The notification process is initiated by calling: 1-800-708-4414. Please see section I.F. NOTIFICATION AND PRIOR APPROVAL for more information.

20. House Calls

The Plan covers house calls.
### Benefit Description

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<tr>
<th>Benefit</th>
<th>Description</th>
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</table>
| **21. Human Organ Transplant Services** | The Plan covers human organ transplants, including bone marrow transplants for a Member with metastasized breast cancer in accordance with the criteria of the Massachusetts Department of Public Health. The Plan covers the following services when the recipient is a Member of the Plan:  
- Care for the recipient  
- Donor search costs through established organ donor registries  
- Donor costs that are not covered by the donor's health plan  
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. |
| **22. Hypodermic Syringes and Needles** | The Plan covers hypodermic syringes and needles to the extent Medically Necessary. You must get a prescription from your Provider and present it at a participating pharmacy for coverage. For information on coverage of pharmacy items please contact your pharmacy administrator at 1–844–265–1224. |
| **23. Infertility Services and Treatment** | Infertility is defined as the inability of a woman aged 35 or younger to conceive or produce conception during a period of one year. In the case of a woman over age 35, the time period is reduced to 6 months. If a woman conceives but is unable to carry the pregnancy to live birth, the time she attempted to conceive prior to that pregnancy is included in the one year or 6 month period, as applicable. The Plan covers the following diagnostic services for infertility:  
- Consultation  
- Evaluation  
- Laboratory tests  
The Plan covers the following infertility treatment:  
- Therapeutic artificial insemination (AI), including related sperm procurement and banking  
- Donor egg procedures, including related egg and inseminated egg procurement, processing and banking  
- Assisted hatching  
- Gamete intrafallopian transfer (GIFT)  
- Intra-cytoplasmic sperm injection (ICSI)  
- Intra-uterine insemination (IUI)  
- In-vitro fertilization and embryo transfer (IVF)  
- Zygote intrafallopian transfer (ZIFT)  
- Preimplantation genetic diagnosis (PGD)  
- Microsurgical epididiymal sperm aspiration (MESA)  
- Testicular sperm extraction (TESE)  
- Sperm collection, freezing and up to one year of storage is also covered for male Members in active infertility treatment.  
- Cryopreservation of eggs |
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<th>Benefit</th>
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| **Infertility Services and Treatment (Continued)** | **Important Notice:** We use clinical guidelines to evaluate whether the use of infertility treatment is Medically Necessary. If you are planning to receive infertility treatment we recommend that you review the current guidelines. To obtain a copy, please call 1-888-888-4742 ext. 38723.  

**Prior Approval or Notification Required:** You must obtain Prior Approval for all services for the treatment of infertility. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: 1-800-708-4414. Please see section I.F. NOTIFICATION AND PRIOR APPROVAL for more information. |
| **24. Laboratory and Radiology Services**    | The Plan covers diagnostic laboratory and x-ray services, including Advanced Radiology, on an outpatient basis. The term “Advanced Radiology” means CT scans, PET Scans, MRI and MRA, and nuclear medicine services. Coverage includes:  

- The facility charge and the charge for supplies and equipment.  
- The charges of anesthesiologists, pathologists and radiologists.  

In addition, the Plan covers the following:  

- Human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish bone marrow transplant donor suitability (including testing for A, B, or DR antigens, or any combination, consistent with rules, regulations and criteria established by the Department of Public Health).  
- Diagnostic screenings and tests as required by law including: hereditary and metabolic screening at birth; tuberculin tests; lead screenings; hematocrit, hemoglobin or other appropriate blood tests, and urinalysis.  
- Mammograms, including a baseline mammogram for women between the ages of thirty-five and forty, and an annual mammogram for women forty years of age and older.  

**Prior Approval or Notification Required:** You must obtain Prior Approval for computerized axial tomography (CAT and CT and CTA scans); Magnetic resonance imaging (MRI and MRA scans); Nuclear cardiac studies; and Positron emission tomography (PET scans). If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: 1-800-708-4414. Please see section I.F. NOTIFICATION AND PRIOR APPROVAL for more information. |
| **25. 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 acids up to the limit stated in your Schedule of Benefits. |
### Benefit Description

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<th>Benefit</th>
<th>Description</th>
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| **26 . 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.  
- 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.E. ADDING A DEPENDENT for more enrollment information.  
- Routine outpatient postpartum care for the mother, up to six weeks after delivery.  

**Prior Approval or Notification Required:** You must notify HPHC in advance of any planned inpatient admission or when a newborn is admitted to a neonatal intensive care unit. If you use a Plan Provider, he/she will notify HPHC for you. The notification process is initiated by calling: **1-800-708-4414**. Please see section I.F. NOTIFICATION AND PRIOR APPROVAL for more information. |
| **27 . Medical Formulas** | The Plan covers the following up to the limit stated in your Schedule of Benefits:  
- Non-prescription enteral formulas for home use for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction and inherited diseases of amino acids and organic acids.  
- Prescription formulas for the treatment of phenylketonuria, tyrosinemia, homocystinuria, 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 or Notification Required:** You must obtain Prior Approval for outpatient formulas and enteral nutrition. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section I.F. NOTIFICATION AND PRIOR APPROVAL for more information. |
| **28 . Mental Health Care (Including the Treatment of Substance Use Disorders)** | The Plan covers both inpatient and outpatient mental health care to the extent Medically Necessary as outlined below. As used in this section the term “mental health care” includes the Medically Necessary treatment of substance use disorders.  

For Out-of-Network coverage of certain mental health care (including the treatment of substance use disorders), you must obtain Prior Approval from the Behavioral Health Access Center by calling **1-888-777-4742**.  

**Please Note:** Prior Approval is not required to obtain substance use disorder treatment from a Plan Provider. In addition, when services are obtained from a Plan Provider, the Plan will not deny coverage for the first 14 days of (1) Acute Treatment Services or (2) Clinical Stabilization Services for the
Benefit Description

Mental Health Care (Including the Treatment of Substance Use Disorders) (Continued)

treatment of substance use disorder so long as the Plan receives notice from the Plan Provider within 48 hours of admission. The terms “Acute Treatment Services” and “Clinical Stabilization Services” are defined in the Glossary at section II of this Benefit Handbook. Services beyond the 14 day period may be subject to concurrent review as described in section X.J. UTILIZATION REVIEW PROCEDURES of this Handbook.

The following is a list of the mental health and substance use treatment services that require Prior Approval when obtained from a Non-Plan Provider:

- **Intensive Outpatient Program Treatment** - Treatment programs at an outpatient clinic or other facility generally lasting three or more hours a day on two or more days a week.

- **Partial Hospitalization and Day Treatment Programs**

- **Extended Outpatient Treatment Visits** - Outpatient visits of more than 50 minutes duration with or without medication management. Also included is any treatment routinely involving more than one outpatient visit in a day.

- **Outpatient Electro-Convulsive Treatment (ECT)**

- **Psychological Testing** – Outpatient visits of more than 50 minutes duration with or without medication management. Also included is any treatment routinely involving more than one outpatient visit in a day.

- **Applied Behavioral Analysis (ABA) for the treatment of Autism**

Even when Prior Approval is not required, mental health care may be arranged through the Behavioral Health Access Center by calling 1-888-777-4742. (The only exception applies to care required in a Medical Emergency.) The Behavioral Health Access Center phone line is staffed by licensed mental health clinicians. A clinician will assist you in finding an appropriate Provider and arranging the services you require.

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

The Plan requires consent to the disclosure of information regarding services for mental disorders to the same extent it requires consent for disclosure of information for other medical conditions. Any determination of Medical Necessity for mental health care will be made in consultation with a Licensed Mental Health Professional.

**Minimum Requirements for Covered Providers**

To be eligible for coverage under this benefit, all services must be provided either (1) at the office of a Licensed Mental Health Professional, or (2) at a facility licensed or approved by the health department or mental health department of the state in which the service is provided. (In Massachusetts those departments are the Department of Public Health and the Department of Mental Health, respectively.) To qualify, a facility must be both licensed as, and function primarily as, a health or mental health care facility. A facility that is also licensed as an educational or recreational institution will not meet this requirement unless the predominate purpose of the facility is the provision of mental health care services.

To qualify for coverage, all services rendered outside of a state licensed or approved facility must be provided by an independently Licensed Mental Health Professional. For services provided in Massachusetts, a Licensed Mental Health Professional must be one of the following types of Providers: a licensed...
### Mental Health Care (Including the Treatment of Substance Use Disorders) (Continued)

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<th>Benefit</th>
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<td>A physician who specializes in the practice of psychiatry; a licensed psychologist; a licensed independent clinical social worker; a licensed nurse mental health clinical specialist; a licensed marriage and family therapist; a licensed mental health counselor or a level I licensed alcohol and drug counselor. For services provided outside of Massachusetts, a Licensed Mental Health Professional is an independently licensed clinician with at least a Masters degree in a clinical mental health discipline from an accredited educational institution and at least two years of clinical experience. The term “clinical mental health discipline” includes the following: psychiatry; psychology; clinical social work; marriage and family therapy; clinical counseling; developmental psychology; pastoral counseling; psychiatric nursing; developmental or educational psychology; counselor education; or any other discipline deemed acceptable by the Plan.</td>
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</table>

### Benefits

The Plan will provide coverage for the care of all conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. (The only exception is conditions for which only a “Z Code” designation applies, which means that the condition is not attributable to a mental disorder.)

Covered mental health services include the following:

a) **Mental Health Care Services**

   Subject to the Member cost sharing and any benefit limits stated in your Schedule of Benefits, the Plan provides coverage for the following Medically Necessary mental health care services:

   1) **Inpatient Services**

      - Hospitalization, including detoxification

   2) **Intermediate Care Services**

      - Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization

      - Intensive outpatient programs, partial hospitalization and day treatment programs

   3) **Outpatient Services**

      - Care by a Licensed Mental Health Professional

      - Detoxification

      - Medication management

      - Methadone maintenance

      - Psychological testing and neuropsychological assessment.

### 29. Ostomy Supplies

The Plan covers ostomy supplies up to the Benefit Limit stated in the Schedule of Benefits. Only the following supplies are covered:

- Irrigation sleeves, bags and catheters
- Pouches, face plates and belts
- Skin barriers
### 30. Physician and Other Professional Office Visits

Physician services, including services of all covered medical professionals, can be obtained on an outpatient basis at 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 childhood immunizations as recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention and the American Academy of Pediatrics
- Well baby and well child care, including physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and developmental screening, and assessment at the following intervals:
  - At least six visits per Calendar Year are covered for a child from birth to age one.
  - At least three visits per Calendar Year are covered for a child from age one to age two.
  - At least one visit per Calendar Year is covered for a child from age two to age six.
- School, camp, sports and premarital examinations
- Health education and nutritional counseling
- Sickness and injury care
- Vision and Hearing screenings
- Medication management
- Consultations concerning contraception and hormone replacement therapy
- Chemotherapy
- Radiation therapy

**Please Note:** The Plan covers certain preventive services and tests with no Member Cost Sharing. Please see your Schedule of Benefits for the coverage that applies to your Plan.

### 31. Prosthetic Devices

The Plan covers prosthetic devices as described below. The cost of the repair and maintenance of a covered device is also covered. In order to be covered, all devices must be able to withstand repeated use.

Coverage is only available for:

- The least costly prosthetic device adequate to allow you to perform Activities of Daily Living. (Activities of Daily Living do not include special functions needed for occupational purposes or sports.); and
- One item of each type of prosthetic device. No back-up items or items that serve a duplicate purpose are covered.

Covered prostheses include:

- Breast prostheses, including replacements and mastectomy bras
- Prosthetic arms and legs (including myoelectric and bionic arms and legs)
- Prosthetic eyes
### 32. Reconstructive Surgery

The Plan covers reconstructive and restorative surgical procedures as follows:

- Reconstructive surgery is covered when the surgery can reasonably be expected to improve or correct a Physical Functional Impairment resulting from an accidental injury, illness, congenital anomaly, birth injury or prior surgical procedure. If reconstructive surgery is performed to improve or correct a Physical Functional Impairment, as stated above, Cosmetic Services that are incidental to that surgery are also covered. After a Physical Functional Impairment is corrected, no further Cosmetic Services are covered by the Plan.
- Restorative surgery is covered to repair or restore appearance damaged by an accidental injury. (For example, this benefit would cover repair of a facial deformity following an automobile accident.)

Benefits are also provided for post mastectomy care, including coverage for:

- Prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient;
- Reconstruction of the breast on which the mastectomy was performed; and
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.

Benefits include coverage for procedures that must be done in stages, as long as you are an active Member. Membership must be effective on all dates on which services are provided.

There is no coverage for Cosmetic Services or surgery except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care as described above.

**Important Notice:** We use clinical guidelines to evaluate whether different types of reconstructive and restorative procedures are Medically Necessary. If you are planning to receive such treatment, you may review the current guidelines. To obtain a copy, please call 1-888-888-4742 ext. 38732.

**Prior Approval or Notification Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section **I.F. NOTIFICATION AND PRIOR APPROVAL** for more information.
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<th>Benefit</th>
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<tr>
<td><strong>33. Rehabilitation Hospital Care</strong></td>
<td>The Plan covers care in a facility licensed to provide rehabilitative care on an inpatient basis. Coverage is provided when you need daily Rehabilitation Services that must be provided in an inpatient setting. Rehabilitation Services include cardiac rehabilitation therapy, physical therapy, pulmonary rehabilitation therapy, occupational therapy and speech therapy. The Benefit Limit is stated in the Schedule of Benefits. <strong>Prior Approval or Notification Required:</strong> You must obtain Prior Approval for rehabilitation care. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: <strong>1-800-708-4414.</strong> Please see section <strong>I.F. NOTIFICATION AND PRIOR APPROVAL</strong> for more information.</td>
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<tr>
<td><strong>34. Rehabilitation and Habilitation Services – Outpatient</strong></td>
<td>The Plan covers the following outpatient Rehabilitation and Habilitation Services: • Occupational therapy • Physical therapy • Pulmonary rehabilitation therapy Outpatient Rehabilitation and Habilitation Services are covered up to the Benefit Limit stated in the Schedule of Benefits. Services are covered only: • If, in the opinion of your 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. Activities of Daily Living do not include special functions needed for occupational purposes or sports. Rehabilitation and Habilitation Services are also covered under your inpatient hospital and home health benefits. <strong>Prior Approval or Notification Required:</strong> You must obtain Prior Approval for coverage of outpatient pulmonary rehabilitation. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: <strong>1-800-708-4414.</strong> Please see section <strong>I.F. NOTIFICATION AND PRIOR APPROVAL</strong> for more information. <strong>Please Note:</strong> Outpatient physical and occupational therapies for children under the age of 3 are covered to the extent Medically Necessary. The benefit limit stated in the Schedule of Benefits does not apply.</td>
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<td><strong>35. Scopic Procedures – Outpatient Diagnostic</strong></td>
<td>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</td>
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<td>Benefit</td>
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<tr>
<td><strong>36. Skilled Nursing Facility Care</strong></td>
<td>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 stated in the Schedule of Benefits. <strong>Prior Approval or Notification Required:</strong> You must obtain Prior Approval for Skilled Nursing Facility care. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: 1-800-708-4414. Please see section I.F. NOTIFICATION AND PRIOR APPROVAL for more information.</td>
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<tr>
<td><strong>37. Speech-Language and Hearing Services</strong></td>
<td>The Plan covers diagnosis and treatment of speech, hearing and language disorders to the extent Medically Necessary by speech-language pathologists and audiologists.</td>
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<tr>
<td><strong>38. Spinal Manipulative Therapy (including care by a chiropractor)</strong></td>
<td>The Plan covers musculoskeletal adjustment or manipulation up to the Benefit Limit stated in the Schedule of Benefits.</td>
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<tr>
<td><strong>39. Surgery - Outpatient</strong></td>
<td>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. <strong>Please Note:</strong> In Massachusetts, Maine, Connecticut, Rhode Island and New Hampshire there are certain specialized services that must be received from designated Plan Providers, referred to as “Centers of Excellence” to receive In-Network coverage. Please see section I.D.4. Centers of Excellence for further information. <strong>Prior Approval or Notification Required:</strong> You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: 1-800-708-4414. Please see section I.F. NOTIFICATION AND PRIOR APPROVAL for more information.</td>
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<tr>
<td><strong>40. Telemedicine Services</strong></td>
<td>The Plan covers Medically Necessary telemedicine services for the purpose of diagnosis, consultation or treatment in the same manner as an in-person consultation between you and your Provider. Telemedicine services include the use of real-time interactive audio, video or other electronic media telecommunications, telemonitoring, and telemedicine services involving stored images forwarded for future consultations, i.e. “store and forward” telecommunication as a substitute for in-person consultation with Providers. Member Cost Sharing for telemedicine services is the same as the Member Cost Sharing for the same type of service if it had been provided through an in-person consultation. Please refer to your Schedule of Benefits for specific information on Member Cost Sharing you may be required to pay.</td>
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<td>Benefit</td>
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| 41. Temporomandibular Joint Dysfunction Services | The Plan covers medical treatment of Temporomandibular Joint Dysfunction (TMD). Only the following services are covered:  
- Initial consultation with a physician  
- Physical therapy, (subject to the visit limit for outpatient physical therapy stated 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 or Notification Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: 1-800-708-4414. Please see section 1.F. NOTIFICATION AND PRIOR APPROVAL for more information. |
| 42. Urgent Care Services | The Plan covers Urgent Care you receive at (1) a convenience care clinic or (2) an urgent care clinic.  
Convenience care clinics provide treatment for minor illnesses and injuries. They are usually staffed by non-physician providers, such as nurse practitioners, and are located in stores, supermarkets or pharmacies. To see a list of convenience care clinics covered by the Plan, please refer to your Provider Directory and search under “convenience care.”  
Urgent care clinics provide treatment for illnesses and injuries that require urgent attention but are not life threatening. Urgent care clinics are independent clinics or certain hospital-owned clinics that provide urgent care services. Urgent care clinics are staffed by doctors, nurse practitioners, and physician assistants. To see a list of urgent care clinics covered by the Plan, please refer to your Provider Directory and search under “urgent care.”  
Some hospitals provide urgent care services as part of the hospital's outpatient services. Because the services provided are considered outpatient hospital services, only the hospitals are listed in the Provider Directory. These services may require higher Member Cost Sharing than urgent care services received at independent urgent care clinics. Please refer to your Schedule of Benefits for your specific Member Cost Sharing requirements for urgent care services.  
Coverage for Urgent Care is provided for services that are required to prevent deterioration to your health resulting from an unforeseen sickness or injury. Covered Benefits include but are not limited to the following:  
- Care for minor cuts, burns, rashes or abrasions, including suturing  
- Treatment for minor illnesses and infections, including ear aches  
- Treatment for minor sprains or strains  
Whenever possible, you should contact your PCP prior to obtaining care at either a convenience care clinic or an urgent care clinic. Your PCP may be able to provide the services you require at a lower out-of-pocket cost.  
**Important Notice:** Urgent care is not emergency care. You should call 911 or go directly to a hospital emergency room if you suspect you are having a Medical Emergency. These include heart attack or suspected heart attack, shock, major blood loss, or loss of consciousness. Please see section 1.D.7. Medical Emergency Services for more information. |
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| 43. Vision Services | **Routine Eye Examinations:**  
The Plan covers routine eye examinations.  
**Vision Hardware for Special Conditions:**  
The Plan provides coverage for contact lenses or eyeglasses needed for the following conditions:  
- Keratoconus. One pair of contact lenses is covered per Calendar Year. The replacement of lenses, due to a change in the Member’s condition, is limited to 3 per affected eye per Calendar Year.  
- Post cataract surgery with an intraocular lens implant (pseudophakes). Coverage is limited to $140 per surgery toward the purchase of eyeglass frames and lenses. The replacement of lenses due to a change in the Member’s prescription of .50 diopters or more within 90 days of the surgery is also covered up to a limit of $140.  
- Post cataract surgery without lens implant (aphakes). One pair of eyeglass lenses or contact lenses is covered per Calendar Year. Coverage up to $50 per Calendar Year is also provided for the purchase of eyeglass frames. The replacement of lenses due to a change in the Member’s condition is also covered. Replacement of lenses due to wear, damage, or loss, is limited to 3 per affected eye per Calendar Year.  
- Post retinal detachment surgery. For a Member who wore eyeglasses or contact lenses prior to retinal detachment surgery, the Plan covers the full cost of one lens per affected eye up to one Calendar Year after the date of surgery. For Members who have not previously worn eyeglasses or contact lenses, the Plan covers either (1) a pair of eyeglass lenses and up to $50 toward the purchase of the frames, or (2) a pair of contact lenses. |
| 44. Voluntary Sterilization | The Plan covers voluntary sterilization, including tubal ligation and vasectomy. |
| 45. Voluntary Termination of Pregnancy | The Plan covers voluntary termination of pregnancy. |
| 46. Wigs and Scalp Hair Prostheses | The Plan covers wigs and scalp hair prostheses when needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis or permanent hair loss due to injury up to the Benefit Limit stated in the Schedule of Benefits. |
IV. Exclusions

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

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

<table>
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<tr>
<th>Exclusion</th>
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<tbody>
<tr>
<td>1. Alternative Treatments</td>
<td>1. Acupuncture services that are outside the scope of standard acupuncture care.</td>
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<td></td>
<td>2. Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments.</td>
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<td>3. Aromatherapy, treatment with crystals and alternative medicine.</td>
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<td>4. Any of the following types of programs: Health resorts, spas, recreational programs, camps, wilderness programs (therapeutic outdoor programs),</td>
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<td>outdoor skills programs, educational programs for children in residential care, self-help programs, life skills programs, relaxation or lifestyle</td>
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<td>programs, including any services provided in conjunction with, or as part of such types of programs and wellness clinics.</td>
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<td>5. Massage therapy.</td>
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<td>6. Myotherapy.</td>
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<tr>
<td>2. Dental Services</td>
<td>1. Dental Care, except when specifically listed as a Covered Benefits in this Benefit Handbook and your Schedule of Benefits.</td>
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<tr>
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<td>2. All services of a dentist for Temporomandibular Joint Dysfunction (TMD).</td>
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<td>4. Dentures.</td>
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<tr>
<td>3. Durable Medical Equipment and Prosthetic Devices</td>
<td>1. Any devices or special equipment needed for sports or occupational purposes.</td>
</tr>
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<td>2. Any home adaptations, including, but not limited to home improvements and home adaptation equipment.</td>
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<td>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.</td>
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<td>4. Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.</td>
</tr>
<tr>
<td>4. Experimental, Unproven or Investigational Services</td>
<td>1. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental,</td>
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<tr>
<td></td>
<td>Unproven, or Investigational.</td>
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<td></td>
<td>2. Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not</td>
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<td></td>
<td>apply to preventive foot care for Members with diabetes.</td>
</tr>
</tbody>
</table>
### Exclusion Description

7. Mental Health Care

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Biofeedback.</td>
</tr>
<tr>
<td>2.</td>
<td>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, (2) to resolve problems of school performance, (3) to treat learning disabilities, (4) for driver alcohol education, or (5) for community reinforcement approach and assertive continuing care.</td>
</tr>
<tr>
<td>3.</td>
<td>Sensory integrative praxis tests.</td>
</tr>
<tr>
<td>4.</td>
<td>Services for any condition with only a “Z Code” designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder.</td>
</tr>
<tr>
<td>5.</td>
<td>Mental health care that is (1) provided to Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health.</td>
</tr>
<tr>
<td>6.</td>
<td>Services or supplies for the diagnosis or treatment of mental health and substance use disorders that, in the reasonable judgment of the Behavioral Health Access Center, are any of the following:</td>
</tr>
<tr>
<td>• Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.</td>
<td></td>
</tr>
<tr>
<td>• Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.</td>
<td></td>
</tr>
<tr>
<td>• Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Services related to autism spectrum disorders 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.</td>
</tr>
</tbody>
</table>

8. Physical Appearance

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care.</td>
</tr>
<tr>
<td>2.</td>
<td>Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy.</td>
</tr>
<tr>
<td>3.</td>
<td>Liposuction or removal of fat deposits considered undesirable.</td>
</tr>
<tr>
<td>4.</td>
<td>Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).</td>
</tr>
<tr>
<td>5.</td>
<td>Skin abrasion procedures performed as a treatment for acne.</td>
</tr>
<tr>
<td>6.</td>
<td>Treatment for skin wrinkles or any treatment to improve the appearance of the skin.</td>
</tr>
<tr>
<td>7.</td>
<td>Treatment for spider veins.</td>
</tr>
</tbody>
</table>
### Exclusion

<table>
<thead>
<tr>
<th>#</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.1</td>
<td>Procedures and Treatments</td>
</tr>
<tr>
<td>1.</td>
<td>Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial X-ray.</td>
</tr>
<tr>
<td>2.</td>
<td>Commercial diet plans, weight loss programs and any services in connection with such plans or programs.</td>
</tr>
<tr>
<td>3.</td>
<td>Gender reassignment surgery and all related drugs and procedures, except the specific services listed as Covered Benefits in this Handbook. The following services are not covered for the purpose of gender reassignment: face-lifting; lip reduction/enhancement; blepharoplasty; laryngoplasty, or other voice modification surgery; facial implants or injections; silicone injections of the breast; liposuction; electrolysis, hair removal, or hair transplantation; collagen injections; and removal of redundant skin.</td>
</tr>
<tr>
<td>4.</td>
<td>Reversal of gender reassignment surgery and all related procedures.</td>
</tr>
<tr>
<td>5.</td>
<td>If a service received in Massachusetts, Maine, Connecticut, Rhode Island or New Hampshire is listed as requiring that it be provided at a Center of Excellence, no In-Network coverage will be provided under this Handbook. If that service is received in Massachusetts, Maine, Connecticut, Rhode Island or New Hampshire from a Provider that has not been designated as a Center of Excellence. Please see Handbook section “Centers of Excellence” for more information.</td>
</tr>
<tr>
<td>6.</td>
<td>Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).</td>
</tr>
<tr>
<td>7.</td>
<td>Physical examinations and testing for insurance, licensing or employment.</td>
</tr>
<tr>
<td>8.</td>
<td>Services for Members who are donors for non-Members, except as described under Human Organ Transplant Services.</td>
</tr>
<tr>
<td>10.</td>
<td>Group diabetes training, educational programs or camps.</td>
</tr>
</tbody>
</table>

### Providers

<table>
<thead>
<tr>
<th>#</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>10.1</td>
<td>Charges for services which were provided after the date on which your membership ends.</td>
</tr>
<tr>
<td>2.</td>
<td>Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit under this Handbook.</td>
</tr>
<tr>
<td>3.</td>
<td>Charges for missed appointments.</td>
</tr>
<tr>
<td>4.</td>
<td>Concierge service fees. Please see Handbook section “Provider Fees For Special Services” for more information.</td>
</tr>
<tr>
<td>5.</td>
<td>Inpatient charges after your hospital discharge.</td>
</tr>
<tr>
<td>6.</td>
<td>Provider's charge to file a claim or to transcribe or copy your medical records.</td>
</tr>
<tr>
<td>7.</td>
<td>Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.</td>
</tr>
<tr>
<td>Exclusion</td>
<td>Description</td>
</tr>
<tr>
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</tbody>
</table>
| **11. Reproduction** | 1. Any form of Surrogacy or services for a gestational carrier.  
2. Infertility drugs if a Member is not in a Plan authorized cycle of infertility treatment.  
3. Infertility drugs that must be purchased at an outpatient pharmacy.  
4. Infertility treatment for Members who are not medically infertile.  
5. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal).  
6. Sperm collection, freezing and storage except as described in section “Covered Benefits”, *Infertility Services and Treatment*.  
7. Sperm identification when not Medically Necessary (e.g., gender identification).  
8. The following fees; wait list fees, non-medical costs, shipping and handling charges etc. |
| **12. Services Provided Under Another Plan** | 1. Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities.  
2. Costs for services for which payment is required to be made by a Workers' Compensation plan or an employer under state or federal law. |
| **13. Telemedicine Services** | 1. Telemedicine services involving e-mail, fax, texting, or audio-only telephone.  
2. Provider fees for technical costs for the provision of telemedicine services. |
2. Recovery programs including rest or domiciliary care, sober houses, transitional support services, and therapeutic communities.  
3. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary.  
4. Pain management programs or clinics.  
5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.  
6. Private duty nursing.  
7. Sports medicine clinics.  
8. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation. |
### 15. Vision and Hearing

1. Eyeglasses, contact lenses and fittings, except as listed in this Benefit Handbook.
2. Hearing aids, except as listed in your Schedule of Benefits.
3. Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD.
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.

### 16. All Other Exclusions

1. Any service or supply furnished in connection with a non-Covered Benefit.
2. Beauty or barber service.
3. Any drug or other product obtained at an outpatient pharmacy. Exceptions may apply for diabetes services and hypodermic syringes and needles. Please see section III. Covered Benefits of this Handbook for further details.
4. All food or nutritional supplements except those covered under the benefits for (1) low protein foods and (2) medical formulas.
5. Guest services.
6. 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.
7. Services for non-Members.
8. Services for which no charge would be made in the absence of insurance.
9. Services for which no coverage is provided by the Plan.
10. Services that are not Medically Necessary.
11. Taxes or governmental assessments on services or supplies.
12. Transportation other than by ambulance.
13. 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
<table>
<thead>
<tr>
<th>Exclusion</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Other Exclusions (Continued)</td>
<td>• Strollers</td>
</tr>
<tr>
<td></td>
<td>• Safety equipment</td>
</tr>
<tr>
<td></td>
<td>• Vehicle modifications including but not limited to van lifts</td>
</tr>
<tr>
<td></td>
<td>• Telephone</td>
</tr>
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<td></td>
<td>• Television</td>
</tr>
</tbody>
</table>
V. Reimbursement and Claims Procedures

The information in this section applies when you wish to file a claim or seek reimbursement following receipt of Covered Benefits. In most cases, you should not receive bills from Plan Providers.

A. BILLING BY PROVIDERS

You may receive bills from a Non-Plan Provider. 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.

B. REIMBURSEMENT FOR BILLS YOU PAY

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

Claims for Mental Health Care:
Behavioral Health Access Center
P.O. Box 30602
Slat Lake City, UT 84130-0783

All Other Claims:
HPhC Claims
P.O. Box 699183
Quincy, MA 02269–9183

Please Note: Prior Approval is required to receive full coverage for certain Out-of-Network services. Please see section I.F. NOTIFICATION AND PRIOR APPROVAL for more information on these requirements.

C. INFORMATION NEEDED FOR CLAIMS PROCESSING

To obtain reimbursement for a bill you have paid, other than for pharmacy items, you must provide us with all of the following information:

- The Member’s full name and address
- The Member’s date of birth
- The Member’s Plan ID number (on the front of the Member’s Plan ID card)
- The name and address of the person or facility providing the services for which a claim is made and their tax identification number
- The Member’s diagnosis or ICD 10 code
- The date the service was rendered
- The CPT code (or a brief description of the illness or injury) for which payment is sought
- The amount of the Provider’s charge
- Proof that you have paid the bill (if reimbursement is sought)

Important Notice: We may need more information for some claims. If you have any questions about claims, please call our Member Services Department at 1–888–333–4742.

1. International Claims

If you are requesting reimbursement for services received while outside of the United States you must submit an International Claim Form. The form can be obtained online at www.harvardpilgrim.org or by calling the Member Services Department. In addition to the International Claim Form you will need to submit an itemized bill and proof of payment. We may also require you to provide additional documentation, including, but not limited to: (1) records from financial institutions clearly demonstrating that you have paid for the services that are the subject of the claim; and (2) the source of funds used for payment.

D. TIME LIMITS ON FILING CLAIMS

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

E. TIME LIMITS FOR THE REVIEW OF CLAIMS

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

- Pre-service claims. A pre-Service claim is one in which coverage is requested for a health care service that the Member has not yet received. Pre-service claims will generally be processed within 15 days after receipt of the claim by HPhC.
• **Post-service claims.** A post-service claim requests coverage of a health care service that the Member has already received. Post-service claims will generally be processed within 30 days after the receipt of the claim by HPHC.

• **Urgent Care claims.** Urgent Care claims will generally be processed within 72 hours of receipt of the claim by HPHC. An Urgent Care claim is one in which the use of the standard time period for processing pre-service claims:
  1. Could seriously jeopardize a Member’s life or health or ability to regain maximum function; or
  2. Would result in severe pain that cannot be adequately managed without the care or treatment requested.

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

**F. PAYMENT LIMITS**

The Plan limits the amount payable for services that are not rendered by Plan Providers. The most the Plan will pay for such services is the Allowed Amount. If a service is provided by a Non-Plan Provider, you are responsible for any amount in excess of the Allowed Amount.

✔ **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.

**G. NOTICE OF CLAIM**

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

**H. MISCELLANEOUS CLAIMS PROVISIONS**

Benefits will be paid to the Member who received the services for which a claim is made unless such Member is a minor. In such case, benefits will be paid to the parent or custodian with whom the child resides. The Member may authorize the Plan to pay benefits directly to the health care Provider whose charge is the basis for the claim.
VI. Appeals and Complaints

This section explains the procedures for processing appeals and complaints and the options available if an appeal is denied.

A. BEFORE YOU FILE AN APPEAL

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

B. MEMBER APPEALS PROCEDURES

Any Member who is dissatisfied with a decision on the coverage of services may appeal to HPHC. Appeals may be filed by a Member or a Member’s authorized representative, including a Provider acting on a Member’s behalf. HPHC has established the following steps to ensure that Members receive a timely and fair review of internal appeals.

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

If you need assistance filing your appeal, there may be consumer assistance programs in your state available to you. Also, HPHC staff is available to assist you with the filing of an appeal. If you wish such assistance or would like the telephone number for one of these programs, please call (888) 333-4742.

1. Initiating Your Appeal

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

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

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

For all appeals, except those involving mental health care (including the treatment of substance use disorders), please send your request to the following address:

 Appeals and Grievances Analyst  
 Customer Service Department  
 1600 Crown Colony Drive  
 Quincy, MA 02169  
 Telephone: 1-888-333-4742  
 Fax: 1–617–509–3085  
 www.harvardpilgrim.org

If your appeal involves mental health care (including the treatment of substance use disorders), please send it to the following address:

 HPHC Behavioral Health Access Center  
 c/o United Behavioral Health  
 Appeals Department  
 P.O. Box 30512  
 Slat Lake City, UT 84130-0512  
 Telephone: 1–888–777–4742  
 Fax: 1–855–312–1470

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

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

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

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

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

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

HPHC will review Pre-Service Appeals and send a written decision within 30 days of the date the appeal was received by HPHC. HPHC will review Post-Service Appeals and send a written decision within 60 days of the date the appeal was received by HPHC. These time limits may be extended by mutual agreement between you and HPHC.

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

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

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

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

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

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

You, your representative or a Provider acting on your behalf may request an expedited appeal by telephone or fax. (Please see “Initiating Your Appeal,” above, for the telephone and fax numbers.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appeals and Grievances Analyst
Customer Service Department
1600 Crown Colony Drive
Quincy, MA 02169
Telephone: 1-888-333-4742
Fax: 1–617–509–3085

THE HARVARD PILGRIM HDHP PLAN FOR HARVARD UNIVERSITY - MASSACHUSETTS

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

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

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

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

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

3. 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 governmental plans are not subject to ERISA.

D. THE FORMAL COMPLAINT PROCESS

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

HPHC Member Service Department
Harvard Pilgrim Health Care, Inc.
Attention: Member Concerns
1600 Crown Colony Drive
Quincy, MA 02169
Telephone: 1-888-333-4742
Fax: 1-617-509-3085
www.harvardpilgrim.org

For a complaint involving mental health care (including the treatment of substance use disorders), please call or write to us at:

HPHC Behavioral Health Access Center
c/o United Behavioral Health Complaints Department
100 East Penn Square, Suite 400
Philadelphia, PA 19107
Telephone: 1–888–777–4742
Fax: 1–888–881–7453

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

Important Notice: Your membership in the Plan is effective on the date of enrollment by your Plan Sponsor. Because your Plan Sponsors may notify HPHC of enrollment changes retroactively, HPHC may not have current information concerning membership status. Only your Plan Sponsor can confirm membership status.

This section describes requirements concerning eligibility under the Plan. It is important to understand that eligibility of Dependents and effective dates of coverage are determined by the Plan Sponsor. Please see your Plan Sponsor for descriptions of eligibility for Dependents and effective dates of coverage.

A. ELIGIBILITY

1. Subscriber Eligibility
   To be a Subscriber under this Plan, you must:
   - Be an employee of the Plan Sponsor, in accordance with employee eligibility guidelines agreed to by the Plan Sponsor and HPHC; and
   - Be enrolled through a Plan Sponsor that is up-to-date in the payment of the applicable payment for coverage.

2. Dependent Eligibility
   Please see your Plan Sponsor for a description of Dependent eligibility as agreed upon by your Plan Sponsor and HPHC.

B. EFFECTIVE DATE - NEW AND EXISTING DEPENDENTS

Please see your Plan Sponsor for information on enrollment and effective dates of coverage. Please also see section VII.H. SPECIAL ENROLLMENT RIGHTS

C. 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.H. SPECIAL ENROLLMENT RIGHTS for additional rights upon adoption of a child.

D. CHANGE IN STATUS

It is your responsibility to inform your Plan Sponsor and us of all changes that affect Member eligibility. These changes include: address changes and death of a Member.

E. ADDING A DEPENDENT

It is important to understand that eligibility of Dependents and effective dates of coverage are determined by the Plan Sponsor. Dependents of eligible employees who meet the Plan Sponsor’s eligibility guidelines will be enrolled in the Plan using HPHC enrollment forms or in a manner otherwise agreed to in writing by HPHC and the Plan Sponsor.

HPHC must receive proper notice from the Plan Sponsor of any Member enrollment in, or termination from, the Plan.

Please see your Plan Sponsor for information on Dependent eligibility and effective dates of coverage.

F. NEWBORN COVERAGE

A newborn infant of a Member is eligible for coverage under the Plan from the moment of birth. Please see section VII.E. ADDING A DEPENDENT for information on enrollment procedures. Please see section VII.H. SPECIAL ENROLLMENT RIGHTS for additional rights upon the birth of a child.

G. HOW YOU’RE COVERED IF MEMBERSHIP BEGINS WHILE YOU’RE HOSPITALIZED

If your membership happens to begin while you are hospitalized, coverage starts on the day membership is effective. Please see your Plan Sponsor for information on enrollment and effective date of coverage. All other terms and conditions of coverage under this Handbook will apply.

For In-Network coverage, you must be hospitalized in an In-Network hospital.

If you are hospitalized at an Out-of-Network hospital, you must notify HPHC by calling 1-800-708-4414 for medical services. For all mental health care (including the treatment of substance use disorders) please call 1-888-777-4742. Please see section I.F.
H. SPECIAL ENROLLMENT RIGHTS

If an employee declines enrollment for the employee and his or her Dependents (including his or her spouse) because of other health insurance coverage, the employee may be able to enroll himself or herself, along with his or her Dependents in this Plan if the employee or his or her Dependents lose eligibility for that other coverage (or if the employer stops contributing toward the employee's or Dependents' other coverage). However, enrollment must be requested within 30 days after the other coverage ends (or after the employer stops contributing toward the employee's or Dependents' other coverage).

In addition, 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. However, 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 under Medicaid or CHIP as a result of the loss of Medicaid or CHIP eligibility may be able to enroll in this Plan, if enrollment is 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 if enrollment is requested within 60 days after the employee or Dependent is determined to be eligible for such premium assistance.
THE HARVARD PILGRIM HDHP PLAN FOR HARVARD UNIVERSITY - MASSACHUSETTS

VIII. Termination and Transfer to Other Coverage

**Important Notice:** HPHC may not have current information concerning membership status. Plan Sponsors may notify HPHC of enrollment changes retroactively. As a result, the information we have may not be current. Only your Plan Sponsor can confirm membership status.

**A. TERMINATION BY THE SUBSCRIBER**

You may end your membership under this Plan with your Plan Sponsor’s approval. HPHC must receive a completed Enrollment/Change form from the Plan Sponsor to end your membership.

**B. TERMINATION FOR LOSS OF ELIGIBILITY**

A Member’s coverage will end under this Plan if the Plan Sponsor’s contract with HPHC is terminated. A Member’s coverage may also end under this Plan for failing to meet any of the specified eligibility requirements. You will be notified if coverage ends for loss of eligibility. HPHC or the Plan Sponsor will inform you in writing.

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

**Please Note:** We may not have current information concerning membership status. Plan Sponsors may notify us of enrollment changes retroactively. As a result, the information we have may not be current. Only your Plan Sponsor can confirm membership status.

**C. MEMBERSHIP TERMINATION FOR CAUSE**

The Plan may end a Member’s coverage for any of the following causes:

- Misrepresentation of a material fact on an application for membership;
- Committing or attempting to commit fraud to obtain benefits for which the Member is not eligible under this Handbook;
- Obtaining or attempting to obtain benefits under this Handbook for a person who is not a Member; or
- The commission of acts of physical or verbal abuse by a Member, which pose a threat to Providers,

or other Members and which are unrelated to the Member’s physical or mental condition.

Termination of membership 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. Termination of membership for the other causes will be effective fifteen days after notice.

**D. CONTINUATION OF COVERAGE REQUIRED BY LAW**

Under Federal law, if you lose Plan Sponsor, you may be eligible for continuation of group coverage under the Federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA). You should contact the Plan Sponsor for more information if health coverage ends due to: 1) separation from employment; 2) reduction of work hours; or 3) loss of dependency status.
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 providing coverage for any service or supply that is not expressly covered under this Handbook and the Schedule of Benefits or to increase the level of coverage provided.

A. BENEFITS IN THE EVENT OF OTHER INSURANCE

Benefits under this handbook and the Schedule of Benefits will be coordinated to the extent permitted by law with other plans covering health benefits, including: motor vehicle insurance, medical payment policies, governmental benefits (including Medicare), and all Health Benefit Plans. The term "Health Benefit Plan" means all group HMO and other group prepaid health plans, medical or hospital service corporation plans, commercial health insurance and self-insured health plans. There is no coordination of benefits with Medicaid plans or with hospital indemnity benefits amounting to less than $100 per day.

Coordination of benefits will be based upon the Allowed Amount 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.

When a Member is covered by two or more Health Benefit Plans, one plan will be "primary" and the other plan (or plans) will be secondary. The benefits of the primary plan are determined before those of secondary plan(s) and without considering the benefits of secondary plan(s). The benefits of secondary plan(s) are determined after those of the primary plan and may be reduced because of the primary plan's benefits.

In the case of Health Benefit Plans that contain provisions for the coordination of benefits, the following rules shall decide which Health Benefit Plans are primary 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 rule in this Plan (the "birthday rule") will determine the order of benefits.

ii. Dependent Child/Separated or Divorced Parents
Unless a court order, of which HPHC 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 PLAN COVERAGE IS SECONDARY

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

C. WORKERS’ COMPENSATION/GOVERNMENT PROGRAMS

If HPHC has information indicating that services provided to you are covered under Workers’ Compensation, Employer’s liability or other program of similar purpose, or by a federal, state or other government agency, payment may be suspended for such services until a determination is made whether payment will be made by such program. If payment is made for services for an illness or injury covered under Workers’ Compensation, Employer’s liability or other program of similar purpose, or by a federal, state or other government agency, the Plan will be entitled to recovery of its expenses from the Provider of services or the party or parties legally obligated to pay for such services.

D. SUBROGATION AND REIMBURSEMENT FROM RECOVERY

Subrogation is a means by which health plans recover expenses of services where a third party is legally responsible or alleged to be legally responsible for a Member’s injury or illness. If another person or entity is, or is alleged to be, liable to pay for services related to a Member’s illness or injury which have been paid for or provided by the Plan, the Plan will be subrogated and succeed to all rights to recover against such person or entity for the value of the services paid for or provided by the Plan. The Plan will also have the right to be reimbursed from any recovery a Member obtains from such person or entity for the value of the services paid for or provided by the Plan. The Plan will have the right to seek such recovery from, among others, the person or entity that caused or allegedly caused the injury or illness, his/her liability carrier or your own auto insurance carrier, in cases of uninsured or underinsured motorist coverage. The Plan’s right to reimbursement from any recovery will apply even if the recovery the Member receives for the illness or injury is designated or described as being for injuries other than health care expenses or does not fully compensate the Member for his or her damages, fees or costs. Neither the “make whole rule” nor the “common fund doctrine” apply to the Plan’s rights of subrogation and/or reimbursement from recovery. The Plan’s reimbursement will be made from any recovery the Member receives from any insurance company or any third party and the Plan’s reimbursement from any such recovery will not be reduced by any attorney’s fees, costs or expenses of any nature incurred by, or for, the Member in connection with the Member’s receiving such recovery, and the Plan will have no liability for any such attorney’s fees, costs or expenses.

To enforce its subrogation and reimbursement rights under this Handbook, the Plan will have the right to take legal action, with or without your consent, against any party to secure reimbursement from the recovery for the value of services provided or paid for by the Plan for which such party is, or is alleged to be, liable.

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

E. MEDICAL PAYMENT POLICIES

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 you are entitled under any medical payment policy or benefit. All sums payable for services provided under this Benefit Handbook to Members that are covered under any medical payment policy or benefit are payable to the Plan.

F. MEMBER COOPERATION

You agree to cooperate with the Plan in exercising its rights of subrogation and coordination of benefits. Such cooperation will include, but not be limited to, a) the provision of all information and documents requested by the Plan, b) the execution of any instruments deemed necessary by the Plan to protect its rights, c) the prompt assignment to the Plan of any monies received for services provided or paid for by the Plan, and d) the prompt notification to the Plan of any instances that may give rise to the Plan’s rights. You further agree to do nothing to prejudice or interfere with the Plan’s rights to subrogation or coordination of benefits.

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

G. THE PLAN’S RIGHTS

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

H. MEMBERS ELIGIBLE FOR MEDICARE

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

For a Member who is eligible for Medicare by reason of End Stage Renal Disease, the Plan will be the primary payor for Covered Benefits during the "coordination period" specified by federal regulations at 42 CFR Section 411.162. Thereafter, Medicare will be the primary payor. When Medicare is primary (or would be primary if the Member were timely enrolled), the Plan will pay for services only to the extent payments would exceed what would be payable by Medicare.
**X. Plan Provisions and Responsibilities**

**A. IF YOU DISAGREE WITH RECOMMENDED TREATMENT**

You enroll in the Plan with the understanding that, when you obtain In-Network services, Plan Providers are responsible for determining treatment appropriate for 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 recommendations of Plan Providers. In such a case, the Plan shall have no further obligation to provide In-Network 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 the Plan has no responsibility for the cost or outcome of such care.

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

**B. LIMITATION ON LEGAL ACTIONS**

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

**C. ACCESS TO INFORMATION**

You agree that, except where restricted by law, HPHC and the Plan Sponsor 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. HPHC and the Plan Sponsor 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 care records. Information from a Member’s medical record and information about a Member’s physician patient and hospital patient relationships will be kept confidential and will not be disclosed without the Member’s consent, except for:

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

You can obtain a copy of the Notice of Privacy Practices through the Harvard Pilgrim Web site, [www.harvardpilgrim.org](http://www.harvardpilgrim.org) or by calling the Member Services Department at 1-888-333-4742.

**D. SAFEGUARDING CONFIDENTIALITY**

HPHC is committed to ensuring and safeguarding the confidentiality of our Members’ information in all settings, including personal and medical information. Our staff access, use and disclose Member information only in connection with providing services and benefits and in accordance with our confidentiality policies. We permit only designated employees, who are trained in the proper handling of Member information, to have access to and use of your information. We sometimes contract with other organizations or entities to assist with the delivery of care or administration of benefits. Any such entity must agree to adhere to our confidentiality and privacy standards.

When you enrolled in the Plan, you agreed to certain uses and disclosures of information which are necessary for us to provide and administer services and benefits, such as: authorizations; conducting quality activities, including member satisfaction surveys and disease management programs; verifying eligibility; fraud detection and certain oversight reviews, such as accreditation and regulatory audits. When we disclose Member information, we do so using the minimum amount of information necessary to accomplish the specific activity.

HPHC discloses Members’ personal information only (1) in connection with the delivery of care or administration of benefits, such as utilization review, quality assurance activities and third-party reimbursement by other payers, including self-insured employer groups; (2) when you specifically authorize the disclosure; (3) in connection with certain
activities allowed under law, such as research and fraud detection; (4) when required by law; or (5) as otherwise allowed under the terms of your Benefit Handbook. Whenever possible, we disclose Member information without Member identifiers and in all cases only disclose the amount of information necessary to achieve the purpose for which it was disclosed. We will not disclose to other third parties, such as employers, Member-specific information (i.e. information from which you are personally identifiable) without your specific consent unless permitted by law or as necessary to accomplish the types of activities described above.

In accordance with applicable law, we, and our Plan Providers, agree to provide Members access to, and a copy of, their medical records upon a Member’s request. In addition, your medical records cannot be released to a third party without your consent or unless permitted by law.

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 Web site, www.harvardpilgrim.org.

E. NOTICE

Any notice to a Member may be sent to the last address of the Member on file with HPHC. Notice to HPHC, other than a request for a Member appeal, should be sent to:

HPHC Member Services Department
1600 Crown Colony Drive
Quincy, MA 02169

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

F. MODIFICATION OF THIS HANDBOOK

This Benefit Handbook, Schedule of Benefits, and applicable riders or amendments comprise the entire Plan as agreed to by HPHC and the Plan Sponsor. They can only be amended by HPHC and the Plan Sponsor as stated below. No other action by HPHC or the Plan Sponsor, including the deliberate non-enforcement of any benefit limit, shall be deemed to waive or alter any part of these documents.

This Benefit Handbook, Schedule of Benefits, and any applicable riders may be amended by agreement, in writing, between HPHC and the Plan Sponsor or, if required by law, by HPHC upon written notice to the Plan Sponsor. Amendments do not require the consent of Members.

G. HPHC’S RELATIONSHIP WITH PLAN PROVIDERS

HPHC’s relationship with Plan Providers is governed by separate agreements. They are independent contractors. Such Providers may not modify this Handbook or Schedule of Benefits, and any applicable riders, or create any obligation for the Plan. We are not liable for statements about this Handbook by them, their employees or agents. HPHC may change it’s arrangements with service Providers, including the addition or removal of Providers, without notice to Members.

H. IN THE EVENT OF A MAJOR DISASTER

HPHC will try to provide or arrange for services in the case of a major disaster. This might include war, riot, epidemic, public emergency, or natural disaster. Other causes include the partial or complete destruction of our facility(ies) or the disability of service Providers. If the Plan cannot provide or arrange services due to a major disaster, it is not responsible for the costs or outcome of this inability.

I. EVALUATION OF NEW TECHNOLOGY

HPHC has dedicated staff that evaluates new diagnostics, testing, interventional treatment, therapeutics, medical/behavioral therapies, surgical procedures, medical devices and drugs as well as ones with new applications. The team manages the evidence-based evaluation process from initial inquiry to final policy recommendation in order to determine whether it is an accepted standard of care or if the status is Experimental, Unproven or Investigational. The team researches the safety and effectiveness of these new technologies by reviewing published peer reviewed medical reports and literature, consulting with expert practitioners, and benchmarking. The team 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.
J. UTILIZATION REVIEW PROCEDURES

HPHC uses the following utilization review procedures described below to evaluate the Medical Necessity of selected health care services utilizing clinical criteria, and 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, and outpatient/ambulatory procedures prior to the provision of such services to determine whether proposed services meet clinical criteria for coverage. Please see section LE NOTIFICATION AND PRIOR APPROVAL for further information on HPHC’s Prior Approval requirements, including procedures for which Prior Approval is required. Prior Approval determinations will be made within two working days of obtaining all necessary information. In the case of a determination to approve an admission, procedure or service, HPHC will give notice to the requesting Provider by telephone within 24 hours of the decision and will send a written or electronic confirmation of the telephone notification to you and the Provider within two working days. In the case of a determination to deny or reduce benefits (“an adverse determination”), HPHC will notify the Provider rendering the service by telephone within 24 hours of the decision and will send a written or electronic confirmation of the telephone notification to you and the Provider within one working day thereafter.

**Please Note:** Prior Approval is not required to obtain substance use disorder treatment from a Plan Provider. In addition, when services are obtained from a Plan Provider, the Plan will not deny coverage for the first 14 days of (1) Acute Treatment Services or (2) Clinical Stabilization Services for the treatment of substance use disorders so long as the Plan receives notice from the Plan Provider within 48 hours of admission. The terms “Acute Treatment Services” and “Clinical Stabilization Services” are defined in the Glossary at section II of this Benefit Handbook.

- **Concurrent Utilization Review.** We review ongoing admissions for selected services at hospitals, including acute care hospitals, rehabilitation hospitals and skilled nursing facilities, skilled home health providers and behavioral health and substance use disorder treatment facilities to assure that the services being provided meet clinical criteria for coverage. Concurrent review decisions will be made within one working day of obtaining all necessary information. In the case of either a determination to approve additional services or an adverse determination, we will notify the Provider rendering the service by telephone within 24 hours of the decision. We will send a written or electronic confirmation of the telephone notification to you and the Provider within one working day. In the case of ongoing services, coverage will be continued without liability to you until you have been notified of the 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 circumstances where services were provided before authorization was obtained. This will include the review of emergency medical admissions for appropriateness of level of care.

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**. For information about decisions concerning mental health care (including treatment of substance use disorders), you may call the Behavioral Health Access Center at **1-888-777-4742**.

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 HPHC. 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.
K. QUALITY ASSURANCE PROGRAMS

The goal of our quality program is to ensure the provision of consistently excellent health care, health information and service to our Members, enabling them to maintain and improve their physical and behavioral health and well-being. Some components of the quality program are directed to all Members and others address specific medical issues and Providers.

Examples of quality activities in place for all Members include a systematic review and re-review of the credentials of Plan Providers and contracted facilities, as well as the development and dissemination of clinical standards and guidelines in areas such as preventive care, medical records, appointment access, confidentiality, and the appropriate use of drug therapies and new medical technologies.

Activities affecting specific medical issues and Providers include disease management programs for those with chronic diseases like asthma, diabetes and congestive heart failure, and the investigation and resolution of quality-of-care complaints registered by individual Members.

Please Note: Your Plan Sponsor may not cover all these disease management programs. Please check with your Plan Sponsor for a description of programs available under your Plan.

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

HPHC uses a standardized process to evaluate inquiries and requests for coverage received from internal and/or external sources, and/or identified through authorization or payment inquiries. 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.

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

M. PROCESS TO DEVELOP CLINICAL GUIDELINES AND UTILIZATION REVIEW CRITERIA

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

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

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

HPHC Clinician Advisory Committees, comprised of actively practicing physicians from throughout the network, serve as the forum for the discussion of specialty-specific clinical programs and initiatives, and provide guidance on strategies and initiatives to evaluate or improve care and service.

N. NON-ASSIGNMENT OF BENEFITS

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

O. 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 Harvard Pilgrim’s Medical Policy Department 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.

**Please Note:** You have limited coverage under this Benefit Handbook for drugs received during inpatient and outpatient treatment. Your Plan does not provide coverage for outpatient prescription drugs through Harvard Pilgrim. For information on coverage of outpatient prescription drugs please contact your pharmacy administrator at **1–844–265–1224.**
XI. MEMBER RIGHTS & RESPONSIBILITIES

Members have a right to receive information about HPHC, 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 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 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.