Benefit Handbook

THE HARVARD PILGRIM CHOICENET℠ BEST BUY TIERED COPAYMENT HMO

MASSACHUSETTS

IMPORTANT NOTICE: This plan includes a tiered provider network called the "ChoiceNet" Network. In this plan, Members pay different levels of Copayments, Coinsurance or Deductibles depending on the tier of the provider delivering a covered service or supply. This plan may make changes to a Provider's benefit tier annually on January 1. Please consult the HPHC ChoiceNet Provider Directory or visit the provider search tool at www.harvardpilgrim.org to determine the tier of Providers in the ChoiceNet Network.

EFFECTIVE DATE 07/11
FORM #1376

INTRODUCTION

Welcome to The Harvard Pilgrim ChoiceNet℠ Best Buy Tiered Copayment HMO and thank you for choosing us to help meet your health care needs.

When we use the words "we," "us," and "our" in this Handbook, we are referring to Harvard Pilgrim Health Care. When we use the words "you" or "your" we are referring to Members as defined in the Glossary.

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

When you enroll, you receive the covered health care services described in this Handbook, the Schedule of Benefits, the Prescription Drug Brochure (if applicable) and any riders or amendments to those documents. These services must be provided or arranged by your PCP, except as described in section *I.E.1. Your PCP Manages Your Health Care*.

The Massachusetts Managed Care Reform Law requires disclosure of premium information and information concerning Harvard Pilgrim Health Care's voluntary and involuntary disenrollment rate. This information will be sent to you in a separate letter. Please keep that letter with this Handbook for your records.

As a Member, you can take advantage of a wide range of helpful online tools and resources. For instance, **HPHConnect** offers you a secure place to help manage your health care. You are able to check your Schedule of Benefits and Benefit Handbook, review prescription drug and medical claim histories, change PCPs, compare hospitals and much more! For details on how to register for an **HPHConnect** account, log on to **www.harvardpilgrim.org**.

You may also call the Member Services Department if you have any questions. Member Services staff are available to help you with questions about the following:

- Selecting a PCP
- Your Benefit Handbook
- Your benefits
- Your enrollment
- Your claims
- Pharmacy management procedures
- Provider Information
- Requesting a ChoiceNet 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 directly with the Member Services Department by calling our TTY machine at **1-800-637-8257**.

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
Member Services Department
1600 Crown Colony Drive
Quincy, MA 02169
Telephone: Phone: 1-888-333-4742
www.harvardpilgrim.org

The Office of Patient Protection. The Office of Patient Protection of the Department of Public Health is the agency responsible for enforcing the Massachusetts laws concerning managed care grievance rights and for administering appeals to external review organizations. The Office of Patient Protection can be reached at:

Department of Public Health
Office of Patient Protection
99 Chauncy Street
Boston, MA 02111
Telephone: Telephone: 1–800–436-7757
Fax: 1–617–624-5046
http://www.state.ma.us/dph/opp/index.htm

The following information is available to consumers from the Office of Patient Protection:

- A list of sources of independently published information assessing insureds' satisfaction and evaluating the quality of health care services offered by a carrier;
- The percentage of physicians who voluntarily and involuntarily terminated participation contracts with the carrier during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary physician disenrollment;
- The percentage of premium revenue expended by the carrier for health care services provided to insureds for the most recent year for which information is available;
- A report detailing, for the previous calendar year, the total number of: a) filed grievances, grievances that were approved internally, grievances that were denied internally, and grievances that were withdrawn before resolution; and b) external appeals pursued after exhausting the internal grievance process and the resolution of all such external appeals.

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

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

[Spanish]

Los miembros que no dominan el inglés pueden llamar al Departamento de servicios para miembros de Harvard Pilgrim Health Care al 1-888-333-4742, donde se responderá a sus preguntas. El Plan ofrece un servicio de interpretación gratuito en más de 120 idiomas.

[Russian]

Те, кто не владеет английским языком, могут также получить ответы на свои вопросы, позвонив по телефону 1-888-333-4742 в отдел обслуживания медицинского центра Harvard Pilgrim. Данный план предоставляет бесплатные услуги по обеспечению устного перевода более, чем на 120 иностранных языков.

[Arabic]

كما يستطيع الأعضاء الغير الناطقين باللغة الإنجليزية أن يتصلوا بقسم خدمات الأعضاء بهيئة للعناية الصحية (Harvard Pilgrim)هارفارد بيلجريم ، وذلك للحصول على 1-888-333-4742على الرقم إجابات لاستفساراتهم. ويقدم البرنامج خدمات ترجمة مجانية بأكثر من 120 لغة.

[Portuguese]

Os membros que não falarem inglês também podem telefonar para o Departamento dos Serviços de Saúde Harvard Pilgrim para membros através do número 1 888 333 4742, de forma a obterem os esclarecimentos pretendidos. Este plano oferece serviços de interpretação gratuitos em mais de 120 idiomas.

[French]

Harvard Pilgrim Health Care propose des services d'interprétation gratuits dans plus de 120 langues pour répondre aux questions des membres qui ne parlent pas anglais. Pour utiliser ce service, appelez la section des services aux membres au 1-888-333-4742.

[Greek]

Τα Μέλη που δε μιλούν Αγγλικά μπορούν επίσης να τηλεφωνήσουν στο Τμήμα Εξυπηρέτησης Μελών του Harvard Pilgrim Health Care στον αριθμό 1-888-333-4742 για τυχόν ερωτήσεις. Το Πρόγραμμα παρέχει δωρεάν ξενόγλωσσες υπηρεσίες διερμηνείαςγια περισσότερες από 120 γλώσσες.

[Haitian Creole]

Manm yo ki pa pale Angle ka rele Depatman Sèvis Manm Harvard Pilgrim Health Care tou nan 1-888-333-4742 pou jwenn repons a keksyon yo. Plan an ofri sèvis entèpretasyon gratis nan plis ke 120 lang.

[Italian]

I Partecipanti che non parlano inglese possono anche rivolgere le proprie domande al Reparto Servizi Partecipanti dell'Harvard Pilgrim Health Care, chiamando il numero 1-888-333-4742. Il Piano offre servizi di interpretariato gratuiti in oltre 120 lingue.

[Traditional Chinese]

不說英語的會員亦可致電 1-888-333-4742，請 Harvard Pilgrim 醫療保健的 會員服務部門回答所提出的問題。該計劃免費提供120多種語言的翻譯服務。

[Lao]

ສະມາຊິກ ທັງ ຫລາຍ ທີ່ ປາກ ພາສາ ຈັງກິດ ບໍ່ ເປັນກໍ ສາມາດ ຕິດ ຕໍ່ ກັບ ພະແນກ ບໍລິການ ລູກ ຄ້າ ຂອງ ໄຄງ ການ ຮັກສາ ສຸຂະພາບ **Harvard Pilgrim** ໄດ້ ໂດຍ ໂທ ໄປ ຫາ **1-888-333-4742** ເພື່ອ ຂໍ ຊາບ ຄໍາ ຕອບ ຂອງ ຄໍາ ຖາມ ຕ່າງໆ ຂອງ ຕົນ. ໄຄງ ການ ນີ້ ຂໍ ສະນີ ບໍລິການ ແປ ພາສາ ໃນ ຫລາຍ ກວ່າ **120** ພາສາ ໂດຍ ່ ຄິດ ຄ່າ ບໍລິການ ໃດໆ ທັງ ສິ້ນ.

[Cambodian]

សមាជិកដែលមិនចេះនិយាយភាសាអង់គ្លេស
ក៏អាចទូរស័ព្ទទៅការិយាល័យផ្នែកសេវាបំរើសមាជិកនៃ
ផែនការសុខភាព **Harvard Pilgrim**
Health Care លេខ **1-888-333-4742**
ដើម្បីឲ្យគេត្រើយសំនួរចំងល់ផ្សេងៗ ។
ផែនការសុខភាពនេះមានផ្តល់ជូនសេវាបកប្រែភាសាដោយ
ឥតគិតថ្លៃ រហូតដល់ 120 ភាសា ។

Non-English speaking Members may also call Harvard Pilgrim Health Care's Member Services Department at **1-888-333-4742** to have their questions answered. The Plan offers free language interpretation services in more than 120 languages.

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I. How the Plan Works

This section describes how to use your Benefit Handbook and how your coverage works under the The Harvard Pilgrim ChoiceNet℠ Best Buy Tiered Copayment HMO (the Plan).

A. HOW TO USE THIS BENEFIT HANDBOOK

1. Why This Benefit Handbook Is Important

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

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

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

You can view your Benefit Handbook , and Schedule of Benefits, and Prescription Drug Brochure (if your Plan includes outpatient pharmacy coverage) , and any applicable riders and amendments online by using **HPHConnect** at **www.harvardpilgrim.org**.

2. Words With Special Meaning

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

3. How To Find What You Need To Know

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

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

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

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

B. HOW TO USE YOUR CHOICENET PROVIDER DIRECTORY

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

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

The online ChoiceNet 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 us. In addition, a provider may leave the network because of retirement, relocation or other reasons. This means that we cannot guarantee that the physician you choose will continue to participate in the network for the duration of your membership. If your PCP leaves the network for any reason, we will make every effort tou notify you at least 30 days in advance, and will help you find a new Plan physician. Under certain circumstances you may be eligible for transition services if your provider leaves the network

(please see section *I.F. SERVICES PROVIDED BY A DISENROLLED OR NON-PLAN PROVIDER* for details).

C. TIERED NETWORK PLAN

This Plan has a network of providers in which hospitals and physicians have been placed into 3 benefit levels or Tiers. Harvard Pilgrim determined its tiers by using standard analytical techniques to evaluate network PCPs, specialists and hospitals. Based on this evaluation, providers are grouped into three levels, known as Tier 1, Tier 2 and Tier 3.

You may obtain a list of hospitals and physicians and their tier placements through Harvard Pilgrim's online ChoiceNet Provider Directory at www.harvardpilgrim.org. You may also obtain a paper copy of the directory, free of charge, by calling Harvard Pilgrim's Member Services Department at **1-888-333-4742** .

Tiering of providers is determined by cost efficiency standards and nationally recognized quality of care benchmarks. Cost efficiency is evaluated by comparing how much it cost doctors and hospitals to treat patients for similar conditions. Quality of care is evaluated based on standards derived from clinical guidelines for care. The tier associated with a hospital or physician determines your Member Cost Sharing for covered services, including Deductibles and Copayments. Tier 1 is the lowest cost tier. Tier 2 is the medium cost tier. Tier 3 is the highest cost tier.

Harvard Pilgrim evaluated PCPs and specialists based on the performance of the physician's medical group. Physicians who are not affiliated with a medical group, or for whom insufficient data is available, were placed in Tier 2.

Hospitals within the Harvard Pilgrim network were evaluated based on the individual hospital's performance.

- **Tier 1 Providers** – Includes PCPs, specialists and hospitals that met both Harvard Pilgrim's cost efficiency and quality benchmarks.
- **Tier 2 Providers** – Includes PCPs, specialists and hospitals that have moderate cost efficiency benchmark scores. Tier 2 providers also include PCPs and specialists not affiliated with a medical group or where there was insufficient data available.
- **Tier 3 Providers** – Includes PCPs, specialists and hospitals with the lowest cost efficiency benchmark scores

Any changes to tier placement for providers are made in January of each year. Harvard Pilgrim will not increase the tier placement of providers from January through the following December of each year. However, Harvard Pilgrim may reduce the tier placement of a provider any time during the year.

Because Member Cost Sharing is dependent upon the tier placement of a doctor or hospital, you will have lower out-of-pocket costs when you select providers from lower tiers. You should consider a provider's tier and where the provider has hospital admitting privileges before selecting a PCP or specialist. For example, if you require hospital care and your Tier 1 PCP refers you to a Tier 1 hospital, you would pay the lowest out-of-pocket costs for both your physician and hospital care. However, if your Tier 1 PCP were to refer you to a Tier 3 hospital, you would pay the lowest out-of-pocket costs for physician services but the highest out-of-pocket costs for hospital care.

Only acute care hospitals, Primary Care Physicians (PCPs) and medical specialists that are Plan Providers are assigned to one of three tiers. All other covered providers, including providers covered under the Plan's benefit for mental health services, are always assigned to Tier 1.

D. MEMBER OBLIGATIONS

1. Choose a Primary Care Provider (PCP)

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

A PCP may be a physician or a nurse practitioner specializing in one or more of the following specialties: internal medicine, adult medicine, adolescent medicine, geriatric medicine, pediatrics or family practice. PCPs are listed in the ChoiceNet Provider Directory. You can access our website at **www.harvardpilgrim.org** or call the Member Services Department to confirm that the PCP you select is available.

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

You may change your PCP at any time. Just choose a new PCP from the ChoiceNet Provider Directory. You

can change your PCP online by using **HPHConnect** at **www.harvardpilgrim.org** or by calling the Member Services Department. The change is effective immediately.

2. Obtain Referrals to Specialists

In order to be eligible for coverage by the Plan, most care must be provided or arranged by your PCP. For more information, please see section *I.E. HOW TO OBTAIN CARE*.

If you need to see a specialist, you must contact your PCP for a Referral prior to the appointment. In most cases, a Referral will be given to a Plan Provider who is affiliated with the same hospital as your PCP or who has a working relationship with your PCP. Referrals to Plan Providers may be given orally or in writing.

3. 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 **HPHConnect** at **www.harvardpilgrim.org** or by calling the Member Services Department.

4. 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

As a Tiered Network Plan, member cost sharing amounts for covered services provided by PCPs, specialists or hospitals is dependent upon the tier placement of the provider.

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

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

There may be health products or services you need that are not covered by the Plan. 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.

E. HOW TO OBTAIN CARE

IMPORTANT POINTS TO REMEMBER

1) You and each Member of your family must select a PCP.
2) Your Plan has a tiered network comprised of Tier 1, Tier 2 and Tier 3 providers.
3) Tiering of providers applies to all PCPs, specialists and hospitals.
4) For tiered services, Member Cost Sharing (Deductibles and Copayments) is lowest for Tier 1 providers and highest for Tier 3 providers.
5) In order to receive Covered Benefits you must use Plan Providers, except as noted below.
6) If you need care from a specialist, you must contact your PCP for a Referral. For exceptions, see *I.E.7. Services That Do Not Require a Referral*.
7) In the event of a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. You do not need a Referral for Medical Emergency services.

1. Your PCP Manages Your Health Care

When you need care, call your PCP. In order to be eligible for coverage by the Plan, most services must be provided or arranged by your PCP. The only exceptions are:

- Care in a Medical Emergency.
- Care when you are temporarily traveling outside the Service Area as described below. The Service Area is the state in which you live.
- Care received by a student Dependent attending school outside of the Enrollment Area. (Please see section *V. Student Dependent Coverage* for the requirements that apply to this coverage.)
- Mental health care, for which you must call the Behavioral Health Access Center at **1-888-777-4742** . The telephone number for the Behavioral Health Access Center is also listed on your ID card. Please see section *III. Covered Benefits*, *Mental Health Care (Including the Treatment of Substance Abuse Disorders)* for information on this benefit.

- Special services that do not require a Referral that are listed in section *I.E.7. Services That Do Not Require a Referral*.

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

You may change your PCP at any time. Just choose a new PCP from the ChoiceNet Provider Directory. You can change your PCP online by using **HPHConnect** at **www.harvardpilgrim.org** or by calling the Member Services Department. The change is effective immediately. If you select a new PCP, all Referrals from your prior PCP become invalid. Your new PCP will need to assess your condition and provide new Referrals.

2. Referrals for Hospital and Specialty Care

When you need hospital or specialty care, you must first call your PCP, who will coordinate your care. Your PCP generally uses one hospital for inpatient care. This is where you will need to go for coverage, unless it is Medically Necessary for you to get care at a different hospital.

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

If the services you need are not available through your PCP's referral network, your PCP may refer you to any Plan Provider. If you or your PCP has 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 care 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.

Plan Providers with recognized expertise in specialty pediatrics are covered with a Referral from your PCP. Pediatric mental health care may be obtained by calling the Behavioral Health Access Center at **1–888–777–4742** .

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

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

There are certain specialized services for which you will be directed to a Center of Excellence for care. Please see section *I.E.4. Centers of Excellence* for more information.

Certain specialty services may be obtained without involving your PCP. For more information please see section *I.E.7. Services That Do Not Require a Referral*.

3. Using Plan Providers

Covered Benefits must be received from a Plan Provider to be eligible for coverage. However, there are specific exceptions to this requirement. Covered Benefits from a provider who is not a Plan Provider will be covered if one of the following exceptions applies:

1) The service was received in a Medical Emergency. (Please see section *I.E.5. Medical Emergency Services* for information on your coverage in a Medical Emergency.)
2) The service was received while you were outside of the Service Area and coverage is available under (1) the benefit for temporary travel or (2) the benefit for student Dependents attending school outside the Enrollment Area. Please see sections *I.E.6. Coverage for Services When You Are Temporarily Traveling Outside the Service Area* and *V. Student Dependent Coverage* for information on these benefits.
3) No Plan Provider has the professional expertise needed to provide the required service. In this case, services by a Non-Plan Provider must be authorized in advance by us, unless one of the exceptions above applies.
4) Your physician is disenrolled as a Plan Provider or you are a new Member of the Plan, and one of the exceptions stated in section *I.F. SERVICES PROVIDED BY A DISENROLLED OR NON-PLAN PROVIDER* applies. Please refer to that section for the details of these exceptions.

To find out if a provider is in the Plan network, see the ChoiceNet Provider Directory. The ChoiceNet Provider Directory is available online at

www.harvardpilgrim.org or by calling our Member Services Department at **1–888–333–4742** .

4. Centers of Excellence

Certain specialized services are only covered when received from designated Plan Providers with special training, experience, facilities or protocols for the service. We refer to these Plan Providers 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.

In order to receive benefits for the following service, you must obtain care at a Plan Provider that has been designated as a Center of Excellence:

- Weight loss surgery (bariatric surgery)

Important Notice: No coverage is provided for the service listed above unless it is received from a Plan Provider that has been designated as a Center of Excellence. To verify a Provider's status, see the ChoiceNet Provider Directory. The ChoiceNet 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.

5. Medical Emergency Services

You always have coverage for care in a Medical Emergency, including an emergency mental health condition. A Referral from your PCP is not needed. In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. Your emergency room Member Cost Sharing is listed in your Schedule of Benefits. Please remember that if you are hospitalized, you must call the Plan at **1-888-333-4742** within 48 hours or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to the Plan or PCP by an attending emergency physician no further notice is required. Your PCP will help to arrange for any follow-up care you may need.

6. Coverage for Services When You Are Temporarily Traveling Outside the Service Area

When you are temporarily traveling outside the Service Area the Plan covers urgently needed Covered Benefits for sickness or injury. You do not have to call your PCP before getting care. However, the following services are not covered:

- Care you could have foreseen the need for before leaving the Service Area;
- Routine examinations and preventive care, including immunizations;
- Childbirth and problems with pregnancy after the 37th week of pregnancy, or after being told that you were at risk for early delivery; and
- Follow-up care that can wait until your return to the Service Area.

The "Service Area" is the state in which you live.

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

You must file a claim whenever you obtain services from a Non-Plan Provider. For more information, please see section *VI. Reimbursement and Claims Procedures* . Member Cost Sharing amounts will be applied as listed in your Schedule of Benefits.

Please Note: We must have your current address on file in order to correctly process claims for care outside the Service Area. To change your address, please call our Member Services Department at **1–888–333–4742.**

7. Services That Do Not Require a Referral

While in most cases you will need a Referral from your PCP to get covered care from any other Plan Provider, you do not need a Referral for the services listed below. However, you must get these services from a Plan Provider. Plan Providers are listed in the ChoiceNet Provider Directory. We urge you to keep your PCP informed about such care so that your medical records are up-to-date and your PCP is aware of your entire medical situation.

i. Family Planning Services:

- Contraceptive monitoring
- Family planning consultation, including pregnancy testing

- Tubal ligation(if a covered benefit - please see your Schedule of Benefits)
- Voluntary termination of pregnancy(if a covered benefit - please see your Schedule of Benefits)

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

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

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

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

iv. Dental Services:

- Emergency Dental Care
- Extraction of teeth impacted in bone(if a covered benefit - please see your Schedule of Benefits)
- Preventive dental care for children(if a covered benefit - please see your Schedule of Benefits)

v. Other Services:

- Acupuncture treatment for injury or illness(if a covered benefit - please see your Schedule of Benefits)
- Spinal manipulative therapy (if a covered benefit - please see your Schedule of Benefits)
- Routine eye examination(if a covered benefit - please see your Schedule of Benefits)
- Urgent Care Center Services(if a covered benefit - please see your Schedule of Benefits)

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

1. Disenrollment of Primary Care Provider (PCP)
If your PCP is disenrolled as a Plan Provider for reasons unrelated to fraud or quality of care, we will use our best efforts to provide you with written notice at least 30 days prior to the date of your PCP's disenrollment. That notice will also explain the process for selecting a new PCP. You may be eligible to continue to receive coverage for services provided by the disenrolled PCP, under the terms of this Handbook and your Schedule of Benefits, for at least 30 days after the disenrollment date. If you are undergoing an active course of treatment for an illness, injury or condition, we may authorize additional coverage through the acute phase of illness, or for up to 90 days (whichever is shorter).

2. 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 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.

3. 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 coverage for services delivered by the disenrolled provider, under the terms of this Handbook and the Schedule of Benefits, until the Member's death.

4. New Membership
If you are a new Member, we will provide coverage for services delivered by a physician 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 is a Non-Plan Provider, and

- The physician is providing you with an ongoing course of treatment or is your PCP.

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

5. 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 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 Referrals, obtaining prior authorization and providing Covered Benefits pursuant to a treatment plan, if any, approved by us.

6. Clinical Review Criteria

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

7. 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 participating providers to be available by telephone 24-hours a day. However, the Plan does require PCPs to provide both an answering service that can be contacted 24-hours a day and prompt appointments when Medically Necessary.

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.

Allowable Amount The amount we pay for Covered Benefits. In most cases the Allowable Amount is the contracted rate the Plan has agreed to pay Plan Providers.

Anniversary Date The date agreed to by HPHC and your Employer Group upon which the yearly Employer Group premium rate is adjusted and benefit changes normally become effective. This Benefit Handbook, Schedule of Benefits, Prescription Drug Brochure and any applicable riders, and the Employer Group agreement will terminate unless renewed on the Anniversary Date.

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

Behavioral Health Access Center The organization, designated by us, that is responsible for arranging for the provision of services for Members in need of mental health care (including the treatment of substance abuse disorders). Except in a Medical Emergency, you must call the Behavioral Health Access Center at **1–888–777–4742** before eceiving such services. The telephone number is also listed on your ID card.

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 listed in your Schedule of Benefits.

✔ FOR EXAMPLE: If your Plan offers 30 visits per Plan Year for physical therapy services, once you reach your 30 visit limit for that Plan Year, no additional benefits for that service will be covered by the Plan.

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

ChoiceNet Provider Directory A directory that identifies Plan Providers. We may revise the ChoiceNet Provider Directory from time to time without notice to Members. The most current listing of Plan Providers is available on **www.harvardpilgrim.org**.

Coinsurance A percentage of the Allowable Amount for certain Covered Benefits that must be paid by the Member. Coinsurance amounts applicable to your Plan are stated in your Schedule of Benefits.

✔ FOR EXAMPLE: If the Coinsurance for a service is 20%, you pay 20% of the Allowable Amount while we pay the remaining 80%.

Copayment A fixed dollar amount you must pay for certain Covered Benefits. The Copayment is usually due at the time of the visit or when you are billed by the provider. Copayment amounts applicable to your Plan are stated in your Schedule of Benefits.

Your Plan may have two levels of Copayments that apply to outpatient services. These are known as Tier 1 Copayments and Tier 2 Copayments. The Tier 1 Copayment is lower than the Tier 2 Copayment. Your specific Copayment amounts, and the services to which they apply, are listed in your Schedule of Benefits.

✔ FOR EXAMPLE: If your Plan has a $20 Copayment for outpatient visits, you'll pay $20 at the time of the visit or when you are billed by the provider.

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

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

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

Deductible A specific dollar amount that is payable by a Member for Covered Benefits received eachPlan 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 in aPlan Year. Deductible amounts are incurred on the date of service. If a Deductible applies to your

plan, it will be stated in the Schedule of Benefits.

> ✔ FOR EXAMPLE: If your Plan has a $500 Deductible and you have a claim with the Allowable Amount of $1,000, you will be responsible for the first $500 to satisfy your Deductible requirement before the Plan begins to pay benefits.

Deductible Rollover A Deductible Rollover allows you to apply any Deductible amount incurred for covered services during the last three (3) months of a Plan Year toward the Deductible for the next Plan Year. To be eligible for a Deductible Rollover, a Member must have had continuous coverage with us through the same Employer Group at the time the prior Plan Year charges were incurred. If your Plan has a Deductible Rollover it will be listed in your Schedule of Benefits.

Dental Care Any service provided by a licensed dentist 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.

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

Enrollment Area A list of cities and towns where Plan Providers are available to manage Members' care. Members, except for a Dependent child attending an accredited educational institution or a child under a Qualified Medical Support Order, must maintain residence in the Enrollment Area, and live there at least nine months a year. We may add or delete cities and towns to the Enrollment Area from time to time.

Evidence of Coverage The legal documents, including the Benefit Handbook, Schedule of Benefits, Prescription Drug Brochure, and any applicable riders and amendments which describe the services covered by the Plan, and other terms and conditions of coverage.

Experimental, Unproven, or Investigational Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests, will be deemed Experimental, Unproven, or Investigational by us under this Benefit Handbook for use in the diagnosis or treatment of a particular medical condition if any the following is true: a) The product or service is not recognized in accordance with generally accepted medical standards as being safe and effective for the use in the evaluation or treatment of the condition in question. In determining whether a service has been recognized as safe or effective in accordance with generally accepted evidence-based medical standards, primary reliance will be placed upon data from published reports in authoritative medical or scientific publications that are subject to established peer review by qualified medical or scientific experts prior to publication. In the absence of any such reports, it will generally be determined a service, procedure, device or drug is not safe and effective for the use in question. b) In the case of a drug, the drug has not been approved by the United States Food and Drug Administration (FDA). (This does not include off-label uses of FDA approved drugs). c) For purposes of the treatment of infertility only, the service, procedure, drug or device has not been recognized as a "non-experimental infertility procedure" under the Massachusetts Infertility Benefit Regulations at 211 CMR Section 37.00 et. seq.

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

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

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

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; 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 the Plan.

Medical Emergency A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the 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.

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.

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

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

Out-of-Pocket Maximum An Out-of-Pocket Maximum is a limit on the amount of Copayments, Coinsurance and Deductibles that you must pay for Covered Benefits in a Plan Year. Member Cost Sharing for durable medical equipment, prosthetic devices and outpatient prescription drugs may be excluded from your Out-of-Pocket Maximum. The Out-of-Pocket Maximum, if applicable to your Plan, is specified in your Schedule of Benefits.

Please Note: Charges above the Usual, Reasonable and Customary Charge never apply to the Out-of-Pocket Maximum.

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

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

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

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

Plan Provider Providers of health care services that are under contract with us to provide care to Members. Plan Providers include, but are not limited to physicians, podiatrists, psychologists, psychiatrists, nurse practitioners, physician's assistants, psychiatric social workers, certified psychiatric nurses, psychotherapists, licensed independent clinical social workers, licensed nurse mental health clinical specialist, nurse midwives, nurse anesthetists, and licensed mental health counselors, and early intervention specialists who are credentialed and certified by the Massachusetts Department of Public Health. Plan Providers are listed in the ChoiceNet Provider Directory.

✔ FOR EXAMPLE:

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

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

Prior Carrier Credit A credit given for the first Plan Year of coverage under the Plan for any amounts incurred by the Member toward the Deductible or the Out-of-Pocket Maximum under your current Employer Group's prior health insurance plan. The Prior Carrier Credit will be applied to the Deductible or the Out of Pocket Maximum of this Plan if the following requirements were met:

- You were enrolled in your Employer Group's prior plan on the termination date of coverage; and
- Your coverage became effective with us on the same day as the Employer Group's plan.

Qualified Medical Child Support Order (QMCSO) A court order providing for coverage of a child under a group health plan that meets the requirements of the Employee Retirement Income Security Act (ERISA). A child Dependent enrolled under a QMCSO is subject to all the terms and conditions stated in this Handbook, the Schedule of Benefits, the Prescription Drug Brochure and any applicable riders.

Referral An instruction from your PCP that gives you the ability to see another Plan Provider for services that may be out of your PCP's scope of practice.

✔ FOR EXAMPLE: If you need to visit a specialist, such as a dermatologist or cardiologist, you must contact your PCP first. Your PCP will refer you to a specialist who is a Plan Provider. Your PCP will generally refer you to a specialist with whom he or she is affiliated or has a working relationship.

Rehabilitative Therapies
Rehabilitative Therapies are treatments for disease or injury that restore or move an individual toward functional capabilities prior to disease or injury. For treatment of congenital anomalies with significant functional impairment, Rehabilitative Therapies improve functional capabilities to or toward normal function for age appropriate skills. Only the following are covered: cardiac rehabilitation therapy; occupational therapy; physical therapy; pulmonary rehabilitation therapy; speech therapy; or an organized program of these services when rendered by a health care professional licensed to perform these therapies.

Service Area The state in which a Member lives. When you are in the Service Area you must call your PCP for care. Exceptions apply (1) to Medical Emergencies and (2) when you need one of the services in *I.E.7. Services That Do Not Require a Referral* listed in section *I. How the Plan Works*.

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. Urgent Care is usually care needed because of an unforeseen illness, injury or condition that occurs and does not give reasonable time to obtain care through your PCP or a Plan Provider.

Usual, Customary and Reasonable Charge 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 geographical area where the product or services was 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. The Usual, Customary, and Reasonable charge is the maximum amount that we will pay for Covered Benefits minus any applicable Member Cost Sharing.

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 Plan Year basis.

Basic Requirements for Coverage

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

- Listed as a Covered Benefit in this section.
- Medically Necessary.
- Not excluded in section *IV. Exclusions*.
- Received while an active Member of the Plan.
- Provided by or upon Referral from your PCP. This requirement does not apply to care needed in a Medical Emergency. Please see section *I.E.1. Your PCP Manages Your Health Care* for other exceptions that apply.
- Provided by a Plan Provider. This requirement does not apply to care needed in a Medical Emergency. Please see section *I.E.3. Using Plan Providers* for other exceptions that apply.

Benefit	Description
1. Acupuncture Treatment for Injury or Illness	
2. Ambulance Transport	
	Emergency Ambulance Transport If you have a Medical Emergency (including an emergency mental health condition), your Plan covers ambulance transport to the nearest hospital that can provide you with Medically Necessary care. **Non-Emergency Ambulance Transport** 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 Plan Provider. (**Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits.)
3. Autism Spectrum Disorders Treatment	
	Coverage is provided for the diagnosis and treatment of Autism Spectrum Disorders, as defined below. Covered Services include the following: • Diagnosis of Autism Spectrum Disorders. This includes Medically Necessary assessments, evaluations, including neuropsychological evaluations, genetic testing or other tests to diagnose whether an individual has one of the Autism Spectrum Disorders. • Professional services by Plan Providers. This includes care by physicians, Licensed Mental Health Professionals, speech therapists, occupational therapists, and physical therapists. • Habilitative and rehabilitative care, including, but not limited to, applied behavior analysis supervised by a board certified behavior analyst as defined by law. • Prescription drug coverage (if you have the Plan's optional coverage for outpatient prescription drugs). If you have the Plan's outpatient prescription drug coverage, please see your Prescription Drug Brochure for information on this benefit. Autism Spectrum Disorders include any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. These include Autistic Disorder; Asperger's Disorder; and Pervasive Developmental Disorders Not Otherwise Specified. Applied behavior analysis is defined by Massachusetts law as the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior. It includes the use of direct observation, measurement and functional analysis of the relationship between environment and behavior. 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.
4. Cardiac Rehabilitation Therapy	
	The Plan covers cardiac rehabilitation as required by law. Coverage includes only Medically Necessary services for Members with established coronary artery disease or unusual and serious risk factors for such disease.

Benefit	Description
5. Clinical Trials for the Treatment of Cancer	
	The Plan covers services for Members enrolled in a qualified clinical trial of a treatment for any form of cancer under the terms and conditions provided for under 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.
6. 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 (**Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits.) **Preventive Dental Care for Children:** The Plan covers two preventive dental exams per Plan Year for children under the age limit listed in the Schedule of Benefits. Only the following services are covered: • Cleaning • Fluoride treatment • Teaching plaque control • X-rays (**Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits.)

Benefit	Description
7. Diabetes Services and Supplies	
	Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care: The Plan covers outpatient self-management education and training for the treatment of diabetes, including medical nutrition therapy services, used to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes. Services must be provided on an individual basis and be provided by a Plan Provider. Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care. The following items are also covered: **Diabetes Equipment:** • Blood glucose monitors • Dosage gauges • Injectors • Insulin pumps (including supplies) and infusion devices • Lancet devices • Therapeutic molded shoes and inserts • Visual magnifying aids • Voice synthesizers **Pharmacy Supplies:** • Blood glucose strips • Insulin, insulin needles and syringes • Lancets • Oral agents for controlling blood sugar • Urine and ketone test strips For coverage of pharmacy items listed above, you must get a prescription from your Plan Provider and present it at a participating pharmacy. You can find participating pharmacies online at **www.harvardpilgrim.org**. Click Pharmacy Program or by calling the Member Services Department at **1-888-333-4742** .
8. 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. Installation of home equipment is covered up to in a Member's lifetime. We must approve dialysis services if you are temporarily traveling outside the Service Area. We will cover dialysis services for up to 30 days of travel per Plan Year. You must make arrangements in advance with your Plan Provider.

Benefit	Description
9. Drug Coverage	
	You have limited coverage for prescription drugs under this Benefit Handbook, which is described in Subsection 1, below. You may also have the Plan's optional coverage for outpatient prescription drugs and certain medical supplies you purchase at a pharmacy. Subsection 2, below, explains how to determine whether you have the Plan's optional pharmacy coverage and how to learn the details of the optional pharmacy plan. **1) Your Coverage under this Benefit Handbook** This Benefit Handbook 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 that Cannot be Self-Administered. The drug cannot be self-administered and is given to you either (a) in a doctor's office or other outpatient medical facility, or (b) at home while you are receiving home health care services covered by the Plan. 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. This Benefit Handbook 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 that coverage. No coverage is provided under this Benefit Handbook for: (1) drugs that have not been approved by the United States Food and Drug Administration; (2) drugs the Plan excludes or limits, including, but not limited to, drugs for cosmetic purposes 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. **2) Optional Outpatient Pharmacy Coverage** In addition to the coverage under this Benefit Handbook, you may also have the Plan's optional outpatient pharmacy benefit. That benefit provides coverage for most prescription drugs and certain medical supplies purchased at an outpatient pharmacy. If you have outpatient pharmacy coverage, your Member Cost Sharing for prescription drugs will be listed on your ID Card. If your Plan includes outpatient pharmacy coverage, please see the Prescription Drug Brochure, included in your Member Kit, for a detailed explanation of your benefits.

Benefit	Description
10. Durable Medical Equipment (DME) and Prosthetic Devices	
	The Plan covers DME and prosthetic devices when Medically Necessary and ordered by a Plan Provider. We will rent or buy all equipment. The cost of the repair and maintenance of covered equipment is also covered. In order to be covered, all equipment must be: • Able to withstand repeated use; • Not generally useful in the absence of disease or injury; • Normally used in the treatment of an illness or injury or for the rehabilitation of an abnormal body part (this does not apply to prostheses); and • Suitable for home use. Coverage is only available for: • • The least costly equipment or prosthetic device adequate to allow you to perform Activities of Daily Living. The Plan will pay the Allowable Amount, minus any applicable Member Cost Sharing, for the least costly item of equipment or prosthetic device. If you rent or purchase equipment or a prosthetic device that is more expensive than the least costly item adequate to permit you to perform Activities of Daily Living, you will be responsible for any additional cost. Activities of Daily Living do not include special functions needed for occupational purposes or sports; and • One item of each type of equipment or prosthetic device. 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 • Ostomy supplies • Oxygen and oxygen equipment • Respiratory equipment • Walkers • Wheelchairs Covered prostheses include: • Breast prostheses, including replacements and mastectomy bras • Prosthetic arms and legs (including myoelectric and bionic arms and legs) • Prosthetic eyes Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan.
11. Early Intervention Services	
	The Plan covers early intervention services provided for Members until three years of age. Covered services include: • Nursing care • Physical, speech, and occupational therapy • Psychological counseling • Screening and assessment of the need for services

Benefit	Description
12. Emergency Room Care	
	If you have a Medical Emergency, you are covered for care in a hospital emergency room. Please remember the following: • If you need follow-up care after you are treated in an emergency room, you must call your PCP. Your PCP will provide or arrange for the care you need. • If you are hospitalized, you must call the Plan at **1-888-333-4742** within 48 hours or as soon as you can. This 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
13. Family Planning Services	
	The Plan covers family planning services, including the following: • Contraceptive monitoring • Family planning consultation • Pregnancy testing • Genetic counseling • Professional services relating to the injection of birth control drugs and the insertion or removal of birth control implants or devices. However, birth control drugs, implants or devices that must be obtained at an outpatient pharmacy, will only be covered if your plan includes optional outpatient pharmacy coverage.
14. Foot Orthotics	
	The Plan covers foot orthotics up to the Benefit Limit listed in the Schedule of Benefits. (**Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits.)
15. Hearing Aids	
	The Plan covers hearing aids for Members up to the age of 19, including repair, up to the Benefit Limit listed in the Schedule of Benefits. (**Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits.)
16. Home Health Care	
	If you are homebound for medical reasons, you are covered for home health care services listed below. To be eligible for home health care, your Plan Provider must determine that skilled nursing care or physical therapy is an essential part of active treatment. There must also be a defined medical goal that your Plan Provider expects you will meet 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 social services • Nutritional counseling • Physical therapy • Occupational therapy • Services of a home health aide • Skilled nursing care • Speech therapy

Benefit	Description
17. Hospice Services	
	The Plan covers hospice services for terminally ill Members who need the skills of qualified technical or professional health personnel for palliative care. Care may be provided at home or on an inpatient basis. Inpatient respite care is covered for the purpose of relieving the primary caregiver and may be provided up to 5 days every 3 months not to exceed 14 days per Plan Year. Inpatient care is also covered in an acute hospital or extended care facility when it is Medically Necessary to control pain and manage acute and severe clinical problems that cannot be managed in a home setting. Covered Benefits include: • Care to relieve pain • Counseling • Drugs that cannot be self-administered • Durable medical equipment appliances • Home health aide services • Medical supplies • Nursing care • Physician services • Occupational therapy • Physical therapy • Speech therapy • Respiratory therapy • Respite care • Social services
18. 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 In order to be eligible for coverage, the following service must be received at a Center of Excellence: • Weight loss surgery (bariatric surgery) Please see section *I.E.4. Centers of Excellence* for more information.
19. House Calls	
	The Plan covers house calls.

Benefit	Description
20. 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 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.
21. Hypodermic Syringes and Needles	
	The Plan covers hypodermic syringes and needles to the extent Medically Necessary, as required by law. You must get a prescription from your PCP or Plan Provider and present it at a participating pharmacy for coverage. You can get more information on participating pharmacies online at **www.harvardpilgrim.org**. Click Pharmacy Program or by calling the Member Services Department at **1-888-333-4742.**
22. 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 donor insemination, 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 (IVF) • Zygote intrafallopian transfer (ZIFT) • Preimplantation genetic diagnosis (PGD) • Miscrosurgical 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. **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**.

Benefit	Description
23. Laboratory and Radiology Services	
	The Plan covers diagnostic laboratory and x-ray services, including High End Radiology, on an outpatient basis. The term "High End 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, human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish bone marrow transplant donor suitability, 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
24. Low Protein Foods	
	The Plan covers food products modified to be low-protein ordered for the treatment of inherited diseases of amino acids and organic acid to the extent required by law.
25. Maternity Care	
	The Plan covers the following maternity services: • Routine outpatient prenatal care, including evaluation and progress screening, physical exams, recording of weight and blood pressure monitoring • Prenatal genetic testing (office visits require a referral) • Delivery, including a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean section. Any decision to shorten the inpatient stay for the mother and her newborn child will be made by the attending physician and the mother. If early discharge is decided, the mother will be entitled to a minimum of one home visit. • Newborn care. Coverage is limited to routine nursery charges for a healthy newborn unless the child is enrolled in the Plan. Please see section *VIII.E. ADDING A DEPENDENT* for more enrollment information. • Routine outpatient postpartum care for the mother, including lactation consultations, up to six weeks after delivery
26. Medical Formulas	
	The Plan covers the following to the extent required by law: • Non-prescription enteral formulas for home use for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction and inherited diseases of amino acids and organic acids. • Prescription formulas for the treatment of phenylketonuria, tyrosinemia, homocystrinuria, maple syrup urine disease, propionic acidemia or methylmalonic acidemia in infants and children or to protect the unborn fetuses of pregnant women with phenylketonuria.

Benefit	Description
27. Mental Health Care (Including the Treatment of Substance Abuse 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 abuse disorders. For coverage of mental health care (including the treatment of substance abuse disorders), you must call the Behavioral Health Access Center at **1-888-777-4742** . All mental health care must be arranged through the Behavioral Health Access Center and provided by a contracted Plan Provider. (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 determining the type of care you need, finding an appropriate Plan Provider, and arranging the services you require. 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. **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 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 , a Licensed Mental Health Professional must be one of the following types of providers: a licensed physician who specializes in the practice of psychiatry; a licensed psychologist; a licensed independent clinical social worker; a licensed nurse mental health clinical specialist; or a licensed mental health counselor. For services provided outside of , 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. **Benefits** Your benefits for mental health care depend on the reason the services are required and whether or not the Federal Mental Health Parity law applies to your Plan. Please refer to your Schedule of Benefits, it will tell you if Federal Mental Health Parity law applies to your Plan.

Benefit	Description
27. Mental Health Care (Including the Treatment of Substance Abuse Disorders) (Continued)	
	Coverage for Massachusetts Parity Conditions Under law, services for three categories of conditions must be covered to the same extent as medical services for physical illnesses. These three categories are (1) services for "biologically-based mental disorders," (2) services required as a result of rape, and (3) services for children with non-biologically-based mental, behavioral or emotional disorders. Further information on the coverage provided for these conditions can be found below. 1) **Services Required to Treat Biologically-Based Mental Disorders** The Plan covers services required to treat biologically based mental disorders. Biologically-based mental disorders are: (1) schizophrenia; (2) schizoaffective disorders; (3) major depressive disorder; (4) bipolar disorder; (5) paranoia and other psychotic disorders; (6) obsessive-compulsive disorder; (7) panic disorder; (8) delirium and dementia; (9) affective disorders; (10) eating disorders; (11) post-traumatic stress disorders; (12) substance abuse disorders; and (13) autism. 2) **Services Required as a Result of Rape** The Plan covers services required to diagnose and treat rape-related mental or emotional disorders for victims of rape or victims of an assault with the attempt to commit rape. 3) **Services for Children With Non-Biologically-Based Mental, Behavioral or Emotional Disorders** The Plan covers services required to diagnose and treat non-biologically-based mental, behavioral or emotional disorders that substantially interfere with or limit functioning and social interactions for children through the age of 18. Substantial interference with, or limitation of, function must be documented by the Member's PCP or HPHC mental health provider, or when evidenced by conduct including, but not limited to: • the inability to attend school • the need for hospitalization as a result of the disorder • a pattern of conduct or behavior caused by the disorder that poses a serious danger to self or others. Coverage under this subsection shall continue after the child's 19th birthday until either the course of treatment specified in the child's treatment plan is completed or coverage under this Handbook is terminated, whichever comes first. If treatment of a 19 year old, as specified in his or her treatment plan, has not been completed at the time coverage under this Handbook is terminated, such treatment may be continued under a replacement plan issued by HPHC. **Coverage for Other Conditions** In addition to the coverage discussed above, the Plan will provide coverage for the care of all other 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 "V Code" designation applies, which means that the condition is not attributable to a mental disorder.) If the Federal Mental Health Parity law applies to your Plan, services for all other conditions not identified above will be covered to the extent Medically Necessary.

Benefit	Description
27. Mental Health Care (Including the Treatment of Substance Abuse Disorders) (Continued)	
	If the Federal Mental Health Parity law does not apply to your Plan, Medically Necessary services for conditions other than those listed above under law will be covered subject to the benefit limits as set forth in your Schedule of Benefits. Please refer to your Schedule of Benefits, it will tell you if Federal Mental Health Parity law applies to your Plan and will also state the Member Cost Sharing and any benefit limits that apply to the coverage of these services. 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 through the Behavioral Health Access Center 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 • Psychological testing and neuropsychological assessment.
28. Ostomy Supplies	
	The Plan covers ostomy supplies up to the Benefit Limit listed in the Schedule of Benefits. Only the following supplies are covered: • Irrigation sleeves, bags and catheters • Pouches, face plates and belts • Skin barriers
29. Physician and Other Professional Services	

	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 Plan Year are covered for a child from birth to age one.
	  • At least three visits per Plan Year are covered for a child from age one to age two.

Benefit	Description
29. Physician and Other Professional Services (Continued)	
	• At least one visit per Plan 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:** Some Plans may cover certain preventive services and tests with no Member Cost Sharing. Please see your Schedule of Benefits for the coverage that applies to your Plan.
30. Prosthetic Devices	
	The Plan covers prosthetic devices when ordered by a Plan Provider. The cost of the repair and maintenance of a covered device is also covered. In order to be covered, all devices must be able to withstand repeated use. Coverage is only available for: • • The least costly prosthetic device adequate to allow you to perform Activities of Daily Living. The Plan will pay the Allowable Amount, minus any applicable Member Cost Sharing, for the least costly prosthetic device. If you purchase a prosthetic device that is more expensive than the least costly item adequate to permit you to perform Activities of Daily Living, you will be responsible for any additional cost. 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 • Wigs and scalp hair prostheses up to the Benefit Limit listed in the Schedule of Benefits Prosthetic devices are covered up to the Benefit Limit listed in the Schedule of Benefits. The Benefit Limit does not apply to: • Breast prostheses (including replacements and mastectomy bras) • Prosthetic arms and legs (including myoelectric and bionic arms and legs) Both the Benefit Limit and any Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan.

Benefit	Description
31. 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.**
32. Rehabilitation Hospital Care	
	The Plan covers care in a facility licensed to provide rehabilitative care on an inpatient basis. Coverage is provided when you need daily Rehabilitative Therapies that must be provided in an inpatient setting. Rehabilitative Therapies include cardiac rehabilitation therapy, physical therapy, pulmonary rehabilitation therapy, occupational therapy and speech therapy. The Benefit Limit is listed in the Schedule of Benefits.

Benefit	Description
33. Rehabilitation Therapy – Outpatient	
	The Plan covers the following outpatient rehabilitation therapies: • Occupational therapy • Physical therapy • Pulmonary rehabilitation therapy Outpatient rehabilitation therapies are covered up to the Benefit Limit listed in the Schedule of Benefits. Services are covered only: • If, in the opinion of your Plan Provider, there is likely to be significant improvement in your condition within the period of time benefits are covered; and • When needed to improve your ability to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports. Rehabilitation Therapies are also covered under your inpatient hospital and home health benefits. When such therapies are part of an approved home care treatment plan they are available on a short-term intermittent basis as described in the section titled, "Home Health Care." **Please Note:** 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.
34. Scopic Procedures – Outpatient Diagnostic	
	The Plan covers diagnostic scopic procedures and related services received on an outpatient basis. Diagnostic scopic procedures are those for visualization, biopsy and/or polyp removal. Scopic procedures are: • Colonoscopy • Endoscopy • Sigmoidoscopy
35. Skilled Nursing Facility Care	
	The Plan covers care in a health care facility licensed to provide skilled nursing care on an inpatient basis. Coverage is provided only when you need daily skilled nursing care that must be provided in an inpatient setting. The Benefit Limit is listed in the Schedule of Benefits.
36. Speech-Language and Hearing Services	
	The Plan covers diagnosis and treatment of speech, hearing and language disorders to the extent Medically Necessary by speech-language pathologists and audiologists.
37. Spinal Manipulative Therapy (including care by a chiropractor)	
	The Plan covers musculoskeletal adjustment or manipulation up to the Benefit Limit listed in the Schedule of Benefits. Only an initial diagnostic x-ray is covered. (**Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits.)

Benefit	Description
38. Surgery - Outpatient	
	The Plan covers outpatient surgery, including related services. Outpatient surgery is defined as any surgery or procedure in a day surgery department, ambulatory surgery department or outpatient surgery center. There are certain specialized services for which you will be directed to a Center of Excellence for care. See section *I.E.4. Centers of Excellence* for more information.
39. 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 listed in the Schedule of Benefits) • Surgery • X-rays **Important Notice:** No Dental Care is covered for the treatment of Temporomandibular Joint Dysfunction (TMD).
40. Urgent Care Center Services	
	The Plan covers services that you receive at an Urgent Care Center. Coverage is provided for services that are required to prevent deterioration to your health resulting from an unforeseen sickness or injury. You do not need to obtain a referral from your PCP or receive services from a Plan Provider to be covered for services at an Urgent Care Center. Services you may obtain at an Urgent Care Center 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 an Urgent Care Center. Your PCP may be able to provide the services you require at a lower out-of-pocket cost. In addition, your PCP is responsible for coordinating your health care services and should know about the services you receive. Please refer to your Schedule of Benefits for your specific Member Cost Sharing requirements. **Important Notice:** Urgent care is not emergency care. You should call 911 or go directly to a hospital emergency room if you suspect you have any life threatening condition. These include heart attack or suspected heart attack, shock, major blood loss, or loss of consciousness. Please see section *I.E.5. Medical Emergency Services* for more information. (**Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits.)

Benefit	Description
41. Vision Services	
	Routine Eye: The Plan covers routine eye examinations. (**Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits.) **Vision Hardware for Special Conditions:** The Plan provides coverage for contact lenses or eyeglasses needed for the following conditions: • Keratonconus. One pair of contact lenses is covered per Plan Year. The replacement of lenses, due to a change in the Member's condition, is limited to 3 per affected eye per Plan 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 Plan Year. Coverage up to $50 per Plan 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 Plan 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 Plan Year after the date of surgery. For Members who have not previously worn eyeglasses or contact lenses, the Plan covers eyeglass lenses up to $50 toward the purchase of the frame or pair of contact lenses. (**Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits.)
42. Voluntary Sterilization	
	The Plan covers voluntary sterilization, including tubal ligation and vasectomy. (**Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits.)
43. Voluntary Termination of Pregnancy	
	The Plan covers voluntary termination of pregnancy. (**Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits.)
44. Wigs and Scalp Hair Prostheses	
	The Plan covers wigs and scalp hair prostheses regardless of the reason for hair loss when needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis or permanent hair loss due to injury up to the Benefit Limit listed in the Schedule of Benefits.

IV. Exclusions

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

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

Exclusion	Description
1. Alternative Treatments	
	1 . Acupuncture services, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). 2 . Acupuncture services that are outside the scope of standard acupuncture treatment, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits), including services for preventive, maintenance, or wellness care, thermography, hair analysis, heavy metal screening or mineral studies, massage or soft-tissue techniques, diagnostic services, x-rays or services related to menstrual cramps. 3 . Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments. 4 . Aromatherapy, treatment with crystals and alternative medicine. 5 . Health resorts, spas, recreational programs, camps, wilderness programs, outdoor skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs. 6 . Massage therapy. 7 . Myotherapy.
2. Dental Services	
	1 . Dental Care, except the specific dental services listed as Covered Benefits in this Benefit Handbook and your Schedule of Benefits. 2 . All services of a dentist for Temporomandibular Joint Dysfunction (TMD). 3 . Extraction of teeth, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). 4 . Preventive dental care for children, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). 5 . Dentures
3. Durable Medical Equipment and Prosthetic Devices	
	1 . Any devices or special equipment needed for sports or occupational purposes. 2 . Any home adaptations, including, but not limited to home improvements and home adaptation equipment. 3 . Myoelectric and bionic arms and legs, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). 4 . Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. 5 . Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.
4. Experimental, Unproven or Investigational Services	
	1 . Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.

Exclusion	Description
5. Foot Care	
	1 . Foot orthotics, except for the treatment of severe diabetic foot disease or when specifically listed as a Covered Benefit. (Please see your Schedule of Benefits). 2 . Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members with diabetes.
6. Maternity Services	
	1 . Delivery outside the Service Area after the 37th week of pregnancy, or after you have been told that you are at risk for early delivery. 2 . Planned home births. 3 . Routine pre-natal and post-partum care when you are traveling outside the Service Area.
7. Mental Health Care	
	1 . Biofeedback. 2 . 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; or (3) to treat learning disabilities. 3 . Methadone maintenance. 4 . Sensory integrative praxis tests. 5 . Services for any condition with only a "V Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder. 6 . 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. 7 . Services or supplies for the diagnosis or treatment of mental health and substance abuse disorders that, in the reasonable judgment of the Behavioral Health Access Center, are any of the following: • Not consistent with prevailing national standards of clinical practice for the treatment of such conditions. • Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome. • Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. 8 . 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.

Exclusion	Description
8. Physical Appearance	
	1 . Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care. 2 . Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. 3 . Liposuction or removal of fat deposits considered undesirable. 4 . Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). 5 . Skin abrasion procedures performed as a treatment for acne. 6 . Treatment for skin wrinkles or any treatment to improve the appearance of the skin. 7 . Treatment for spider veins.
9. Procedures and Treatments	
	1 . Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial X-ray. 2 . Spinal manipulative therapy (including care by a chiropractor), except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). 3 . Commercial diet plans, weight loss programs and any services in connection with such plans or programs. 4 . Gender reassignment surgery and all related drugs and procedures. 5 . If a service is listed as requiring that it be provided at a Center of Excellence, no coverage will be provided under this Handbook if that service is received from a Provider that has not been designated as a Center of Excellence. Please see section *I.E.4. Centers of Excellence* for more information. 6 . 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). 7 . Physical examinations and testing for insurance, licensing or employment. 8 . Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. 9 . Testing for central auditory processing. 10 . Group diabetes training, educational programs or camps.
10. Providers	
	1 . Charges for services which were provided after the date on which your membership ends. 2 . Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit under this Handbook. 3 . Charges for missed appointments. 4 . Concierge service fees. (See section *I.F.7. PROVIDER FEES FOR SPECIAL SERVICES (CONCIERGE SERVICES)* for more information.) 5 . Follow-up care after an emergency room visit, unless provided or arranged by your PCP. 6 . Inpatient charges after your hospital discharge. 7 . Provider's charge to file a claim or to transcribe or copy your medical records. 8 . Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.

Exclusion	Description
11. Reproduction	
	1 . Any form of Surrogacy or services for a gestational carrier. 2 . Birth control drugs, implants and devices that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage. 3 . Infertility drugs if a member is not in a Plan authorized cycle of infertility treatment. 4 . Infertility drugs, if infertility services are not a Covered Benefit. 5 . Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage. 6 . Infertility treatment for Members who are not medically infertile. 7 . Infertility treatment and birth control drugs, implants and devices. 8 . Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). 9 . Sperm collection, freezing and storage except as described in the section *III. Covered Benefits*, *Infertility Services and Treatment*. 10 . Sperm identification when not Medically Necessary (e.g., gender identification). 11 . The following fees; wait list fees, non-medical costs, shipping and handling charges etc. 12 . Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). 13 . Voluntary termination of pregnancy, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). 14 . Voluntary termination of pregnancy, unless the life of the mother is in danger.
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. Types of Care	
	1 . Custodial Care. 2 . Rest or domiciliary care 3 . All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. 4 . Home health care services that extend beyond care on a short-term intermittent basis. 5 . Pain management programs or clinics. 6 . Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. 7 . Private duty nursing. 8 . Sports medicine clinics. 9 . Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.

Exclusion	Description
14. Vision and Hearing	
	1 . Eyeglasses, contact lenses and fittings, except as listed in this Benefit Handbook. 2 . Hearing aids, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). 3 . Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of myopia, hyperopia and astigmatism. 4 . Routine eye examinations, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits).
15. 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, except for pharmacy supplies covered under the benefit for diabetes services and hypodermic syringes and needles, as required by law, unless your Plan includes outpatient pharmacy coverage. 4 . Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law. 5 . Guest services. 6 . Services for non-Members. 7 . Services for which no charge would be made in the absence of insurance. 8 . Services for which no coverage is provided in this Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure. 9 . Services that are not Medically Necessary. 10 . Services your PCP or a Plan Provider has not provided, arranged or approved except as described in the sections *I.E.1. Your PCP Manages Your Health Care* and *I.E.3. Using Plan Providers*. 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. • Strollers. • Safety equipment. • Vehicle modifications including but not limited to van lifts. • Telephone • Television

V. Student Dependent Coverage

If your Dependent child goes to school away from home, he or she may continue to receive Plan benefits. Plan coverage works one of two ways for student Dependents, depending on where they go to school.

Your Dependent child must meet the eligibility criteria in section *VIII. Eligibility* in order to continue coverage as a student Dependent. We may require reasonable evidence that a Member meets these requirements.

A. STUDENTS INSIDE THE ENROLLMENT AREA

If your Dependent child goes to school inside the Enrollment Area, he or she can choose a PCP near school. This PCP manages your child's care just as your PCP does for you.

The Enrollment Area is where Members, except for a Dependent child going to school, must live to be eligible for enrollment. The Enrollment Area includes the places where Plan Providers are available to care for Members. You may obtain a list of the cities and towns of the current Enrollment Area from Member Services. We may revise the Enrollment Area from time to time.

B. STUDENTS OUTSIDE THE ENROLLMENT AREA

If your Dependent child goes to school outside the Enrollment Area, we provide special coverage. This is because there are no nearby Plan PCPs who can manage your child's care while he or she is going to school.

This special coverage allows a student Dependent to receive most Covered Benefits while away at school. This includes the continuation of treatment that began before the student left the Enrollment Area. All the rules and limits on coverage listed in the Benefit Handbook and Schedule of Benefits apply to these benefits, except that your Dependent child does not need to get care through his or her PCP.

Please Note: Your Dependent child is entitled to all the benefits in this Handbook and Schedule of Benefits when he or she returns to the Enrollment Area and receives care from Plan Providers.

C. BENEFITS FOR OUT-OF-AREA STUDENT COVERAGE

For student Dependents who attend school outside the Enrollment Area, the Plan covers Medically Necessary services, as described below, when related to a specific illness or condition.

Any Member Cost Sharing amounts will be applied as listed in your Schedule of Benefits.

1. Outpatient Medical Services

The Plan covers all of the outpatient medical services covered under this Handbook, except for the following:

a) Routine examinations and preventive care, including immunizations

b) Preventive dental care, if a Covered Benefit

c) Home health care, including maternity home care programs and house calls

d) Maintenance or replacement of prosthetic devices or durable medical equipment

e) Procedures, including follow-up care, that can be delayed until the Member returns to the Service Area without damage to the Member's health

Some plans include coverage for preventive dental care. Preventive dental care is only covered within the Enrollment Area from Plan Providers.

✔ FOR EXAMPLE: If your Dependent child needed a physical exam or routine eye exam, these services would NOT be covered until he or she returns to the Enrollment Area and can see a Plan Provider. However, if your child needed to continue coverage for a condition that required ongoing treatment while away at school, e.g., physical therapy, this would be covered as stated in your Schedule of Benefits.

2. Inpatient Services

The Plan covers inpatient services listed in this Handbook, except for services that can be delayed until the Member returns to the Service Area without damage to the Member's health. You or your student Dependent must call the Plan at **1-888-333-4742** within 48 hours of hospitalization or as soon as you can. This telephone number can also be found on your ID card.

3. Mental Health Care (Including the Treatment of Substance Abuse Disorders)

The Plan provides access to a national network of providers of mental health care (including the treatment of substance abuse disorders). If a student Dependent needs such services, he or she must call the Behavioral Health Access Center at **1-800-777-4742** . This number is staffed by licensed mental health clinicians. The staff of the Behavioral Health Access Center will assist in finding the appropriate providers and arranging required services while away at school.

The coverage for out-of-area mental health care (including the treatment of substance abuse disorders) is the same as that provided for services received inside the Enrollment Area. Please see section *III. Covered Benefits*, *Mental Health Care (Including the Treatment of Substance Abuse Disorders)* for additional information on the benefits for mental health care.

VI. Reimbursement and Claims Procedures

The information in this section applies when you receive services from a non-Plan Provider. This should happen only when you get care:

- In a Medical Emergency; or
- When you are temporarily traveling outside the Service Area.

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

A. BILLING BY PROVIDERS

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

1) Bill us on a standard health care claim form (such as the CMS 1500 or the UB-82/92 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, we will reimburse you less your applicable Member Cost Sharing.

Claims for Mental Health Care:

Behavioral Health Access Center
P.O. Box 31053
Laguna Hills,, CA 92654-1053

Pharmacy Claims:

MedImpact
DMR Department
10680 Treena Street, 5th Floor
San Diego, CA 92131

All Other Claims:

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

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 9 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

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

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.

2. Pharmacy Claims

To obtain reimbursement for pharmacy bills you have paid, you must submit a Prescription Claim Form. The form can be obtained online at **www.harvardpilgrim.org** or by calling the Member Services Department.

In addition to the Prescription Claim Form you must send a drug store receipt showing the items for which reimbursement is requested.

The following information must be on the Prescription Claim Form:

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

Important Notice: Reimbursement for prescription drugs will only be made if your plan includes optional

outpatient pharmacy coverage. Please see your Prescription Drug Brochure (if applicable) for more information

Members can contact the MedImpact help desk at **1-800-788-2949** regarding pharmacy claims.

C. TIME LIMITS ON FILING CLAIMS

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

Claims will be reviewed within 45 days of the receipt. If a claim cannot be paid within that time, HPHC will notify the provider in writing:

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

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

D. PAYMENT LIMITS

We limit the amount we will pay for services that are not rendered by Plan Providers. The most we will pay for such services is the Usual, Customary and Reasonable Charge. You may have to pay the balance if the claim is for more than the Usual, Customary and Reasonable Charge.

VII. Appeals and Complaints

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

A. ABOUT OUR APPEAL AND COMPLAINT PROCEDURES

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

- An appeal may be filed whenever a Member is denied coverage. This includes either the denial of a health service sought by a Member or the denial of payment for a health service that a Member has received.
- A complaint may be filed when a Member seeks redress of any action taken by us or any aspect of our services, other than a denial of coverage for health services.

Both appeals and complaints should be filed at the addresses or telephone numbers listed in section *VII.B. HOW TO FILE AN APPEAL OR COMPLAINT*.

B. HOW TO FILE AN APPEAL OR COMPLAINT

Any appeal or complaint may be filed in person, by mail, by fax or by telephone.

Appeals or complaints, other than those concerning mental health or drug and alcohol rehabilitation services, should be submitted to:

HPHC Member Appeals
Member Services Department
1600 Crown Colony Drive
Quincy, MA 02169
Telephone: Telephone: 1-888-333-4742
Fax: 1–617–509–3085
www.harvardpilgrim.org

Appeals or complaints concerning mental health or drug and alcohol rehabilitation services should be submitted to:

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

1. Member Representation

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

A Member's representative may be the Member's guardian, conservator, agent under a power of attorney, health care agent under a health care proxy, family member or any other person appointed in writing to represent the Member in a specific appeal or complaint. We may require documentation that a representative meets one of the above criteria.

2. Time Limit for Filing Appeals

A request for informal inquiry or appeal must be filed within 180 days of the date a service, or payment for a service, when denied.

3. Appeals Involving Medical Necessity Determinations

Special rights apply to appeals involving medical necessity determinations. These appeals could involve a decision that a service (1) is not Medically Necessary, (2) is not being provided in an appropriate health care setting or level of care, (3) is not effective for treatment of the Member's condition, or (4) is Experimental, Unproven or Investigational. These include the right to appeal to an external review organization under contract with the Office of Patient Protection of the Department of Public Health. The procedure for obtaining external review is summarized below in section *VII.F. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED*.

4. The Office of Patient Protection

The Office of Patient Protection of the Department of Public Health is the agency responsible for enforcing the Massachusetts laws concerning managed care grievance rights and for administering appeals to external review organizations. The Office of Patient Protection also enforces health care standards for managed care organizations, answers questions of consumers about managed care and monitors quality-related health insurance information relating to managed care practices. The Office of Patient Protection can be reached at:

Department of Public Health
Office of Patient Protection
99 Chauncy Street
Boston, MA 02111
Telephone: Telephone: 1–800–436-7757
Fax: 1–617–624-5046

5. Report on Appeals and Complaints
We will file an annual report on appeals and complaints with the Office of Patient Protection. After filing, the report for the prior year will be available to Members upon request. A copy may be requested from the Member Services Department at the address or telephone number listed in section *VII.B. HOW TO FILE AN APPEAL OR COMPLAINT*.

6. Membership Required for Coverage
To be eligible for coverage, a Member must be enrolled under the Plan on the date a service is received. A response to an informal inquiry or an appeal decision approving coverage will not be valid for services received after the termination of membership. However, payment may be made after the termination of membership for services received while membership was effective.

C. THE INFORMAL INQUIRY PROCESS

Most appeals and complaints result from a misunderstanding with a provider or a claim processing error. Since these problems can be easy to resolve, most appeals and complaints will first be considered in our informal inquiry process. However, the informal inquiry process will not be used to review a denial of coverage involving a medical necessity determination. Coverage decisions involving medical necessity determinations will be transferred directly to the formal appeal process described below in "The Formal Appeal Process."

During the informal inquiry process a Member Services Representative will investigate an appeal or complaint and attempt to resolve it to the Member's satisfaction. Whenever possible, the Member Services Representative will provide the Member with a response within 3 business days of receipt of the inquiry. This response will normally be communicated by telephone.

If the Member Services Representative responds to an inquiry within 3 business days of receipt but the inquiry is not resolved to the Member's satisfaction, the Member may either file a formal complaint or appeal, as appropriate.

If the Member Services Representative cannot respond to the inquiry within 3 business days, we will transfer the inquiry to the formal appeal or formal complaint process, as appropriate.

D. THE FORMAL APPEAL PROCESS

Our internal appeal process is available whenever a Member is denied coverage. This includes either the denial of a health service sought by a Member or the denial of payment for a health service that a Member has received. If a denial involves a medical necessity determination, an appeal may be filed immediately. All other appeals will be considered in the informal inquiry process, described above.

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

2. Documentation of Oral Appeals
If an appeal is filed by telephone, an Appeal Coordinator will write a summary of the appeal and send it to the member within 48 hours of receipt. This time limit may be extended by written mutual agreement between the Member and us.

3. Acknowledgment of Appeals
Appeals will be acknowledged in writing within 15 days of receipt. This time limit may be extended by written mutual agreement between the Member and us. No acknowledgment of an appeal will be sent if an Appeal Coordinator has previously sent a summary of an appeal submitted by telephone.

4. Release of Medical Records
Any appeal that requires the review of medical information must include a signed "Authorization for Release of Medical Information." This form must be signed and dated by the Member or the Member's authorized representative (when signed by an authorized representative, appropriate proof of authorization to release medical information must be provided). If an Authorization for Release of Medical Information form is not provided when the appeal is filed, the Appeal Coordinator will promptly send a blank form to the Member or the Member's representative. If a signed Authorization for Release of Medical Information is not received within 30 business

days of the date the appeal is received, we may issue a decision based on the information already in the file.

5. What are "Pre-Service" and "Post-Service" Appeals?

We divide appeals into two types, "Pre-Service Appeal" and "Post-Service Appeal" as follows: A "Pre-Service Appeal" requests coverage of a health care service that the Member has not yet received.

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

6. Time Limit for Processing Appeals

For Pre-Service Appeals, Members will be provided with a written appeal decision within 30 days of the date the appeal was received. For Post-Service Appeals, Members will be provided with a written appeal decision within 30 business days of the date the appeal was received. These time limits may be extended by mutual agreement, in writing, between the Member and us. Any extension will not exceed 30 business days from the date of the agreement. We may decline to extend the review period for an appeal if a service has been continued pending an appeal.

If an appeal requires the review of medical information, the date of receipt will be the date we receive a signed Authorization for Release of Medical Information. If we do not respond to an informal inquiry within 3 business days, the date of receipt will be the 4th business day following the date we received the inquiry or the date we receive the signed Authorization for Release of Medical Information, whichever is later. No appeal will be deemed received until actual receipt of the appeal at the appropriate address or phone number listed in section *VII.B. HOW TO FILE AN APPEAL OR COMPLAINT*.

If we do not act on an appeal within 30 business days plus any extension of time mutually agreed upon in writing by the Member and us, the appeal will be deemed to be resolved in favor of the Member.

7. Medical Records and Information

The Appeal Coordinator will try to obtain all information, including medical records, relevant to the appeal. Due to the limited time available for the processing of appeals, Members may be asked to assist the Appeal Coordinator in obtaining any missing information or to extend the appeal time limit until this information can be obtained. If information cannot be obtained by the 15th day following the receipt of the Authorization for Release of Medical Information and no agreement can be reached on extending the appeal time limit, the appeal may be decided without the missing information.

8. Continuation of Services Pending Appeal

If an appeal is filed concerning the termination or reduction of coverage for ongoing treatment, the coverage will be continued through the completion of our internal appeal process if:

a) The service was authorized by us prior to a request for an informal inquiry or the filing of an appeal;

b) The service was not terminated or reduced due to a benefit limit under this Handbook or Schedule of Benefits; and

c) The appellant is, and continues to be, a duly enrolled Member under this Handbook.

9. The Appeal Process

Upon receipt of an appeal, we will review, investigate and decide an appeal within the applicable time limit unless the time limit is extended by mutual agreement.

The Appeal Coordinator will investigate the appeal and determine if additional information is required from the Member. This information may include medical records, statements from doctors, and bills and receipts for services the Member has received. The Member may also provide us with any written comments, documents, records or other information related to the claim. Should we need additional information to decide an appeal, the Appeal Coordinator will contact the Member and request the specific information needed.

Appeals that involve a medical necessity determination will be reviewed by a health care professional in active practice in a specialty that is the same as, or similar to, the medical specialty that typically treats the medical condition that is the subject of the appeal. The health care professional conducting the review must not have either participated in any prior decision on the Member's appeal or be the subordinate of such a person.

We will make a decision following the investigation and review of the appeal. In making a decision, we will consider the following review criteria: (1) the benefits and the terms and conditions of coverage stated in this Handbook and Schedule of Benefits; (2) the views of medical professionals who have cared for the Member; (3) the views of any specialist who has reviewed the

appeal; (4) any relevant records or other documents provided by the Member; and (5) any other relevant information available to us.

Our decision of an appeal will be sent to the Member in writing. The decision will identify the specific information considered in your appeal and an explanation of the basis for the decision with reference to the plan provisions on which the decision was based. If the decision is to deny coverage based on an Medical Necessity determination, the decision will include: (1) the specific information upon which the decision was based; (2) the Member's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons this medical evidence fails to meet the relevant medical review criteria; (3) identification of any alternative treatment option covered by us; and (4) the applicable clinical practice and review criteria information relied on to make the decision. The decision will also include a description of other options available for further review of the appeal. These options are described in section *VII.F. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED*.

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

E. THE EXPEDITED APPEAL PROCESS

Members may obtain expedited review of certain types of appeals. An expedited appeal may be requested if we deny coverage for health services involving: (1) continued hospital care, (2) care that a physician certifies is required to prevent serious harm, or (3) a member with a terminal illness. An expedited appeal will not be granted to review a termination or reduction in coverage resulting from (1) a benefit limit or cost sharing provision of this Handbook or (2) the termination of membership.

Members may request an expedited appeal – other than an appeal involving mental health or drug and alcohol rehabilitation services – by contacting us orally or in writing at the following phone numbers or addresses:

HPHC Member Appeals
Member Services Department
Harvard Pilgrim Health Care
1600 Crown Colony Drive
Quincy, MA 02169
Telephone: Telephone: 1-888-333-4742
Fax: 1-617-509-3085

Members may request orally or in writing an expedited appeal that involves a mental health or drug and alcohol rehabilitation service by contacting:

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

We will make a decision of an expedited appeal within 72 hours from receipt of the appeal unless a different time limit is specified below. If we do not act on an expedited appeal within the time limits stated below, including any extension of time mutually agreed upon in writing by the Member and us, the appeal will be deemed to be resolved in favor of the Member. Our decision will be sent to the Member in writing.

The circumstances and procedures under which Members may obtain an expedited appeal are as follows:

1. **Hospital Discharge**

   A Member who is an inpatient in a hospital will be provided with an expedited review of any action by us to terminate or reduce coverage for continued hospital care based upon the medical necessity of the hospitalization or the services provided. Any such appeal will be decided prior to the termination or reduction of coverage for the Member's hospital stay. Coverage for services will be continued through the completion of the appeals process. We will provide the Member with written notification of the appeal decision prior to discharge from a hospital

2. **Services or Durable Medical Equipment Required to Prevent Serious Harm**

   An expedited review will be provided for appeals for services or durable medical equipment that, if not immediately provided, could result in serious harm to the Member. "Serious harm" means circumstances that could (1) jeopardize the life or health of the Member, (2) jeopardize

the ability of the Member to regain maximum function, or (3) result in severe pain that cannot be adequately managed without the care or treatment requested.

An expedited review will be provided in any case in which we have denied coverage for a service or durable medical equipment if the physician recommending the treatment or durable medical equipment provides us with a written certification stating that:

a) The service or durable medical equipment is Medically Necessary;

b) A denial of coverage for the service or durable medical equipment would create a substantial risk of serious harm to the Member; and

c) The risk of serious harm is so immediate that the provision of the services or durable medical equipment should not await the outcome of the normal appeal process.

Any such certification must contain the name, address and telephone number of the certifying physician and his or her signature. Certifications may be delivered in person, by mail or by fax at the addresses and telephone numbers listed above in this subsection. Upon receipt of a proper certification, HPHC will review the denial of coverage and provide the Member with notice of the decision within 48 hours. A decision may take place earlier than 48 hours for durable medical equipment if (1) a request for the early reversal is included in the certification and (2) the physician's certification includes specific facts indicating that immediate and severe harm to the Member that will result from a 48-hour delay.

3. Member with a Terminal Illness

If a Member with a terminal illness files an appeal of a denial of coverage, a decision will be made by us within 5 business days of receipt of the appeal. A terminal illness is an illness that is likely to cause death within 6 months.

If a decision is made on appeal to deny coverage to a Member with a terminal illness, we will provide the Member with a written decision within 5 business days of the decision. In the event a decision is made to deny the coverage requested, the decision will include:

a) A statement of any medical and scientific reasons for the denial; and

b) A description of any relevant alternative treatment, services, or supplies covered by us.

If a decision is made on appeal to deny coverage to a Member with a terminal illness, the Member may request a meeting with our review committee to reconsider the denial. The meeting will be held within 10 days of request, unless the treating physician requests that it be held earlier. In such event, the meeting will be held within 5 business days. At the meeting, the Member and the committee will review the information previously provided in response to the Member's appeal. The review committee will have authority to approve or deny the appeal. The review committee's decision will be our final decision.

F. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED

If you disagree with the decision of your appeal, you may have a number of options for further review. These options may include (1) reconsideration of appeals that involve a Medical Necessity determination (as described in *VII.B. HOW TO FILE AN APPEAL OR COMPLAINT*) by our review committee, (1 or 2) external review by an independent organization appointed by the Office of Patient Protection, or (2 or 3) legal action. Below is a summary of these options.

a. Reconsideration by the Plan

If a Member disagrees with a decision concerning an appeal that involves Medical Necessity determination, the Member may request reconsideration of such appeal by our review committee. The Member must request reconsideration within 15 days of the date of our letter denying the appeal.

Reconsideration is not available for the following types of appeals:

- Decisions involving a benefit limitation where the limit is stated in the Handbook or Schedule of Benefits
- Decisions involving excluded services, except Experimental, Unproven or Investigational services, and
- Decisions concerning Member Cost-Sharing requirements

The Member may request that the committee review the appeal based upon the documents and records in the appeal file without participating in the meeting. Alternately, the Member, or the Member's

representative, may participate in the committee's meeting via telephone conference call to discuss the appeal.

Members are welcome to provide us with any additional documents or records concerning the Member's appeal prior to the meeting. Our review committee will provide the Member with a written decision of the review of the Member's appeal.

Our reconsideration process is voluntary and optional. A Member may request reconsideration before or after seeking any other dispute resolution process described below. The only exception involves appeals that have been accepted by the Office of Patient Protection for external review. For example, a Member may request reconsideration of an appeal before seeking external review from the Office of Patient Protection, or the Member may proceed directly to external review. A Member may also request reconsideration if the Office of Patient Protection has determined that an appeal is not eligible for external review. However, we will not reconsider an appeal that has been accepted for external review by the Office of Patient Protection.

Reconsideration by our review committee will not affect the Member's rights to any other benefits. A Member's authorized representatives may file a request for reconsideration and participate in the review committee meeting on a Member's behalf. On reconsideration, our review committee will make an impartial evaluation of the Member's appeal based on the review criteria in "The Formal Appeal Process," above without deference to any prior decisions made on the claim.

We will not assert that a Member has failed to exhaust administrative remedies because the Member has chosen not to seek reconsideration of an appeal that has been denied under the formal appeal process. We also agree that any statute of limitations or defense based on timeliness is tolled during the time period in which a request for reconsideration is pending. No fees or costs will be charged for reconsidering an appeal decision.

a. or b. External Review

Any Member who wishes to contest a final appeal decision involving a medical necessity determination may request external review of the decision by an independent organization under contract with the Office of Patient Protection of the Department of Public Health. To obtain external review, a written request for external review must be filed with the Office of Patient Protection within 45 days of receipt of the written notice of our appeal decision. A copy of the external review form will be enclosed with your notice from us of its decision to deny your appeal.

A request for an external review must meet the following requirements:

1) The request must be submitted on the Office of Patient Protection's application form called, "Request for Independent External Review of a Health Care Decision." A copy of this form may be obtained by calling the Member Services Department at **1–888–333–4742** . It may also be obtained from the Office of Patient Protection by calling **1-800-436–7757** . In addition, copies of the form may be downloaded from the Department's website at **www.state.ma.us/dph/opp/forms.htm.**
2) The form must include the Member's signature or the signature of the Member's authorized representative, consenting to the release of medical information
3) A copy of our final appeal decision must be enclosed.
4) A fee of $25 must be paid. The Office of Patient Protection may waive this fee for extreme financial hardship.

The Office of Patient Protection will screen requests for external review to determine whether external review can be granted. If the Office of Patient Protection determines that a request is eligible for external review, the appeal will be assigned to an external review agency and the Member (or Member representative) and HPHC will be notified. The decision of the external review agency is binding, and we must comply with the decision.

If the Office of Patient Protection determines that a request is not eligible for external review, the Member (or Member representative) will be notified within 10 business days or, in the case of requests for expedited review, 72 hours.

The Office of Patient Protection may be reached at:

Department of Public Health
Office of Patient Protection
99 Chauncy Street
Boston, MA 02111
Telephone: Telephone: 1–800–436-7757
Fax: 1–617–624-5046
http://www.state.ma.us/dph/opp/index.htm

The Office of Patient Protection may arrange for an expedited external review. A request for expedited external review must include a written certification from a physician that a delay in providing or continuing the health services that are the subject of the appeal decision would pose a serious and immediate threat to the health of the insured.

If the subject of an external review involves the termination of ongoing services, the Member may ask the external review panel to continue coverage for the service while the review is pending. Any request for continuation of coverage must be made before the end of the second business day following receipt of the final adverse decision. The review panel may order the continuation of coverage if it finds that substantial harm to the Member's health may result from the termination of coverage. The panel may also order the continuation of coverage for good cause. Any such continuation of coverage shall be at our expense regardless of the final external review determination.

b. or c. Legal Action

A Member enrolled through an Employer Group may be able to bring legal action under Section 502(a) of the Employee Retirement Income Security Act of 1974.

G. THE FORMAL COMPLAINT PROCEDURE

A complaint may be filed when a Member seeks redress of any action taken by us or any aspect of our services, other than a denial of coverage for health services. All complaints will initially be considered through the informal inquiry process described above in "The Informal Inquiry Process."

Complaints may be filed in person, by mail, by fax or by telephone at the addresses or telephone numbers listed in section *VII.B. HOW TO FILE AN APPEAL OR COMPLAINT*. A Member Services Representative will investigate each complaint and respond in writing.

1. Documentation of Oral Complaints

If a complaint is filed by phone, a Member Services Representative will write a summary of the complaint and send it to the Member within 48 hours of receipt. This time limit may be extended by mutual agreement between the Member and us. Any such agreement must be in writing.

2. Acknowledgment of Complaints

Written complaints will be acknowledged in writing within 15 days of receipt. This time limit may be extended by written mutual agreement between the Member and us. No acknowledgment of a complaint will be sent if a Member Services Representative has previously sent a summary of a complaint submitted by phone.

3. Release of Medical Records

Any complaint that requires the review of medical information must include a signed "Authorization for Release of Medical Information." This form must be signed and dated by the Member or the Member's authorized representative (when signed by an authorized representative, appropriate proof of authorization to release medical information must be provided). If an Authorization for Release of Medical Information form is not provided when the complaint is filed, a Member Services Representative will send a blank form to the Member or the Member's representative. If a signed Authorization for Release of Medical Information is not received within 30 business days of the date the complaint is received, we may respond to the complaint without the missing information.

4. Time Limit for Responding to Complaints

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

If a complaint requires the review of medical records, the date of receipt will be the date we receive a signed Authorization for Release of Medical Information. If we do not respond to an informal inquiry within 3 business days, the date of receipt will be the fourth business day following the date we receive the informal inquiry. No complaint will be deemed received until actual receipt of the complaint at the appropriate address or phone number listed in the section *VII.B. HOW TO FILE AN APPEAL OR COMPLAINT*.

If we do not act on a complaint concerning benefits under this contract within 30 business days, plus any extension of time mutually agreed upon in writing by the Member and us, the complaint will be deemed to be resolved in favor of the Member.

5. Medical Records and Information

The Member Services Representative will try to obtain all information, including medical records, relevant to a complaint. Due to the limited time available for processing complaints, Members may be asked to assist the Member Services Representative in obtaining any missing information or to extend the

time limit for response to the complaint until such information can be obtained. If information cannot be obtained by the 15th day following the receipt of the Authorization for Release of Medical Information and no agreement can be reached on extending the time limit for responding to the complaint, the Member Services Representative may respond to the complaint without the missing information.

VIII. Eligibility

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

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 Employer Group.

A. MEMBER ELIGIBILITY

1. Residence Requirement

To be eligible for coverage under this Plan, you must live, and maintain a permanent residence, within the Enrollment Area at least nine months of a year. This does not apply to a Dependent child who is:

- Enrolled as a full-time student attending an accredited educational institution, or
- Enrolled as a Dependent child under a Qualified Medical Child Support Order. Dependents who enroll under a Qualified Medical Support Order whose permanent residence is outside the Enrollment Area will be subject to the limitations described in section *VIII.H. COVERAGE FOR MEMBERS WHO LIVE OUTSIDE THE ENROLLMENT AREA*.

If you have any questions about these requirements, you may call the Member Services Department. They can give you a current list of the cities and towns in the Enrollment Area.

2. Subscriber Eligibility

To be a Subscriber under this Plan, you must:

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

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

3. Dependent Eligibility

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

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

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

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

5) An unmarried child under the age of 19* years for whom the Subscriber or Subscriber's spouse is the court appointed legal guardian. Proof of guardianship must be submitted to us prior to enrollment.

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

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

B. EFFECTIVE DATE - NEW AND EXISTING DEPENDENTS

Please see your Employer Group's Benefit Administrator for information on enrollment and effective dates of coverage. Please also see section *VIII.I. 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 *VIII.I. SPECIAL ENROLLMENT RIGHTS* for additional rights upon adoption of a child.

D. CHANGE IN STATUS

It is your responsibility to inform your Employer Group and us of all changes that affect Member eligibility. These changes include: address changes; marriage of a Dependent; death of a Member; and when a Dependent is no longer enrolled in an accredited educational institution on a full-time basis.

Please Note: We must have your current address on file in order to correctly process claims for care outside the Service Area.

E. ADDING A DEPENDENT

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

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

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

F. NEWBORN COVERAGE

A newborn infant of a Member or a newborn infant of a Dependent of a Member is eligible for coverage under the Plan from the moment of birth as required by Massachusetts law. Please see section *VIII.E. ADDING A DEPENDENT* for information on enrollment procedures. Please see section *VIII.I. 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. To obtain coverage, you must call both your PCP and the Plan and allow us to manage your care. This may include transfer to a Plan affiliated facility, if medically appropriate. All other terms and conditions of coverage under this Handbook will apply.

H. COVERAGE FOR MEMBERS WHO LIVE OUTSIDE THE ENROLLMENT AREA

You must live within the Enrollment Area to be eligible for full benefits under this Handbook. The only exception applies to student Dependents enrolled in an accredited educational institution located outside the Enrollment Area. All other Members, including Members covered under a Qualified Medical Child Support Order (QMCSO), who live outside of the Enrollment Area are only eligible for coverage of services required in a Medical Emergency as described in section *I.E.5. Medical Emergency Services*. The benefits available to Members traveling outside the Service Area, described in section *I.E.6. Coverage for*

Services When You Are Temporarily Traveling Outside the Service Area are not available to Members who live outside of the Enrollment Area.

Please Note: Members who live outside the Enrollment Area may obtain full coverage for the Covered Benefits provided under this Handbook from Plan Providers within the Enrollment Area.

Please refer to section *V. Student Dependent Coverage* for coverage available to eligible student Dependents who are enrolled in an accredited institution outside the Enrollment Area.

I. 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.

IX. Termination and Transfer to Other Coverage

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

A. TERMINATION BY THE SUBSCRIBER

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

B. TERMINATION FOR LOSS OF ELIGIBILITY

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

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

C. TERMINATION FOR NON-PAYMENT BY THE EMPLOYER GROUP

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

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

You may be eligible for continued enrollment under federal or state law, if your membership is terminated. See "Continuation of Employer Group Coverage" in this Section for more information.

D. MEMBERSHIP TERMINATION FOR CAUSE

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

- Providing false or misleading information to the Plan on an application for membership or in an attempt to obtain benefits for which you or a Dependent are not eligible;
- 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. Termination of membership for the other causes will be effective fifteen (15) days after notice. Premium paid for periods after the effective date of termination will be refunded.

E. CONTINUATION OF EMPLOYER GROUP COVERAGE REQUIRED BY LAW

1. Massachusetts Law

If you lose Employer Group eligibility under a Massachusetts employer with 2 - 19 employees, you may be eligible for continuation of group coverage under the Massachusetts Small Group Continuation Coverage law. Under this law you have 60 days to elect coverage. You should contact the Employer Group or the Member Services Department for more information about coverage under this law. In addition to the Small Group Continuation Coverage law, there are other state laws which may apply. You should contact the Employer Group for more information if membership ends due to: 1) plant closing or partial closings; 2) loss of dependency status due to age or divorce or legal separation; 3) separation from employment or reduction of work hours. .

2. Federal Law

If you lose Employer Group eligibility and the Employer Group has twenty (20) or more employees, you may be eligible for continuation of group coverage under the Federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA). You should contact the Employer Group for more information if health coverage ends due to:1) separation from employment; 2) reduction of work hours; or 3) loss of dependency status. Continuation

of coverage may not be extended beyond the applicable time allowed under federal law. The size of your Employer Group will determine whether you select your continuation of coverage rights under state or federal law.

F. BUY DIRECT OR NONGROUP COVERAGE

We offer "Buy Direct" health plans for Massachusetts residents, and "Nongroup" health plans for Maine residents. Coverage purchased on a Buy Direct or Nongroup basis may differ from the coverage under your previous Plan. Individuals may enroll only in a plan offered in their state of residence and must satisfy all eligibility guidelines. Your state of residence will have specific rules about eligibility and coverage.

1. Massachusetts residents:
The plans we sell directly to residents of Massachusetts are called Buy Direct plans, and there are many options available. If you are eligible, your effective date will be the first of the month following the date we receive complete and accurate enrollment materials and your first month's premium payment. We must receive the enrollment material at least five days prior to your coverage start date (e.g., by June 25 for a July 1 start date).

2. Maine residents:
The plans we sell directly to residents of Maine are called Nongroup plans. We must receive your application within 90 days of your last date of Employer coverage to avoid a possible preexisting condition exclusion period.

3. Questions
If you have any questions, please call us at one of the following numbers. One of our representatives will be glad to assist you.

Massachusetts residents

For Buy Direct coverage questions **1-800-208-1221** - weekdays 8:30 a.m. -5 p.m.

Maine residents

For Nongroup coverage questions **1-888-333-4742** - weekdays 8 a.m. - 5:30 p.m. Monday and Wednesday until 7:30 p.m.

X. 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 the Handbook, Schedule of Benefits and Prescription Drug Brochure or to increase the level of coverage provided.

A. BENEFITS IN THE EVENT OF OTHER INSURANCE

Benefits under this Handbook, Schedule of Benefits, and Prescription Drug Brochure 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 Usual, Customary and Reasonable Charges 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 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 will determine which health benefit plans are primary or secondary:

1. Dependent/Non-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. A Dependent Child Whose Parents Are Not Separated or Divorced
The order of benefits is determined as follows:

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

3. 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.

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

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

B. PAYMENT WHEN HPHC COVERAGE IS PRIMARY OR SECONDARY

When HPHC is primary, HPHC is responsible for processing and paying claims for Covered Benefits first. Coverage will be provided to the full extent of benefits available under this Handbook, Schedule of Benefits and Prescription Drug Brochure.

When HPHC is secondary, HPHC is responsible for processing claims for Covered Benefits after the primary plan has issued a benefit determination. HPHC will first review the primary plan's benefit determination. HPHC will then pay or provide Covered Benefits as the secondary payor. HPHC's benefits will be reduced so that the total amount paid by all plans for a Covered Benefit will not exceed the amount payable under this Handbook. HPHC may recover any payments made for services in excess of HPHC's liability as the secondary plan, either before or after payment by the primary plan.

C. WORKER'S COMPENSATION/GOVERNMENT PROGRAMS

If HPHC has information indicating that services provided to you are covered under Worker's Compensation, Employer's liability or other program of similar purpose, or by a federal, state or other government agency, HPHC may suspend payment for such services until a determination is made whether payment will be made by such program. If HPHC provides or pays for services for an illness or injury covered under Worker's Compensation, Employer's liability or other program of similar purpose, or by a federal, state or other government agency, HPHC 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

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

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

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

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

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

Nothing in this Handbook shall be construed to limit HPHC'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 benefits under the medical payment benefit of a motor vehicle, motorcycle, boat, homeowners, hotel, restaurant, or other insurance policy, including a Massachusetts MedPay policy, such coverage shall become primary to the coverage under this Benefit Handbook for services rendered in connection with a covered loss under that policy. The benefits under this Benefit Handbook shall not duplicate any benefits to which the Member is entitled under any medical payment policy or benefit. All sums payable for services provided under this Benefit Handbook to Members that are covered under any medical payment policy or benefit are payable to HPHC.

F. MEMBER COOPERATION

You agree to cooperate with HPHC in exercising its rights of subrogation and coordination of benefits under this Handbook. Such cooperation will include, but not be limited to, a) the provision of all

information and documents requested by HPHC, b) the execution of any instruments deemed necessary by HPHC to protect its rights, c) the prompt assignment to HPHC of any monies received for services provided or paid for by HPHC, and d) the prompt notification to HPHC of any instances that may give rise to HPHC's rights. You further agree to do nothing to prejudice or interfere with HPHC's rights to subrogation or coordination of benefits.

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

G. HPHC'S RIGHTS

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

H. MEMBERS ENROLLED IN 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 HPHC. HPHC 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, HPHC 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), HPHC will pay for services only to the extent payments would exceed what would be payable by Medicare.

XI. Plan Provisions and Responsibilities

A. IF YOU DISAGREE WITH RECOMMENDED TREATMENT

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

B. LIMITATION ON LEGAL ACTIONS

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

C. ACCESS TO INFORMATION

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

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

D. SAFEGUARDING CONFIDENTIALITY

We are 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 with us, you agreed to certain uses and disclosures of information which are necessary for us to provide and administer services and benefits, such as: coordination of care, including referrals and 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.

We disclose our 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 all of our contracted health care 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 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 *VII. Appeals and Complaints*.

F. MODIFICATION OF THIS HANDBOOK

This Benefit Handbook, Schedule of Benefits, Prescription Drug Brochure and applicable riders, may be amended by us upon thirty (30) days written notice to your Employer Group. Amendments do not require the consent of Members.

This Benefit Handbook, the Schedule of Benefits, Prescription Drug Brochure, applicable riders and amendments comprise the entire contract between you and the Plan. The responsibilities of HPHC to the Member are only as stated in those documents. They can only be modified in writing by an authorized officer of the Plan. No other action by us, including the deliberate non-enforcement of any benefit limit shall be deemed to waive or alter any part of these documents.

G. OUR RELATIONSHIP WITH PLAN PROVIDERS

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

H. IN THE EVENT OF A MAJOR DISASTER

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

I. EVALUATION OF NEW TECHNOLOGY

We have a dedicated team of 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, Investigational or Unproven. The team researches the safety and effectiveness of these new technologies by reviewing published peer reviewed medical reports and literature, consulting with expert practitioners, and benchmarking. The team presents its recommendations to internal policy committees responsible for making decisions regarding coverage of the new technology under the Plan. The evaluation process includes:

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

The team presents its recommendations to internal policy committees responsible for making decisions regarding coverage of the new technology under the Plan.

J. CERTIFICATE OF CREDITABLE COVERAGE

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Members are entitled to a Certificate of Creditable Coverage, which verifies the most recent period of coverage under the Member's Employer Group.

The Certificate shows how many months of coverage a Member has, up to a maximum of eighteen (18) months. It also shows the date coverage ended. It may be used to prove to a new Employer the number of days of "credit" a person has from a prior health plan. If there has not been a gap in coverage of sixty-three (63) days or more, preexisting condition exclusion periods in a new Employer's health plan must be reduced by the number of days of coverage shown on the Certificate.

We will send you a Certificate of Creditable Coverage upon termination of membership unless your Employer Group has agreed to do so. You may also call the Member Services Department at any time within two years from the date coverage ended to request a free copy of the Certificate from us.

K. GOVERNING LAW

This Evidence of Coverage is governed by Massachusetts law.

L. UTILIZATION REVIEW PROCEDURES

We use 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.

- Prospective utilization review (prior authorization) of selected elective inpatient admissions (including admissions to acute rehabilitation hospitals and skilled nursing facilities), surgical day care, and outpatient/ambulatory procedures to determine whether proposed services meet clinical criteria for coverage. Prospective utilization review 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, we 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"), we 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.
- Concurrent utilization review of authorized admissions to inpatient rehabilitation hospitals, skilled nursing facilities and skilled home health services. Concurrent review decisions will be made within one working day of obtaining all necessary information. In the case of a determination to approve additional services, we 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. In the case of an adverse determination, we 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. 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 may be used in situations where services were provided before authorization was obtained.

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 the treatment of substance abuse services), 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 us. The reconsideration will take place within one working day of your provider's request. If the adverse determination is not reversed on reconsideration you may appeal. Your appeal rights are described in section *VII. Appeals and Complaints*. Your right to appeal does not depend on whether or not your provider sought reconsideration.

M. 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.

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

We use 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.

O. PROCESS TO DEVELOP CLINICAL GUIDELINES AND UTILIZATION REVIEW CRITERIA

We use 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.

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

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.

Our 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.

XII. 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' right 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.

Harvard Pilgrim Health Care, Inc.

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