HPHC Insurance Company

Benefit Handbook

MEDICARE ENHANCE
MASSACHUSETTS

This benefit plan is provided to you by your Plan Sponsor on a self-insured basis. HPHC Insurance Company, Inc. administers the Plan on behalf of the Plan Sponsor.

This booklet gives the details about your Medicare health coverage and explains how to get the care you need. This booklet is an important legal document. Please keep it in a safe place.

EFFECTIVE DATE: 01/01/2025
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INTRODUCTION

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

Medicare Enhance is a self-insured plan financed by your Plan Sponsor and administered by HPHC Insurance Company, Inc.

To use the Plan effectively, you must review this Handbook and the Schedule of Benefits together.

Your Covered Benefits, and the terms and conditions of coverage, are described in this Handbook, the Schedule of Benefits, the Prescription Drug Brochure (if applicable), and any riders or amendments to those documents.

The Plan is designed to complement your Medicare coverage by:

1. Paying most Medicare Deductible and Coinsurance amounts for services covered by Medicare Parts A and B;
2. Covering certain services that Medicare does not cover at all; and
3. Paying for some Medicare covered services after your Medicare benefits have been exhausted.

To use Plan benefits, obtain services from a health care Provider who accepts payment by Medicare. (A few cases in which you do not need to use a Provider who accepts payment by Medicare are described in Section *III. Covered Benefits*.)

See Section *I. About the Plan* of this Handbook for more information on how to use the Plan.

To learn more about health coverage for people with Medicare, you can review the *Guide to Health Insurance for People with Medicare*. You can get Medicare publications at most Social Security Offices or call Medicare at **1-800-633-4227**. (For TTY service, call **1-877-486-2048**.)

There are a number of publications that explain Medicare benefits. They can be found on the Internet at: **http://www.medicare.gov/publications/home.asp**.

Changes in the Medicare benefits or program can result in changes to this Handbook. HPHC does not notify you or Plan Sponsors of these changes.

HPHC will notify Plan Sponsors and send you amendments to this Handbook that affect the terms and conditions of this Handbook or Plan benefits.

The Plan will provide premium information and HPHC's voluntary and involuntary disenrollment rate as required by law. This information will be sent to you in a separate letter. Please keep that letter with this Handbook for your records.

Important Note: THIS PLAN IS ONLY AVAILABLE THROUGH PLAN SPONSORS. IF YOUR ELIGIBILITY FOR COVERAGE ENDS, ENROLLMENT IN THE PLAN MUST ALSO END.

We have helpful online tools and resources at **www.harvardpilgrim.org**.

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

- benefits,
- cost sharing,
- claims history, and
- activity statements.

To use these tools and resources, visit **www.harvardpilgrim.org** and select the Member Login button. First time users must create an account and then log in. After you log in, click on the "Tools and Resources" link from your dashboard.

When you receive Covered Benefits under the Plan, you will receive an activity statement. This is also known as a Summary of Payment. The activity statement lists the Covered Benefits, the cost for those Covered Benefits, and your cost sharing. You have the right to ask that your activity statement be sent to you. It may be sent to a specific mailing address, or electronically through your secure online account, or to an authorized third party on your behalf. In some instances, you may also request that we not send an activity statement for a specific service. You may contact Member Services to make these requests.

For questions, call Member Services at **1-888-333-4742**..

Member Services staff can help you with questions about:

- Your Benefit Handbook
- Your enrollment
- Your claims
- Pharmacy management procedures
- Requesting ID cards
- Registering a complaint

We can help with questions from Subscribers who do not speak English. We offer language interpretation services in more than 180 languages.

Deaf and hard-of-hearing Subscribers can call Member Services at **711** for TTY services.

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

HPHC Insurance Company, Inc.
Member Services Department
1 Wellness Way
Canton, MA 02021
1-888-333-4742
www.harvardpilgrim.org

Exclusions or Limitations for Preexisting Conditions

The Plan has no preexisting condition restrictions, limitations or exclusions on your Covered Benefits.

Language Assistance Services

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

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

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

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

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

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

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

ខ្មែរ (Cambodian) ប្រសិនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, បើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយ ឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

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

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

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

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

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

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

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

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

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

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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General Notice About Nondiscrimination and Accessibility Requirements

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

HPHC:

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

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

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with: Civil Rights Compliance Officer, 1 Wellness Way, Canton, MA 02021-1166, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@point32health.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

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

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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TABLE OF CONTENTS

Benefit Handbook

I. About the Plan

This section describes:

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

A. HOW TO USE THIS BENEFIT HANDBOOK

1. The Documents That Explain Your Coverage

This Benefit Handbook, the Schedules of Benefits, and the Prescription Drug Brochure (if applicable) make up the Evidence of Coverage (EOC). The EOC is the legal agreement stating the terms of the Plan.

The Handbook contains most of the details of your coverage. The Schedule of Benefits states the cost sharing that apply to your Plan Sponsor's plan. It also may be used as a brief summary of your benefits.

If your Plan Sponsor provides the Plan's coverage for prescription drugs, it is described in your Prescription Drug Brochure. Please read it to know how to get medications at the lowest out-of-pocket cost to you.

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

- What is covered;
- What is not covered;
- Any limits or special rules for coverage;
- Any cost sharing you have to pay for Covered Benefits; and
- Procedures for filing claims and obtaining reimbursement for services.

2. Words With Special Meaning

Some words in this Handbook have special meanings. We list such words and what they mean in the *II. Glossary*.

3. How To Find What You Need To Know

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

We put the most important information first. For example, Section *I. About the Plan* explains important requirements for coverage.

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

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

4. Information About Your Medicare Benefits

Medicare Enhance complements your Medicare coverage. The information on Medicare benefits contained in this Handbook is designed to help you make use of your benefits under the Plan.

Read the Medicare program handbook, *Medicare & You* for information on your Medicare benefits. You can get a copy at most Social Security Offices or call Medicare at **1-800-633-4227**. (TTY service is available at **1-877-486-2048**.)

A number of publications that explain Medicare benefits can be found on the Internet at: **http://www.medicare.gov/publications/home.asp**.

5. Your Identification Card

You will receive an identification card. The card contains important information about your coverage. Present it along with your Medicare card whenever you receive health care services.

B. HOW MEDICARE ENHANCE WORKS

Medicare Enhance (the "Plan") provides Plan Sponsored health coverage for persons enrolled in Medicare Parts A and B.

The Plan complements Medicare coverage by:

- Paying most Medicare Deductible and Coinsurance amounts for services covered by Medicare;
- Covering a number of preventive care services not covered by Medicare;
- Covering services received in a Medical Emergency outside the United States; and
- Covering a number of special services, if your Plan Sponsor provides such coverage.

Plan benefits are explained in detail in Section *III. Covered Benefits* below.

To use Plan benefits, obtain services from a health care Provider who accepts payment by Medicare. (A few cases in which you do not need to use a Provider who accepts payment by Medicare are described in Section *III.C. ADDITIONAL COVERED SERVICES*).

For Medicare covered services, your health care Provider will first bill Medicare for services you receive. You or your Provider then submit a Medicare Summary Notice (MSN) to the Plan for payment of the Medicare Deductible and Coinsurance amount.

For services not covered by Medicare, the Plan may be billed directly by either you or your Provider. See Section *V. Reimbursement and Claims Procedures*, for the Plan's claim filing procedures.

C. COVERAGE IN A MEDICAL EMERGENCY

You are always covered for care in a Medical Emergency within the United States.

In a Medical Emergency, obtain services from a physician, a Hospital, or a Hospital emergency room.

Within the United States, you are also covered for ambulance transportation to the nearest Hospital that can provide the care needed. See your Schedule of Benefits for information on the Copayments that apply.

In a Medical Emergency, go to the nearest emergency facility or call 911 or other local emergency number.

The Plan also provides benefits for emergency care outside of the United States. (With very limited exceptions, Medicare does not cover services received outside of the United States.) See Section III. *Services Received Outside the United States* on coverage for these services.

See the *II. Glossary* for the definition a Medical Emergency.

D. SUBSCRIBER COST SHARING AND PLAN PAYMENT LIMITS

You are required to share the cost of the benefits provided under the Plan. In some cases there are limits on the Plans payments for certain services.

General information about cost sharing and payment limits is set forth below. The specific cost sharing and payment limits that apply are explained in your Schedule of Benefits.

1. Plan Copayments

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

The Copayments that apply to your Plan are listed in your Schedule of Benefits.

2. Plan Deductible

A Deductible is a specific dollar amount that is paid by you for Covered Benefits received each calendar year. Please see your Schedule of Benefits to see if a Deductible applies to your Plan.

A Deductible is applied:

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

3. Limits on Payments by the Plan

The Plan has established a maximum amount it will pay for different types of Covered Services. This is called the "Payment Maximum."

For services covered by Medicare, the Payment Maximum is the Medicare approved (or "allowable") amount for the service.

Medicare Providers who do not "accept assignment" may charge more than the Medicare allowable amount. This is explained in Section *V.D. CLAIMS FOR SERVICES COVERED BY MEDICARE PART B*.

The Payment Maximum may also apply to services that are not covered by Medicare. This is explained in Section *V.K. THE PAYMENT MAXIMUM*.

II. Glossary

The Plan follows the definitions adopted by the Medicare program in providing benefits for services covered by Medicare.
The following terms, as used in this Handbook, have the meanings indicated below:

Glossary Term	Definition
1 . Anniversary Date	
	The date agreed to by HPHC and your Plan Sponsor upon which the yearly Plan Sponsor administrative fees are adjusted and benefit changes become effective. The EOC will terminate unless renewed on the Anniversary Date.
2 . 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.
3 . Benefit Period	
	A Benefit Period is a way to measure your use of services under Medicare Part A to determine Medicare coverage and your benefits under this Benefit Handbook. A Benefit Period begins with the first day of a Medicare covered inpatient Hospital stay. It ends with the close of a period of 60 consecutive days during which you were neither an inpatient of a Hospital nor of a Skilled Nursing Facility (SNF). Generally, you are an inpatient of a Hospital if you are receiving inpatient services in the Hospital. The type of care actually received is not relevant. However, for purposes of determining when a Benefit Period starts and ends, you are an inpatient of a Skilled Nursing Facility only when your care in the Skilled Nursing Facility meets certain skilled level of care standards established by the Medicare program. Please refer to the definition of "Skilled Nursing Care."
4 . Centers of for Medicare and Medicaid Services (CMS)	
	The Centers for Medicare and Medicaid Services is the federal agency responsible for administering the Medicare program.
5 . Coinsurance	
	Cost sharing amounts established by Medicare that Medicare beneficiaries must pay after any Medicare Deductible has been met. Coinsurance is usually a percentage. (For example, many services covered under Medicare Part B require beneficiaries to pay a 20% Coinsurance amount.) As used in this Handbook, "Coinsurance" also includes fixed dollar amounts established by Medicare that Medicare beneficiaries must pay for certain services. The Plan provides coverage for Medicare established Coinsurance amounts minus any Deductibles or Copayments required by the Plan.
6 . Copayments	
	A fixed dollar amount you must pay for certain Covered Benefits. The Copayment is usually due at the time services are rendered or when billed by the Provider. Your specific Copayment amounts, and the services to which they apply are listed in your Schedule of Benefits.
7 . Covered Benefits (Covered Services)	
	The products and services that a Subscriber is eligible to receive, or obtain payment for, under the Plan.
8 . Custodial Care	
	Services provided to a person for the primary purpose of meeting non-medical personal needs (e.g., bathing, dressing, bathing, preparing meals, eating, including special diets, taking medications, assisting with mobility).

Glossary Term	Definition
9 . Deductible	
	A Deductible is a dollar amount that is payable each calendar year for Covered Services before benefits are available under an insurance plan. The Plan provides coverage for Medicare Deductible amounts minus any Plan Deductibles or Copayments required by the Plan. See *Medicare & You* for information on Medicare's Deductibles. Some Plan Sponsor plans include a Plan Deductible that applies to specific Covered Services. If your Plan includes a Deductible, it will be listed in your Schedule of Benefits.
10 . Dental Services	
	Services furnished for the care, treatment, removal or replacement of teeth or the structures directly supporting teeth.
11 . Durable Medical Equipment (DME)	
	Equipment that can withstand repeated use; is primarily and usually used to serve a medical purpose; is generally not useful to a person in the absence of illness or injury; and is appropriate for use in the home. However, an institution may not be considered a Subscriber's home if it meets the basic requirements of a Hospital or Skilled Nursing Facility. Durable Medical Equipment includes items such as oxygen equipment, wheelchairs, hospital beds and other items that are determined to be Medically Necessary.
12 . Evidence of Coverage (EOC)	
	The legal documents, including the Benefit Handbook, Schedules of Benefits, Prescription Drug Brochure (if applicable), and any applicable riders and amendments which describe the services covered by the Plan, and other terms and conditions of coverage.
13 . Experimental, Unproven, or Investigational	
	The Plan does not cover Experimental, Unproven, or Investigational drugs, devices, medical treatment or procedures. A service, procedure, device, or drug will be deemed Experimental, Unproven, or Investigational by the Plan for use in the diagnosis or treatment of a particular medical condition if any of the following is true: a. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or b. The service, procedure, device, or drug 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 medical standards, primary reliance will be placed upon data from published reports in authoritative medical or scientific publications that are subject to peer review by qualified medical or scientific experts prior to publication. In the absence of any such reports, it will generally be determined that a service, procedure, device or drug is not safe and effective for the use in question. The Plan will not determine that a product or service that is covered by Medicare is Experimental, Unproven, or Investigational if such determination would conflict with a National Coverage Decision or a local coverage determination issued by the Centers for Medicare and Medicaid Services or its contractors.
14 . Home Health Agency	
	A Medicare certified agency that provides Medically Necessary Skilled Nursing Care and other therapeutic services in your home.

Glossary Term	Definition
15 . Home Health Care Services	
	Medically Necessary health care services provided at a Subscriber's residence (other than a Hospital, Skilled Nursing Facility, rehabilitation facility, Religious Nonmedical Health Care Institution) rendered by a Home Health Agency. Home health services must be provided by an organization eligible to receive payment from Medicare.
16 . Hospice	
	A Medicare certified organization or agency that is primarily engaged in providing pain relief, symptom management and supporting services to terminally ill people and their families.
17 . Hospital	
	A Medicare certified institution licensed by the state in which it is located, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services or, when used in connection with Massachusetts mandated benefits, an accredited or licensed hospital. The term "Hospital" does not include a Skilled Nursing Facility, convalescent nursing home, rest facility or a facility for the aged that primarily provides Custodial Care, including training in routines of daily living.
18 . HPHC Insurance Company, Inc. (HPHC)	
	HPHC Insurance Company, Inc. is an insurance company that underwrites the Plan. HPHC may also be referred to as "we," "us" and the "Plan."
19 . Inpatient Mental Health Facility	
	An inpatient mental health facility is one of the following: a general Hospital licensed to provide Mental Health services; a facility under the direction and supervision of the Massachusetts Department of Mental Health; a private mental hospital licensed by the Massachusetts Department of Mental Health; or a substance use disorder treatment facility licensed by the Massachusetts Department of Public Health.
20 . Licensed Mental Health Professional	
	For services provided in Massachusetts, a Licensed Mental Health Professional is any one of the following: a licensed physician who specializes in the practice of psychiatry; a licensed psychologist; a licensed independent clinical social worker; a licensed certified social worker; a licensed mental health counselor; a licensed supervised mental health counselor; a licensed psychiatric nurse mental health clinical specialist; a licensed psychiatric mental health nurse practitioner; a licensed physician assistant who practices in the area of psychiatry; a level I licensed alcohol and drug counselor; a clinician practicing under the supervision of a licensed professional and working towards licensure in a clinic licensed under chapter 111; or a licensed marriage and family therapist. For services provided outside of Massachusetts, a Licensed Mental Health Professional is an independently licensed clinician with at least a masters degree in a clinical mental health discipline from an accredited educational institution and at least two years of clinical experience. The term "clinical mental health discipline" includes the following: psychiatry; psychology; clinical social work; marriage and family therapy; clinical counseling; developmental psychology; pastoral counseling; psychiatric nursing; developmental or educational psychology; counselor education; or any other discipline deemed acceptable by HPHC.

Glossary Term	Definition
21 . Medical Emergency	
	A medical condition, whether physical or mental (including a condition resulting from a substance use disorder), manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the Subscriber 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
22 . Medically Necessary or Medical Necessity	
	In the case of services eligible for coverage by Medicare, Medically Necessary means that the service is reasonable and necessary in accordance with Medicare criteria. In the case of services not eligible for coverage by Medicare, Medically Necessary means that the service is consistent with generally accepted principles of professional medical practice as determined by whether: a. it is the most appropriate supply or level of service for the Subscriber's condition, considering the potential benefit and harm to the individual; b. it is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; and c. for a service that is not widely used, its use for the Subscriber's condition is based on scientific evidence.
23 . Medicare	
	A program of health benefits established by federal law and administered by the Centers for Medicare and Medicaid Services (CMS). The Plan covers services in conjunction with a Subscriber's benefits under Medicare Parts A and B. (It does not cover services in conjunction with Medicare Advantage Plan under Medicare Part C or a prescription drug plan under Medicare Part D.) Unless otherwise stated, when the term "Medicare" is used in this Handbook it refers to Medicare Parts A and B.
24 . Medicare Part B Premium	
	The monthly premium paid by Medicare beneficiaries for coverage under Medicare Part B.
25 . Medicare Participating Provider	
	A Hospital, SNF, Hospice, Home Health Agency, any other facility identified by Medicare, or a physician or physician group that satisfies Medicare's conditions of participation and enters into a participation agreement with Medicare.

Glossary Term	Definition
26 . Outpatient Mental Health Facility	
	An Outpatient Mental Health Facility is one of the following: a licensed Hospital; a mental health or substance use disorder treatment clinic licensed by the Department of Public Health; a public community mental health center; a professional office; or home-based services.
27 . Outpatient Surgery (or Surgery - Outpatient)	
	A surgery or procedure in a day surgery department, ambulatory surgery department or outpatient surgery center that requires an operating room, anesthesia and recovery room services.
28 . Payment Maximum	
	The maximum amount the Plan will pay for any Covered Service. The Payment Maximum is as follows: a. **For Medicare Covered Items.** If Medicare covers a product or service, the Payment Maximum is the Medicare Coinsurance amount plus any unmet Medicare Deductible amount. The Medicare Coinsurance amount is the portion or percentage of the Medicare approved payment amount for a product or service that a beneficiary is responsible for paying. In some cases, Providers may bill Medicare patients for amounts that exceed the Medicare approved payment amount. Any amount that exceeds the Medicare approved amount is your responsibility and is not payable either by Medicare or the Plan. See the discussion of "assignment" in the Medicare publication *Medicare & You* for information on limits that apply to Provider charges. b. **For Items Not Covered by Medicare.** If Medicare does not cover a product or service, the Payment Maximum depends upon whether the Provider is under contract to provide services to Subscribers of HPHC Insurance Company, Inc.. If a Provider is under contract to HPHC, the Payment Maximum is the contract rate for the service. If the Provider is not under contract to HPHC, the Payment Maximum is the amount, as determined by HPHC, that is within the normal range of charges made by health care Providers for the same, or similar, products or services in Boston, Massachusetts.
29 . Plan	
	The program where health care services and supplies are covered under the contract between the Plan Sponsor and HPHC through which the Subscriber is a participant.
30 . Plan Sponsor	
	The entity, normally your former employer or your spouse's former employer, that has contracted with HPHC to administer the benefits of the Plan. The Plan Sponsor is responsible for payment for all covered services under the Plan.
31 . Prosthetic Devices	
	Prosthetic Devices replace all or part of an internal body organ or all or part of the function of a permanently inoperative or malfunctioning internal body organ. Examples of Prosthetic Devices are cardiac pacemakers, prosthetic lenses, breast prostheses, maxillofacial devices, colostomy bags and supplies.

Glossary Term	Definition
32 . Provider	
	A doctor, Hospital, health care professional or health care facility licensed and/or certified by Medicare to deliver or furnish health care services. Care must be provided within the lawful scope of the Provider's license. Providers include but are not limited to: physicians, psychologists, psychiatrists, podiatrists, nurse practitioners, advanced practice registered nurses, physician's assistants, psychiatric social workers, licensed nurse mental health clinical specialist, psychotherapists, psychologists, licensed independent clinical social workers, licensed mental health counselors, level I licensed alcohol and drug counselors, physicians with recognized expertise in specialty pediatrics (including mental health and substance use disorder treatment), nurse midwives, nurse anesthetists, chiropractors, acupuncturists, optometrists, speech-language pathologists and audiologists, and early intervention specialists who are credentialed and certified by the Massachusetts Department of Public Health. Dentists may also be Providers when providing services under this Plan. (Please note that coverage for dental services is very limited.)
33 . Schedule of Benefits	
	A summary of the benefits selected by your Employer and covered under your Plan. A more detailed description of the benefits is in this Benefit Handbook. In addition, the Schedule of Benefits contains any limitations and Copayments or Deductible you must pay.
34 . Skilled Nursing Care	
	Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that: a. Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and b. Must be provided directly by, or under the general supervision of, skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.
35 . Skilled Nursing Facility (SNF)	
	A facility (or distinct part of a facility), which is primarily engaged in providing to its residents skilled nursing or rehabilitation services and is certified by Medicare. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility or a facility for the aged, which primarily furnishes Custodial Care, including training in routines of daily living.
36 . Special Services	
	Those services and supplies a facility ordinarily furnishes to its patients for diagnosis or treatment when the patient is in the facility. Special Services include: a. The use of special rooms and their equipment, such as operating rooms or treatment rooms; b. Tests and exams, including electrocardiograms, laboratory, and x-ray; c. Use of special equipment on the facility premises, and the services of persons hired by the facility to operate the equipment; d. Services by a person with whom the Hospital or Skilled Nursing Facility, public community mental health center, or similar facility has a contractual agreement, by salary or otherwise, in conjunction with the use of the equipment specified above; e. Drugs, medications, solutions, and biological preparations; f. Administration of infusions or transfusions and other charges for services related to the administration of infusions or transfusions, (excluding the cost of whole blood, packed red blood cells, and donor fees); and

Glossary Term	Definition
Special Services (Continued)	
	g. Internal Prosthetic Devices or appliances (artificial replacements of part of the body) that are an integral part of an operation. This includes hip joints, skull plates, and pacemakers. You are also covered for breast prostheses following mastectomy and surgery for treatment of breast cancer as required by federal law. These items are covered by Medicare Part A.
37 . Subscriber	
	The person who meets the Subscriber eligibility requirements described in this Benefit Handbook and is enrolled in the Plan. Subscriber may also be referred to as "you".
38 . 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.
39 . Terminal Illness	
	A Terminal Illness is an illness that is likely to cause death within six months, as determined by a physician.
40 . Urgent Care	
	Medically Necessary services for a condition that requires prompt medical attention but is not a Medical Emergency.

III. Covered Benefits

A. INTRODUCTION

This section describes the products and services covered by the Plan.

The Plan covers services in conjunction with your benefits under Medicare Parts A and B. Medicare is the primary payer for Medicare covered services. The Plan will only provide coverage for such services after your Medicare benefits have been determined.

The Plan also provides coverage for a number of benefits required by state law that may not be covered by Medicare. These benefits are described in Section *III.C. ADDITIONAL COVERED SERVICES*, and your Schedule of Benefits.

Some Plans may include coverage for additional benefits not covered by Medicare. If your Plan includes such benefits you will find them in Section *III.C. ADDITIONAL COVERED SERVICES* or your Schedule of Benefits.

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

- Medically Necessary;
- Received while an active Subscriber of the Plan;
- Either covered by Medicare or listed as a Covered Service in this Benefit Handbook, the Schedule of Benefits or the Prescription Drug Brochure; and
- Not listed as a product or service that is excluded from coverage by the Plan.

Important Note: It is important for you to note that some of the benefits listed in this section may not be available to you under the benefits chosen by your Plan Sponsor. All coverage is subject to your cost sharing listed in the Schedule of Benefits. Payments by the Plan are limited to the Payment Maximum described in Sections *V. Reimbursement and Claims Procedures* and *II. Glossary*. You are responsible for any amount billed by a Provider that is in excess of the Payment Maximum.

B. SERVICES COVERED BY MEDICARE

This section describes your benefits for services that are covered by the Medicare program.

The Plan covers the Medicare Deductible and Coinsurance amounts (referred to in this section as "Medicare amounts") for all services covered by Medicare Parts A and B. All coverage is subject to your cost sharing amounts (Copayments and Deductible, if applicable) stated in the Schedule of Benefits. The only services covered by Medicare for which no coverage is provided by the Plan are the services specifically listed as exclusions in Section *IV. Exclusions*, below. In all cases, the decision of Medicare to provide coverage for a service must have been made before any Plan benefits will be payable under this section.

No coverage will be provided by the Plan for any service denied by Medicare unless the service is specifically listed in Section*III.C. ADDITIONAL COVERED SERVICES*.

The following is a summary of the services covered by Medicare Parts A and B. When Medicare Parts A or B covers a service but does not pay the full amount, the Plan covers the applicable Medicare Coinsurance and Deductible amounts up to the Payment Maximum.

Medicare Inpatient Services	Inpatient Service Description
41 . Hospital Care	
	Medicare coverage for Hospital inpatient care is determined by Benefit Periods. There is no limit to the number of Benefit Periods covered by Medicare during your lifetime. However, Medicare benefits for inpatient Hospital care are limited to 90 days during a Benefit Period. If you exhaust the 90-day limit, you can elect to use up to 60 additional days of inpatient Hospital care from your Medicare "lifetime reserve days." These are non-renewable days of Hospital coverage that you may use only once in your life. Most Hospital care covered by Medicare may be obtained at any Medicare certified Hospital, including a psychiatric Hospital. However, certain services, including liver, lung, heart, heart-lung, pancreas, and intestine transplants and bariatric surgery must be obtained at Medicare approved Hospital for the specific type of surgery required. These Hospitals are required to meet strict quality standards. If Medicare requires that a service be provided at a Hospital specifically approved for the service, neither Medicare nor the Plan will provide any coverage if the service is obtained at an unapproved Hospital. There is a 190-day Medicare lifetime limit on the coverage of services in a psychiatric Hospital. See your Schedule of Benefits for how the Plan provides coverage in connection with semi-private room and board and Special Services for Medicare covered inpatient Hospital services. **Benefits for Non-Medicare covered Hospital Services.** Some Employers purchase coverage for Hospital care in excess of the Medicare limits described above. If your Plan includes such coverage, it is listed in Section *III.C. ADDITIONAL COVERED SERVICES* and your Schedule of Benefits.
42 . Care in a Skilled Nursing Facility (SNF)	
	The Plan covers the Medicare amounts for covered care in a Skilled Nursing Facility (SNF). Medicare covers up to 100 days per Benefit Period in a Medicare certified SNF. To be eligible for coverage, all rules applicable to Medicare coverage of SNF care must be met. These include the following: • You need skilled nursing or rehabilitative care; • The care is required on a daily basis; • The care can only be provided in an inpatient setting; and • You must have been an inpatient in a Hospital for at least three days and enter the SNF within 30 days after Hospital discharge. **There is no coverage for care received in a SNF that does not meet Medicare coverage rules, including the requirements stated above.** See your Schedule of Benefits for a description of coverage provided by the Plan for care in a Medicare certified SNF.
43 . Care in a Religious Nonmedical Health Care Institution	
	The Plan covers the Medicare Part A amounts for inpatient care in a Religious Nonmedical Health Care Institution (RNHCI), such as a Christian Science Sanatorium. All Medicare conditions and limitations on the coverage of services in a RNHCI also apply to the coverage provided by the Plan. Religious aspects of care provided in RNHCIs are not covered.

Medicare Outpatient Services	Outpatient Service Description
44 . Ambulance Services	
	The Plan pays the Medicare Part B amount for covered ambulance transportation. Medicare covers ambulance services only if the Provider meets Medicare requirements and transportation by any other vehicle would endanger your health. In general, Medicare benefits are only provided for transportation between the following locations, (1) home and a Hospital, (2) home and a Skilled Nursing Facility (SNF) or (3) a Hospital and a Skilled Nursing Facility.
45 . Coverage for Clinical Trials	
	The plan pays the Medicare amounts for covered services received during participation in a clinical trial. Please see the Center for Medicare and Medicaid Services (CMS) publication, *Medicare & Clinical Trials*, for more information.
46 . Dental Care and Oral Surgery	
	Medicare does not cover most Dental Services. However, Medicare has determined that certain services provided by dentists or oral surgeons are primarily medical in nature and therefore eligible for coverage. Examples of such services include: • The extraction of teeth to prepare the jaw for radiation treatment for neoplastic disease. • Surgery of the jaw or related structures. • Setting fractures of the jaw or facial bones. • Services of a dentist that would be covered if provided by a physician, such as the treatment of oral infections and tumors. • Dental examinations to diagnose an infection that would contraindicate surgery. The Plan pays the Medicare amounts for the services of dentists and oral surgeons that have been covered by Medicare. No other Dental Services are covered unless your Plan Sponsor has purchased additional coverage for such services. If additional coverage for Dental Services is available to you, it will be listed in your Schedule of Benefits. **Please Note: This benefit may not be covered by all Plan Sponsors. If your Plan Sponsor provides coverage for this benefit, it will be listed in your Schedule of Benefits.**
47 . Diabetes Screening and Treatment	
	The Plan pays the Medicare amounts for covered services for the screening and treatment of Diabetes. Subject to Medicare coverage criteria, these services include, but are not limited to, the following: • Diabetes screening; • Diabetes self-management training; • Diabetic laboratory tests; • Blood sugar self-testing equipment and supplies. These include blood glucose monitors and test strips, lancet devices and lancets and glucose control solutions; • Insulin pumps and insulin used with an insulin pump; • Therapeutic shoes or inserts for people with severe diabetic foot disease (if certified by a physician).

Medicare Outpatient Services	Outpatient Service Description
Diabetes Screening and Treatment (Continued)	
	Insulin (other than insulin administered with an insulin pump) is covered under the Plan's coverage for outpatient prescription drug coverage (if available under your Plan Sponsor's plan). Insulin is also covered under Medicare Part D drug plans.
48 . Diagnostic Tests and Procedures	
	The Plan pays the Medicare amount for covered diagnostic laboratory tests, X-ray examinations and other diagnostic procedures, as well as Medicare covered advanced radiology, such as CT scans, PET scans, MRI, MRA and nuclear medicine services.
49 . Durable Medical Equipment (DME) and Prosthetic Devices	
	The Plan pays the Medicare amounts for covered Durable Medical Equipment and Prosthetic Devices. Medicare coverage is provided only for equipment or devices that are Medically Necessary for the treatment of illness or injury or to improve the functioning of a malformed body part. DME is defined by Medicare as equipment which (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) generally is not useful in the absence of illness or injury and (4) is appropriate for use in the home. Examples of such equipment include oxygen and oxygen equipment, blood glucose monitors, hospital beds, crutches and canes. Medicare defines Prosthetic equipment as a device that replaces an internal body organ. Examples of such devices include cardiac pacemakers, prosthetic lenses, breast prostheses (including mastectomy bras) and eyeglasses or contact lenses after cataract surgery. No coverage is provided for equipment that is not covered by Medicare, including, but not limited to, dentures or dental appliances. In addition, no coverage is provided for equipment provided by a company that is not enrolled in the Medicare program.
50 . Emergency Room Care	
	The Plan pays the Medicare amounts for covered services provided at a Hospital emergency room or other emergency facility.
51 . Home Health Care	
	Medicare provides coverage for Medically Necessary home health services if you are confined to home. Services covered by Medicare may include intermittent skilled nursing care, physical therapy, occupational therapy, speech therapy, medical social services, nutritional counseling, the services of a home health aid, medical supplies and Durable Medical Equipment. A Medicare Participating Home Health Agency must provide Home Health Care Services. Since no Medicare Deductible or Coinsurance amounts apply to home health care (other than Durable Medical Equipment), no additional coverage for home health care is provided by the Plan except that the Plan covers Medicare amounts for Medicare covered Durable Medical Equipment furnished in connection with the Home Health Care Services. See Section III. *Durable Medical Equipment (DME) and Prosthetic Devices*, above, for information on benefits for Durable Medical Equipment.
52 . Home Infusion Therapy	
	The Plan pays the Medicare amounts for covered equipment and supplies for home infusion therapy to administer certain infusion drugs.
53 . Hospice Care	
	Medicare covers Hospice services for a Subscriber with a Terminal Illness, when provided by a Medicare certified Hospice. The Plan provides coverage for Medicare amounts for Medicare covered Hospice care.

Medicare Outpatient Services	Outpatient Service Description
54 . Kidney Dialysis	
	The Plan pays the Medicare amounts for covered kidney dialysis.
55 . Medical Therapies	
	The plan pays the Medicare amounts for covered therapeutic services. These include radiation therapy for cancer, and therapy for any condition for which isotopes, radium, or radon seeds are used. Also covered are chemotherapy and immunosuppressive drugs (and their administration) when such medications cannot be self-administered. (If your Plan Sponsor has purchased the Plan's prescription drug coverage, please see your Prescription Drug Brochure for information on your coverage of self-administered medications.) Medicare covered services include post-mastectomy coverage for (1) surgical reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) physical complications for all stages of mastectomy, including lymphedemas, in a manner determined by the attending physician and the patient.
56 . Outpatient Prescription Drug Coverage	
	If your Plan Sponsor purchased Plan coverage for outpatient prescription drugs, that coverage is described in the Prescription Drug Brochure you received. It provides benefits for most prescription medications, subject to the Copayments listed on your Plan ID card. The Plan's drug coverage meets Medicare Part D creditable coverage requirements. If your Plan Sponsor did not purchase outpatient drug coverage through the Plan, we recommend you purchase a Prescription Drug Plan under Medicare Part D. If you delay getting drug coverage, a late enrollment penalty may apply. See the publication *Medicare & You* for information about Medicare Drug Plans. Even if your Employer does not purchase the Plan's drug coverage, the Plan pays the Medicare amounts for any drug covered by Medicare Part B. **However, Medicare Part B drug coverage is very limited. Most standard outpatient drugs are not covered.**
57 . Outpatient Methadone Maintenance	
	The Plan provides coverage for Outpatient Methadone Maintenance as part of Medically Necessary mental health care and substance use disorder treatment services.
58 . Outpatient Surgery	
	The Plan provides coverage, less any payments made by Medicare, for 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.
59 . Partial Hospitalization	
	The Plan pays the Medicare amounts for covered partial hospitalization for mental health and substance use disorder treatment. Partial hospitalization services are an acute level of care that is more intensive than traditional outpatient services, but less intensive than 24-hour care. Medicare covers partial hospitalization when inpatient care would otherwise be required. Programs providing primarily social or recreational activities are not covered.

Medicare Outpatient Services	Outpatient Service Description
60 . Physical, Occupational and Speech Therapy	
	The Plan pays the Medicare amounts for covered physical, occupational and speech therapy. In order to be covered by Medicare a physician must certify that: (1) the patient required the therapy; (2) a plan of care has been established; and (3) the services were provided while the patient was under the care of a physician. (Additional coverage for the diagnosis and treatment of speech, hearing and language disorders may be available for services not covered by Medicare. Please Section III.C.12., below, for further information.)
61 . Preventive Care Services	
	Medicare covers a number of preventive care services at no cost to Subscribers. The Plan pays the Medicare amounts, if any, for covered preventive care services. Medicare coverage includes a one-time "Welcome to Medicare" preventive visit received within the first 12 months a beneficiary is covered by Medicare Part B. HPHC recommends that Subscribers utilize this benefit if available. After being enrolled in Medicare Part B for one year, Medicare also covers a yearly "Wellness" visit. The first yearly "Wellness" visit must take place at least 12 months after your Part B enrollment or your "Welcome to Medicare" preventive visit. When specific Medicare coverage criteria are met, Medicare also provides coverage for preventive services including, but not limited to: • Pap tests, pelvic and breast exams; • Mammograms; • Prostate cancer screenings; • Diabetes screenings; • Bone mass measurements; • Glaucoma testing; • Medical nutrition therapy; • Counseling to prevent tobacco use & tobacco-caused disease; • Colorectal cancer screening, including fecal occult blood tests, flexible sigmoidoscopy, colonoscopy and barium enema examinations; and • Immunizations for flu, pneumonia and hepatitis B. Consult with your doctor and refer to *Medicare & You* for further information on Medicare covered preventive services. In addition, your Plan covers a number of preventive care services not covered by Medicare. See Section III. *Preventive Care Services* for the details of your coverage.

Medicare Outpatient Services	Outpatient Service Description
62 . Services of Physician and Other Professionals	
	The Plan pays the Medicare amounts for covered services provided by physicians and other health professionals entitled to coverage by the Medicare program. Such health professionals include, but are not limited to, certified nurse-midwives, chiropractors, clinical social workers, clinical psychologists, dentists, nurse anesthetists, nurse practitioners, occupational therapists, physical therapists, physicians' assistants, podiatrists, speech therapists, audiologists, registered dieticians, and acupuncturists. See Section III. *Physical, Occupational and Speech Therapy*, above, for additional information on your coverage for physical, occupational and speech therapy. Medicare coverage includes unlimited visits with mental health professionals eligible for payment by Medicare. These include physicians, clinical psychologists and clinical social workers. Medicare provides very limited coverage for chiropractic and dental care. Medicare only covers chiropractic care for manual manipulation of the spine to correct a spinal subluxation. However, some Employers purchase coverage for chiropractic care in excess of the Medicare limits described above. If your Plan includes such coverage, it will be listed in your Schedule of Benefits. See Section III. *Dental Care and Oral Surgery* for the circumstances under which dental care may be covered. Podiatrists services are covered by Medicare to treat injuries and diseases of the foot. Neither Medicare nor the Plan will cover most routine foot care, such as nail cutting, corn and bunion trimming or callus removal. However, Medicare does cover routine foot care that is Medically Necessary due to circulatory system disease, such as diabetes. Medicare also provides limited coverage for acupuncture treatment. The Plan pays the Medicare amounts for Medicare covered acupuncture treatment. Medicare covers up to 12 acupuncture visits in 90 days for chronic low back pain. An additional 8 visits may be available if you show improvement.
63 . Telemedicine Virtual Visits	
	The Plan covers the Medicare amounts, less any applicable member cost share, for Medicare covered telemedicine virtual visits.
64 . Urgent Care Services	
	The Plan covers the Medicare amounts, less any applicable member cost share, for covered Urgent Care you receive at an urgent care facility. Urgent care facilities provide treatment for minor and moderate illnesses and injuries that require urgent attention but are not life threatening. Covered Services include but are not limited to the following: • Care for minor cuts, burns, rashes, bites, bruises or abrasions, including suturing; • Treatment for minor illnesses and infections, including coughs, cold and flu; or • Treatment for minor injuries including sprains or strains. **Important Notice:** Urgent Care is not emergency care. Call 911 or go directly to a hospital emergency room if you suspect you are having a Medical Emergency. These include heart attack or suspected heart attack, shock, major blood loss, or loss of consciousness. See Section *I.C. COVERAGE IN A MEDICAL EMERGENCY* for more information.

C. ADDITIONAL COVERED SERVICES

This section lists additional Plan benefits that are generally not covered by Medicare. If Medicare coverage is available for any service listed below, the coverage provided by the Plan is reduced by your Medicare benefits.

Medicare Enhance Plan Benefits	Benefit Description
65 . Applied Behavioral Analysis	
	The Plan provides coverage for Medically Necessary Applied Behavioral Analysis services for the treatment of Autism as required by law. **Please Note: This benefit may not be covered by all Plan Sponsors. If your Plan Sponsor provides coverage for this benefit, it will be listed in your Schedule of Benefits.**
66 . Bone Marrow Transplants for Breast Cancer	
	The Plan will provide coverage, less any payments made by Medicare, for autologous bone marrow transplants for metastasized breast cancer in accordance with the criteria established by the Massachusetts Department of Public Health.
67 . Cardiac Rehabilitation	
	The Plan will provide coverage, less any payments made by Medicare, for Medically Necessary inpatient and outpatient cardiac rehabilitation. Cardiac Rehabilitation is a multidisciplinary treatment of persons with documented cardiovascular disease. It may be provided in a Hospital or outpatient setting and must meet standards promulgated by the Commissioner of Public Health, including, but not limited to, outpatient treatment initiated within 26 weeks after the diagnosis of the disease. **Please Note: This benefit may not be covered by all Plan Sponsors. If your Plan Sponsor provides coverage for this benefit, it will be listed in your Schedule of Benefits.**
68 . Chiropractic Services Not Covered by Medicare	
	If your Plan Sponsor purchased Plan coverage for chiropractic services not covered by Medicare, the Plan covers musculoskeletal adjustment or manipulation up to the Benefit Limit listed in the Schedule of Benefits. The following services are covered: initial diagnostic x-ray and care within the scope of standard chiropractic practice. **Please Note: This benefit may not be covered by all Plan Sponsors. If your Plan Sponsor provides coverage for this benefit, it will be listed in your Schedule of Benefits.**
69 . Contraceptive Services and Hormone Replacement Therapy	
	The Plan provides coverage, less any payments made by Medicare, for outpatient professional services for the prevention of pregnancy and in connection with the use of hormone replacement therapy for peri- and post-menopausal women. Such services include consultations, examinations, and procedures related to all methods of contraception that have been approved by the United States Food and Drug Administration. **Please Note: Contraceptive drugs and devices and hormone replacement drugs are only covered if your Plan Sponsor has selected the Plan's prescription drug coverage. If such coverage is available, please see your Prescription Drug Brochure for details.**

Medicare Enhance Plan Benefits	Benefit Description
70 . COVID-19 Coverage	
	The Plan will provide coverage, when Medically Necessary, for the testing, treatment, and vaccines of COVID-19. Coverage includes, but is not limited to: • COVID-19 polymerase chain reaction (PCR) and antigen tests for symptomatic individuals, individuals identified as close contacts by state or local health officials, and asymptomatic individuals under circumstances in accordance with Massachusetts law. Antibody tests are covered when Medically Necessary to support treatment for COVID-19, or for a Subscriber whose immune system is compromised and/or knowledge of COVID-19 antibodies may impact the future outcome of treatment. COVID-19 testing solely intended for return to work, school, or other locations is not Medically Necessary and accordingly not covered. • COVID-19 related treatment for all emergency, inpatient services, outpatient services, and cognitive rehabilitation services, including all related professional, diagnostic, and laboratory services, as required by Massachusetts law. Please note, cost sharing (Deductible and/or Copayments) may apply to covered services related to treatment of reactions to the COVID-19 vaccine. • COVID-19 vaccines.
71 . Diabetes Treatment	
	The Plan will provide coverage, less any payments made by Medicare, for: • Outpatient diabetes self-management training; • Diabetic laboratory tests; • Blood glucose monitors, including coverage for voice-synthesizers and visual magnifying aids when Medically Necessary for use of blood glucose monitors for the legally blind; • Dosage gauges, injectors, lancet devices, molded shoes needed to prevent or treat complications of diabetes; • Insulin pumps and infusion devices; and • Insulin, insulin syringes, insulin pump supplies, insulin pens with syringe; oral agents for controlling blood sugar; lancets; blood test strips; and glucose, ketone, and urine test strips. Pharmacy items are subject to the prescription Copayment listed on your ID card, if your Plan Sponsor has selected prescription drug coverage. If prescription drug coverage is not available, then the Subscriber will pay a $5 copayment for Generic, a $10 Copayment for Select Brand and a $25 Copayment for Non-Select Brand drugs and supplies. **Please Note: This benefit may not be covered by all Plan Sponsors. If your Plan Sponsor provides coverage for this benefit, it will be listed in your Schedule of Benefits.**
72 . Hearing Aids	
	If your Plan Sponsor purchased Plan coverage for hearing aids, the coverage is described in the Schedule of Benefits.

Medicare Enhance Plan Benefits	Benefit Description
73 . Home Infusion Therapy	
	Medicare does not cover most home infusion therapies. Infusion therapy involves the administration of drugs and nutritional products that must be administered intravenously or through a feeding tube. The Plan provides coverage, less any payments made by Medicare, for the following infusion therapies administered in your home: • parenteral nutrition, • enteral nutrition, • hydration, • pain management, and • antibiotic, antifungal and antiviral therapies. Coverage includes the drug or nutritional product being infused and Medically Necessary professional services, including mid-line and PICC line insertions. In order to be covered under this benefit: • all products and services must be Medically Necessary and • there must be a medical reason that appropriate drugs or nutritional products cannot be taken orally. Coverage by the Plan is only available for services that are not covered by Medicare. Please see Section III.B *Home Infusion Therapy*, above, for information on Medicare covered home health care.
74 . Hospice Care	
	In addition to the benefit for Medicare covered Hospice care described in Section *III.B. SERVICES COVERED BY MEDICARE*, above, the Plan will cover Hospice care provided by a Hospice licensed by the Massachusetts Department of Public Health that is not eligible for payment by Medicare. To qualify for coverage, a Subscriber must have a Terminal Illness with a life expectancy of six months and receive authorization for hospice care from a licensed physician.
75 . Human Leukocyte Antigen Testing	
	The Plan will provide coverage, less any payments made by Medicare, for the cost of human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish bone marrow transplant donor suitability. Such coverage will cover the costs of testing for A, B, or DR antigens, or any combination thereof, consistent with the guidelines, criteria, and rules or regulations established by the Massachusetts Department of Public Health.
76 . Low Protein Foods	
	The Plan covers low protein foods for inherited diseases of amino and organic acids up to the amount specified in the Schedule of Benefits.

Medicare Enhance Plan Benefits	Benefit Description
77 . Mental Health and Substance Use Disorder Treatment Services	
	The Plan provides coverage for Medicare amounts for mental health and substance use disorder treatment services covered by Medicare. The Plan also covers additional benefits for such services that are explained in this subsection. Such additional coverage: • allows you to receive coverage for services provided by certain Providers that are not eligible for payment by Medicare, • provides you with minimum benefits you may use if Medicare coverage is not available, and • provides you with special benefits that may increase your coverage for certain medical conditions. When Medicare coverage is available for any of the services listed below, the Plan will cover only the applicable Medicare Deductible and Coinsurance amounts. When Medicare does not cover a service listed, payment for Medically Necessary Covered Services shall be made by the Plan up to the Payment Maximum, minus any applicable Copayment, as described below. **Covered Inpatient and Outpatient Facilities** The Medicare covered services described in Section *III. Covered Benefits*, above, are only available from Providers who are eligible to bill Medicare for Covered Services. The mental health and drug and substance use disorder treatment services may be obtained from any of the following types of Providers. **Inpatient Care:** In addition to Medicare certified institutions, the Plan will cover the Massachusetts mandated mental health and substance use disorder treatment described in this section on an inpatient basis at any Inpatient Mental Health Facility in Massachusetts. An Inpatient Mental Health Facility is any one of the following types of institutions: • A general Hospital licensed to provide such services; • A facility under the direction and supervision of the Massachusetts Department of Mental Health; • A private mental hospital licensed by the Massachusetts Department of Mental Health; or • A substance abuse facility licensed by the Massachusetts Department of Public Health. **Intermediate Care Services:** In addition to care at Medicare certified institutions, the Plan will cover Massachusetts mandated intermediate care services at any of the following types of facilities in Massachusetts that are licensed or approved by the Massachusetts Department of Public Health or the Massachusetts Department of Mental Health: • A Level III Community-Based Detoxification Facility; • An Acute Residential Treatment Facility; • A Partial Hospitalization Program (PHP); • Mobile Crisis Intervention (MCI) - Adult Mobile Crisis Intervention (AMCI) provided a course of treatment intended to promote recovery, ensure safety, and stabilize the crisis. For individuals who do not require inpatient services or another 24 hour level of care, AMCI provides up to three days of daily post-stabilization follow up care. • A Day Treatment Program; or

Medicare Enhance Plan Benefits	Benefit Description
Mental Health and Substance Use Disorder Treatment Services (Continued)	
	• A Crisis Stabilization Program. **Outpatient Care:** The Plan will cover the Massachusetts mandated mental health and substance use disorder treatment described in this section on an outpatient basis at any of the following: • Annual mental health wellness examination performed by a licensed mental health professional or by a primary care Provider during a routine physical exam. A mental health wellness examination is a screening or assessment that seeks to identify any behavioral or mental health needs and appropriate resources for treatment. • A licensed hospital; • A mental health or substance use disorder clinic licensed by the Massachusetts Department of Public Health; • A public community mental health center; • A professional office; or • Home-based services. To be covered, a Licensed Mental Health Professional acting within the scope of his or her license must render such services. For services provided in Massachusetts, a Licensed Mental Health Professional is any one of the following: a licensed physician who specializes in the practice of psychiatry; a licensed psychologist; a licensed independent clinical social worker; a licensed certified social worker; a licensed mental health counselor; a licensed supervised mental health counselor; a licensed psychiatric nurse mental health clinical specialist; a licensed psychiatric mental health nurse practitioner; a licensed physician assistant who practices in the area of psychiatry; a level I licensed alcohol and drug counselor; a clinician practicing under the supervision of a licensed professional and working towards licensure in a clinic licensed under chapter 111; or a licensed marriage and family therapist. For services provided outside of Massachusetts, a Licensed Mental Health Professional is an independently licensed clinician with at least a masters degree in a clinical mental health discipline from an accredited educational institution and at least two years of clinical experience. The term "clinical mental health discipline" includes the following: psychiatry; psychology; clinical social work; marriage and family therapy; clinical counseling; developmental psychology; pastoral counseling; psychiatric nursing; developmental or educational psychology; counselor education; or any other discipline deemed acceptable by HPHC. **Please Note: This benefit may not be covered by all Plan Sponsors. If your Plan Sponsor provides coverage for this benefit, it will be listed in your Schedule of Benefits.** **Additional Benefits for Mental Health and Substance Use Disorder Treatment Services** There are some circumstances in which Medicare does not provide benefits for mental health and substance use disorder treatment services. This might happen (1) where a Subscriber had used all of his or her Medicare covered inpatient days (described above in Section III.B. *Hospital Care* or (2) where a Subscriber wanted to receive care from a provider, such as a licensed Mental Health Counselor, who is not eligible for payment by Medicare. In such cases, when services are Medically Necessary and Medicare coverage is not available, the Plan will provide additional coverage for mental health and substance use disorder treatment services as follows:

Medicare Enhance Plan Benefits	Benefit Description
Mental Health and Substance Use Disorder Treatment Services (Continued)	
	Minimum Benefits for Mental Health Services The Plan will provide coverage, less any payments made by Medicare, for the diagnosis and treatment of all mental disorders, which are described in the most recent edition of the Diagnostic and Statistical Manual and the American Psychiatric Association (DSM), as follows: i. **Inpatient Treatment:** The Plan will cover Medically Necessary inpatient mental health treatment when provided at an Inpatient Mental Health Facility. ii. **Outpatient Treatment:** The Plan will cover Medically Necessary outpatient mental health services rendered by a Licensed Mental Health Professional. **Minimum Benefits for Substance Use Disorder Treatment** The Plan will provide coverage, less any payments made by Medicare, for the diagnosis and treatment of drug abuse and alcoholism as follows: i. **Inpatient Treatment:** The Plan will cover Medically Necessary inpatient substance use disorder treatment at a Mental Health Inpatient Facility. ii. **Outpatient Treatment:** The Plan will cover Medically Necessary substance use disorder treatment services when services are rendered by a Licensed Mental Health Professional. iii. **Services in Conjunction with Mental Health Treatment:** (a) For inpatient treatment at an Inpatient Mental Health Facility to the same extent as the benefits available for hospital care, including any benefit in addition to Medicare benefits provided by your Plan Sponsor. Please see Section III.B. *Hospital Care* and your Schedule of Benefits for information on your coverage for acute hospital care. (b) For outpatient care by a Licensed Mental Health Professional to the extent Medically Necessary. **Please Note: This benefit may not be covered by all Plan Sponsors. If your Plan Sponsor provides coverage for this benefit, it will be listed in your Schedule of Benefits.** **Special Benefits for Certain Conditions** Special benefits are provided for the following specific mental health conditions: i. **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; and (10) eating disorders; (11) post-traumatic stress disorders; (12) substance use disorders; (13) autism; and (14) any mental disorder designated a biologically-based mental disorder by the Commissioner of the Massachusetts Department of Mental Health. ii. **Services Required As A Result Of Rape:** When services are 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. If you are diagnosed as having one of the specific mental conditions described above in this subsection, the Plan will cover Medically Necessary services, less any payments by Medicare, as follows: • In the case of inpatient care, for the same number of days as the benefits available for Hospital care for a physical illness. This includes any coverage, in addition to Medicare benefits, provided by your Plan Sponsor.

Medicare Enhance Plan Benefits	Benefit Description
Mental Health and Substance Use Disorder Treatment Services (Continued)	
	• In the case of intermediate care, to the extent Medically Necessary. • In the case of outpatient care, to the extent Medically Necessary. **Please Note: This benefit may not be covered by all Plan Sponsors. If your Plan Sponsor provides coverage for this benefit, it will be listed in your Schedule of Benefits.** **Detoxification and Psychopharmacological Services** The Plan will provide coverage, less any payments made by Medicare, for detoxification and psychopharmacological services to the extent Medically Necessary. **Psychological Testing and Neuropsychological Assessment** The Plan will provide coverage, less any payments made by Medicare, for psychological testing and neuropsychological assessment to the extent Medically Necessary. **Psychological Collaborative Care** The Plan will provide coverage, less any payments made by Medicare for psychiatric collaborative care in which a primary care team provides structured behavioral health care management to a Subscriber. A primary care team includes a primary care physician and a care manager working in collaboration with a psychiatric consultant that provides regular consultations to the team to review the Subscriber's clinical status and care and to make recommendations. **Please Note:** Not all primary care physicians offices provide this service. **Medically Necessary Emergency Services Program** Coverage is provided for Medically Necessary Emergency Services Programs. The term "Emergency Services Programs" is defined as all programs subject to contract between the Massachusetts Behavioral Health Partnership (MBHP) and nonprofit organizations for the provisions of community-based emergency psychiatric services, including but not limited to, behavioral health crisis assessment, intervention and stabilization services 24 hours per day, 7 days per week, through: i. mobile crisis intervention services for adults; ii. emergency service provider community-based locations; and iii. adult community crisis stabilization services. In Massachusetts, designated Community Based Health Centers (CBHCs) serve as regional hubs of coordinated and integrated mental health and substance use disorder treatment and provide routine and urgent outpatient services, crisis services, and community crisis stabilization services. CBHCs will also provide community-based Mobile Crisis Intervention (MCI). **Please Note: This benefit may not be covered by all Plan Sponsors. If your Plan Sponsor provides coverage for this benefit, it will be listed in your Schedule of Benefits.**

Medicare Enhance Plan Benefits	Benefit Description
78 . Non-Medicare Covered Hospital Services	
	If your Plan Sponsor purchases this coverage, the Plan covers Hospital care in excess of the limits on Medicare coverage summarized in Section B.,*Hospital Care*. If all of the conditions outlined below are met, the Plan provides coverage beyond the last day of Medicare Hospital coverage up to the benefit limit listed in your Schedule of Benefits. If your Plan has this coverage, benefits for Hospital care in excess of Medicare limits will be paid by the Plan only if all of the following conditions are met: (1) the care is provided in a Medicare certified Hospital; (2) all 60 of the Subscriber's Medicare Lifetime Reserve Days, or 190 lifetime days in a psychiatric Hospital, have been used; (3) the Hospital services are Medically Necessary; and (4) Medicare coverage of Hospital care terminated because you reached the day limits on Medicare covered Hospital services and not for any other reason. **Please Note: This benefit may not be covered by all Plan Sponsors. If your Plan Sponsor provides coverage for this benefit, it will be listed in your Schedule of Benefits.**
79 . Preventive Care Services	
	This section lists the preventive care services covered by either Medicare or the Plan. In some cases, Medicare coverage may be available for part of a service, the rest of which is covered by the Plan. If Medicare coverage is available for any service listed below, the Plan pays the Medicare amount. If Medicare coverage is not available, the Plan covers the service up to the Payment Maximum. a. **Physician's Services** The Plan provides coverage, less any payments by Medicare, for the following preventive care services: • An annual routine physical exam by a licensed physician, including education in self-care, blood pressure check, Pap Test and pelvic examination, clinical breast examination, fecal occult blood test, prostate cancer screening, nutritional counseling, and routine laboratory and blood tests. • The following preventive care services are covered to the extent Medically Necessary: immunizations, diabetes screenings, cholesterol measurements, glaucoma screening, prenatal and postpartum care and screenings for sexually transmitted diseases. b. **Diagnostic Tests and Procedures** The Plan or Medicare covers the following diagnostic tests, to the extent Medically Necessary: • Colorectal cancer screening, including flexible sigmoidoscopy, colonoscopy, and barium enema; • Bone Mass Measurements; • A routine vision examination (including glaucoma screening); and • A routine hearing examination. Coverage is also provided for a baseline mammogram for women between ages 35 and 39 and an annual mammogram for women 40 years of age and older.

Medicare Enhance Plan Benefits	Benefit Description
80 . Services Received Outside the United States	
	Generally, Medicare only covers services received within the United States. The Plan's coverage is intended for persons living in the United States who travel to other countries. It is not intended for persons living outside the United States. The Plan covers services received outside of the United States for an unexpected Medical Emergency that takes place while traveling away from home. Covered Services include, but are not limited to, Medically Necessary emergency room care, physician services, and hospital care immediately following a Medical Emergency. Transportation by ambulance is covered only for a road ambulance from the place where a Medical Emergency takes place to the nearest hospital. See the *II. Glossary* for the definition a Medical Emergency. The Plan also covers Urgent Care services received outside of the United States and its territories. Coverage for Urgent Care is provided for services that are required to prevent deterioration to your health resulting from an unforeseen sickness or injury. Covered Benefits include but are not limited to the following: • Care for minor cuts, burns, rashes or abrasions, including suturing • Treatment for minor illnesses and infections, including ear aches • Treatment for minor sprains or strains No benefits will be provided for any service received outside of the United States that is: • a routine or preventive service of any kind; • a service that was, or could have been, scheduled before leaving the United States, even if such scheduling would have delayed travel plans; • a form of transportation, including transportation back to the United States, except road ambulance to the nearest hospital; or • a service that would not be a covered by Medicare or the Plan in the United States.
81 . Special Formulas for Malabsorbtion	
	The Plan provides coverage, less any payments made by Medicare, for nutritional formulas for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, and chronic pseudo-obstruction. In order to be covered, formulas for these conditions must be ordered by a physician.
82 . Special Plan Sponsor Benefits	
	Some Plan Sponsor's purchase coverage for services that are not covered by Medicare, in addition to those listed above. Any such service will be listed in your Schedule of Benefits.
83 . Speech-Language and Hearing Services	
	The Plan will provide coverage, less any payments made by Medicare, for the diagnosis and treatment of speech, hearing and language disorders to the extent Medically Necessary. To be covered, services must be provided by a state licensed speech-language pathologist or audiologist.

Medicare Enhance Plan Benefits	Benefit Description
84 . Wigs	
	The Plan covers wigs and scalp hair prostheses for hair loss as a result of the treatment for any form of cancer or leukemia, or for a certain pathological condition such as alopecia areata, alopecia totalis, alopecia medicamentosa or permanent loss of scalp hair due to injury up to the Benefit Limit listed in the Schedule of Benefits. **Please Note: This benefit may not be covered by all Plan Sponsors. If your Plan Sponsor provides coverage for this benefit, it will be listed in your Schedule of Benefits.**

IV. Exclusions

A. No benefits will be provided by the Plan for any of the following:	
	1. Any product or service not covered by Medicare unless specifically listed as a Covered Service in this Benefit Handbook, the Schedule of Benefits or the Prescription Drug Brochure (if applicable). 2. Any product or service not Medically Necessary. 3. Any product or service (1) which you are legally entitled to treatment at government expense or (2) which payment is required to be made by a Workers' Compensation plan or laws of similar purpose. 4. Any product or service provided to you after the date on which your enrollment in the plan has ended. 5. Any charges for inpatient care over the semi-private room rate, except when a private room is Medically Necessary. 6. Any product or service for which no charge would be made in the absence of insurance. 7. Any product or service received outside of the United States that is: (1) related to the provision of routine or preventive care of any kind; (2) a service that was, or could have been, scheduled before leaving the United States, even if such scheduling would have delayed travel plans; (3) a form of transportation, including transportation back to the United States, except road ambulance to the nearest hospital; or (4) a service that would not be a covered by Medicare or the Plan in the United States. 8. Any product or service that is Experimental, Unproven, or Investigational unless it is covered by Medicare. (Please see the *II. Glossary* for the meaning of "Experimental, Unproven, or Investigational".) 9. Cosmetic services or products, including, but not limited to, cosmetic surgery, except for services required to be covered under the Women's Health and Cancer Rights Act of 1998. 10. Rest or Custodial Care. 11. Massage therapy (including myotherapy), sports medicine clinics, treatment with crystals. Routine foot care services such as corn and bunion trimming, callus removal, unless such care is Medically Necessary due to circulatory system disease such as diabetes. 12. Any form of hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. (See Section III. *Wigs*, for the coverage for wigs.) 13. Ambulance services except as specified in this Benefit Handbook. No benefits are provided for transportation other than by ambulance. 14. Exercise equipment; or personal comfort or convenience items such as radios, telephone, television, or haircutting services. 15. Any product or service provided by (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you. 16. Refractive eye surgery, including laser surgery, orthokeratology or lens implantation for correction of myopia, hyperopia and astigmatism. 17. Any products or services related to diet plans or weight loss programs, including diet foods, drinks or drugs of any kind. (However, the Plan covers Medicare amounts for professional services or surgery covered by Medicare for obesity.) 18. Educational services or testing; services for problems of school performance; sensory integrative praxis tests, vocational rehabilitation, or vocational evaluations focused on job adaptability, job placement, or therapy to restore function for a specific occupation. 19. Planned home births. 20. Devices or special equipment needed for sports or occupational purposes.

21. 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 Service under this Benefit Handbook.
22. Mental health services that are (1) provided to Subscribers 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.
23. Any charges that exceed the Payment Maximum. (Please see Section *II. Glossary* for the definition of "Payment Maximum".)
24. Any product or service obtained at an unapproved facility if Medicare requires that the product or service be provided at a Medicare approved facility. This exclusion applies to weight loss (bariatric) surgery; liver, lung, heart, heart-lung, pancreas, and intestine transplants; and any other product service Medicare determines must be obtained at a Medicare approved facility.
25. Care outside the scope of standard chiropractic practice by a chiropractor, 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. (Note that Medicare provides limited benefits for chiropractic services to correct a subluxation of the spine.)
26. Telemedicine services involving e-mail, fax or non-secure texting.
27. Provider fess for technical costs for the provision of telemedicine services.
28. Hearing aid batteries.
29. Any service or supply (with the exception of contact lenses) purchased from the internet.
30. Services provided by a doula
31. Taxes or governmental assessments on services or supplies.

B. No benefits will be provided by the Plan for any of the following, unless coverage is provided by your Plan Sponsor. If your Plan Sponsor provides such coverage, the following products or services will be listed in your Schedule of Benefits:

1. Chiropractic care, except for manual manipulation of the spine to correct a subluxation.
2. Hearing Aids.
3. Foot orthotics, except as required for the treatment of severe diabetic foot disease or systemic circulatory diseases.
4. Dental Services, including, but not limited to, restorative, periodontal, orthodontic, endodontic, prosthodontic services (including any services related to dentures), or any Dental Services relative to the treatment of temporomandibular joint dysfunction (TMJ), except that (1) the Plan will cover the Medicare Deductible and Coinsurance amount for any Dental Service that has been covered by Medicare and (2) the Plan will cover additional Dental Services if such coverage is purchased by an Plan Sponsor. (Please see *II. Glossary* for the definition of "Dental Services".)
5. Infertility services or any related services supplies or drugs, including, but not limited to, in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intra-cytoplasmic sperm injection, donor egg procedures (including related egg and inseminated egg procurement), the preservation of eggs or sperm, voluntary sterilization or the reversal of voluntary sterilization, or any form or Surrogacy. (Please see Section *II. Glossary* for the definition of "Surrogacy".)
6. Eyeglasses and contact lenses, or examinations to prescribe, fit, or change eyeglasses or contact lenses. (Medicare provides limited benefits for eyeglasses or contact lenses after cataract surgery.)
7. Aromatherapy, or alternative medicine.
8. Drugs or medications that can be self-administered unless (1) the Plan Sponsor purchased prescription drug coverage on behalf of the Subscriber and coverage for

	such drug or medication is provided for in the Prescription Drug Brochure, or (2) the drug or medication is covered by Medicare Parts A or B. 9. Private duty nursing.

V. Reimbursement and Claims Procedures

A. INTRODUCTION

This section explains how to obtain payments for Covered Services from the Plan.

Because Plan benefits generally depend upon the coverage provided by Medicare, Providers must bill Medicare for Medicare covered services before billing HPHC.

The Plan will usually cover benefits by making payments directly to service Providers.

However, there are times when HPHC will pay you instead. This might occur when you have already paid the Provider for a Covered Service or when a Provider does not accept Medicare assignment. In such cases, HPHC may pay benefits directly to you.

Claims will be paid minus the cost sharing listed in your Schedule of Benefits. All payments by the Plan are limited to the Payment Maximum described in Subsection *V.K. THE PAYMENT MAXIMUM*, below.

You are responsible for any amount billed by a Provider that is in excess of the Payment Maximum.

Claims will be reviewed within 45 days of receipt.

If a claim cannot be paid within that time, HPHC will either notify you:

1. that additional documentation is needed or
2. that the claim is denied, in whole or in part, and the reasons for denial.

If the Plan does not provide such notice, interest will be payable to you at the rate of 1.5% per month (not to exceed 18% per year) on the amount of benefits payable, beginning 45 days after receipt of the claim.

No interest will be payable on any claim that HPHC is investigating because of suspected fraud.

B. THE ADDRESSES FOR SUBMITTING CLAIMS

1. **Medical Claims**

   All medical claims for benefits must be submitted to the following address:

   Medicare Enhance Claims
   HPHC Insurance Company, Inc.
   P.O. Box 699183
   Quincy, MA 02269–9183

   The Plan provides limited coverage for certain state mandated outpatient pharmacy products if you do not have the Plan's outpatient prescription drug rider. Claims for these limited services should also be submitted to the address listed above.

2. **Pharmacy Claims**

   If your Plan Sponsor purchased Plan coverage for outpatient prescription drugs, reimbursement request of pharmacy expenses must be sent to:

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

See Subsection *V.G. PHARMACY CLAIMS*, below, for information on filing pharmacy claims.

C. CLAIMS FOR SERVICES COVERED BY MEDICARE PART A (HOSPITAL COVERAGE)

This section explains the procedure to follow to obtain benefits for services covered by Medicare Part A, also known as Medicare Hospital Insurance.

Medicare Part A services include inpatient care received in Hospitals, Skilled Nursing Facilities (SNFs) and Religious Nonmedical Health Care Institutions (RNHCIs). Medicare Part A also covers Hospice services and some home health care.

See Subsections *V.E. CLAIMS FOR SERVICES NOT COVERED BY MEDICARE* and *V.F. CLAIMS FOR SERVICES RECEIVED IN A FOREIGN COUNTRY*, below, for information on how to file a claim for an inpatient service that is not covered by Medicare. To obtain benefits for services under Medicare Part A, please follow these steps:

1. **Bill Medicare First** Providers should first submit claims for Medicare Part A services to Medicare. Medicare will either pay the claim, in whole or in part, or deny coverage. You will be sent a Medicare Summary Notice (MSN). The MSN states the payment made by Medicare and explains any amount that was denied.
2. **Then Bill Medicare Enhance** After the Medicare Summary Notice (MSN) is received from Medicare, you or the Provider must send each of the following items to the address listed above:
    i. A copy of the Medicare Summary Notice (MSN); and
    ii. A standard UB 04 claim form completed by the Provider. (If a completed UB 04 claim form cannot be submitted, please see below.)

If a completed UB 04 claim form cannot be submitted, most claims can be processed using an itemized bill from the Provider. The itemized bill must contain:

1. Your name,
2. Your Plan ID number,
3. The Provider's name and address,
4. The Provider's Medicare identification number,
5. The date the service was rendered,
6. The diagnosis and procedure codes for the service, and
7. The dollar amount of the claim.

HPHC may require the submission of additional information on some claims.

D. CLAIMS FOR SERVICES COVERED BY MEDICARE PART B

This section explains the procedure to follow to obtain benefits for services covered by Medicare Part B, also known as Medicare Supplemental Medical Insurance for the Aged and Disabled.

Medicare Part B covers most outpatient services including most physician care, diagnostic tests, outpatient surgery, outpatient mental health care, physical, occupational and speech-language therapy and Durable Medical Equipment.

1. PROVIDER BILLING FOR PART B SERVICES

Health care professionals, such as physicians, and suppliers of health care equipment and supplies, may bill for Medicare covered services using one of two billing methods; (1) "accept assignment" or (2) "not accept assignment" from Medicare. The following information on these billing methods is provided, for informational purposes only. See your *Medicare & You* book for additional information on assignment and the limits that apply to Provider charges.

a. **The Assignment Method Under Medicare** If a Provider accepts assignment from Medicare, the Provider agrees that he or she will accept Medicare's approved (or "allowable") amount as payment in full for the service rendered. When a physician accepts assignment the physician may not bill for more than the Medicare allowable amount and Medicare pays the physician directly.

    When a Provider accepts assignment, physician payment would generally work as follows: The Provider bills Medicare. Medicare pays the Provider directly and sends you a Medicare Summary Notice (MSN) explaining the payment. Then, either you or the Provider may file a claim with HPHC for the balance due the Provider. For most physician services, the Plan covers any unmet Medicare Deductible amount and the 20% Medicare Coinsurance amount, minus any Copayment you owe.

b. **The Non-Assignment Method Under Medicare** If a Provider does not accept assignment from Medicare, the Provider may charge you more than the Medicare approved amount. If the Provider selects that option, Medicare will not pay the Provider directly. Medicare pays benefits to the Subscriber and you are responsible for paying the Provider.

When a Provider does not accept assignment, physician payment would generally work as follows: The Provider bills Medicare. Medicare pays you and sends you a Medicare Summary Notice (MSN) explaining the payment. In most cases, you would then file a claim with HPHC. For most physician services, the Plan covers any unmet Medicare Deductible amount and the 20% Medicare Coinsurance amount, minus any Copayment you owe.

The 20% Coinsurance amount paid by HPHC is based on the Medicare approved amount, not the Provider's actual charge. If the Provider charged you an amount in excess of the Medicare approved amount, you are responsible for paying that excess. You must pay the physician directly.

2. BILLING THE PLAN

After Medicare has been billed and sent you a Medicare Summary Notice (MSN) for a Medicare Part B service, you or the Provider may file a claim with the Plan for any Copayment and Deductible amounts that have not been paid by Medicare. Since HPHC covers some services that are not covered by Medicare, you may also bill the Plan for services that Medicare has denied.

To file a claim with HPHC, you or the Provider must send each of the following items to the address listed in Subsection *V.B. THE ADDRESSES FOR SUBMITTING CLAIMS*, above:

a. A copy of the Medicare Summary Notice (MSN); and

b. A standard CMS 1500 claim form completed by the Provider. (If a completed CMS 1500 claim form cannot be submitted, please see below.)

If a completed CMS 1500 claim form cannot be submitted, most claims can be processed using an itemized bill from the Provider. The itemized bill must contain:

1. Your name,
2. Your Plan ID number,
3. The Provider's name and address,
4. The Provider's tax identification number,
5. The date the service was rendered,
6. The diagnosis and procedure codes for the service, and
7. The dollar amount of the claim.

HPHC may require the submission of additional information on some claims.

E. CLAIMS FOR SERVICES NOT COVERED BY MEDICARE

The Plan covers a number of services that are not covered by Medicare. These services are described in Section *III.C. ADDITIONAL COVERED SERVICES*, above, or in your Schedule of Benefits.

In addition, professionals or institutions that are not eligible to bill Medicare may provide certain Covered Services under Section *III.C. ADDITIONAL COVERED SERVICES* of this Handbook.

Whenever possible, your Providers should first bill Medicare for the services you receive. Submission of a Medicare Summary Notice (MSN), even if Medicare denies coverage, will prevent delays in the processing of claims that might be eligible for Medicare coverage.

To bill HPHC for a service that is not covered by Medicare, please follow the procedure outlined below. For services rendered outside the United States, please follow the procedures outlined in the next section.

To file a claim with HPHC for a service that is not covered by Medicare, the Subscriber or Provider must send each of the following items to the address listed in Subsection *V.B. THE ADDRESSES FOR SUBMITTING CLAIMS*, above:

1. A copy of the Medicare Summary Notice (MSN), if one has been issued; and
2. A standard claim form, such as a CMS 1500 or UB 04 claim form, completed by the Provider. (If a completed CMS 1500 or UB 04 claim form cannot be submitted, please see below.)

If a standard claim form, such as a CMS 1500 or UB 04 claim form, cannot be submitted, most claims can be processed using an itemized bill from the Provider. The itemized bill must contain:

1. Your name,
2. Your Plan ID number,
3. The Provider's name and address,
4. The Provider's tax identification number,
5. The date the service was rendered,
6. The diagnosis and procedure codes for the service,
7. The dollar amount of the claim, and

HPHC may require the submission of additional information on some claims.

F. CLAIMS FOR SERVICES RECEIVED IN A FOREIGN COUNTRY

If you Plan includes benefits for services received outside the United States, please file claims for such services as follows: Send the Plan an itemized bill for the service rendered to the address listed in Subsection *V.B. THE ADDRESSES FOR SUBMITTING CLAIMS*, above. The itemized bill must contain:

1. Your name,
2. Your Plan ID number,
3. The Provider's name and address,
4. The date the service was rendered,
5. A description of the service, and
6. The dollar amount of the claim.

HPHC may require the submission of additional information on some claims. The Plan may also require that you provide an English translation of the itemized bill.

Payments for services provided outside the United States will be made only to you. You are responsible for paying the Provider.

G. PHARMACY CLAIMS

If your Plan Sponsor provides the Plan's prescription drug coverage, please consult your Prescription Drug Brochure for the details of your coverage.

If you need to submit a claim for the reimbursement of covered pharmacy expenses, submit a drug store receipt with the following information:

1. The Subscriber's name,
2. The Subscriber's Plan ID number,
3. The name of the drug or medical supply,
4. The NDC number,
5. The quantity purchased,
6. The number of days supply,

7. The date the prescription was filled,
8. The prescribing physician's name
9. The name and address of the pharmacy, and
10. The amount paid.

HPHC may require the submission of additional information to process some claims.

Requests for pharmacy reimbursement must be sent to:

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

You may contact Member Services at **1-888-333-4742** for assistance.

H. ASSIGNMENT OF BENEFITS

You may assign payments by HPHC to Providers by signing the appropriate section of the Provider's claim. The Plan pays the Provider directly if benefits are assigned. If you do not assign benefits to the Provider, the Plan will make payment for Covered Services to you. You will then be responsible for paying the Provider.

I. TIME LIMIT FOR FILING CLAIMS

All claims received for Covered Services must be submitted to HPHC at the address above within 365 days of the date of service, or the date of discharge if services were rendered on an inpatient basis.

Whether you or the Provider submits the claims, you are responsible to ensure that the claims are submitted within the above time frame.

J. MISCELLANEOUS CLAIMS PROVISIONS

Generally, benefits will be paid to you or directly to the health care Provider whose charge is the basis for the claim.

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

K. THE PAYMENT MAXIMUM

HPHC limits the amount it will pay for any Covered Service to the "Payment Maximum." The Payment Maximum is as follows:

1. **For Medicare Covered Items** If Medicare Part A or B covers a product or service, the Payment Maximum is the Medicare Coinsurance amount plus any unmet Medicare Deductible amount. The Medicare Coinsurance amount is the portion or percentage of the Medicare approved payment amount for a product or service that a beneficiary is responsible for paying. (Note that any Plan payment will be reduced by any applicable Copayment or unmet Deductible amount specified in your Schedule of Benefits.)

   In some cases, Providers may bill Medicare patients for amounts that exceed the Medicare approved payment amount. Any amount that exceeds the Medicare approved amount is your responsibility and is not payable either by Medicare or HPHC. Please see the discussion of "assignment" in the Medicare publication *Medicare & You* for information on limits that apply to Provider charges.

2. **For Items Not Covered by Medicare** If Medicare Part A or B does not cover a product or service, the Payment Maximum depends upon whether the Provider is under contract to provide services to Subscribers of HPHC.

   If a Provider is under contract to HPHC, the Payment Maximum is the contract rate for the service.

If the Provider is not under contract to HPHC, the Payment Maximum is the amount, as determined by HPHC, that is within the normal range of charges made by health care Providers for the same, or similar, products or services in Boston, Massachusetts.

VI. Appeals and Complaints

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

Important Note: The appeal procedures stated below only apply to benefits of the Plan. If Medicare denies a claim, you must appeal to Medicare. Information on your Medicare appeal rights may be found on the Medicare Summary Notice, the document sent to you by Medicare that explains what action Medicare has taken on a claim.

A. BEFORE YOU FILE AN APPEAL

Claim denials may result from a misunderstanding with a provider or a claim processing error. Since these problems can be easy to resolve, we recommend that you contact an HPHC Member Service Representative prior to filing an appeal. (A Member Service Representative can be reached toll free at **1-888-333-4742** or at **(711** for TTY service.) The Member Service Representative will investigate the claim and either resolve the problem or explain why the claim is being denied. If you are dissatisfied with the response of the Member Service Representative, you may file an appeal using the procedures outlined below.

B. SUBSCRIBER APPEAL PROCEDURES

If you are dissatisfied with a decision on the coverage of services you may appeal to HPHC. Appeals may also be filed by your representative or a Provider acting on your behalf. HPHC has established the following steps to ensure that you receive a timely and fair review of internal appeals.

You may also appeal a rescission of coverage. A rescission of coverage is defined in Section *VI.C.2. External Review*.

If you need assistance filing your appeal, there may be consumer assistance programs in your state available to you. Also, HPHC staff is available to assist you with the filing of an appeal. If you wish such assistance or would like the telephone number for one of these programs, please call **1-888-333-4742**.

1. Initiating Your Appeal

To begin, you may file your appeal:

- in person,
- by mail,
- by fax,
- by telephone, or
- electronically via the secure online member portal.

If your appeal qualifies as an expedited appeal, you may contact us by telephone. Please see Subsection *VI.B.3. The Expedited Appeal Process* for the expedited review procedure.

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

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

For all appeals please send your request to the following address:

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

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

After an appeal is filed, we assign an Appeals and Grievance Analyst. This analyst will be responsible for your appeal during the appeals process. We will send you a letter that will:

- identify your Appeals and Grievance Analyst, and
- provide detailed information on the appeals process.

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

2. The Standard Appeal Process

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

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

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

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

After we receive all the information needed to make a decision, your Appeals and Grievances Analyst will inform you, in writing, whether your appeal is approved or denied. The Plan's decision of your appeal will include:

1. a summary of the facts and issues in the appeal,
2. a summary of the documentation relied upon,
3. the specific reasons for the decision, including the clinical rationale, if any
4. the identification of any medical or vocational expert consulted in reviewing your appeal, and
5. any other information required by law.

This decision is the final decision under the appeal process. If the appeal decision is not fully in your favor, the decision will also include a description of other options for further review of your appeal. These are also described in subsection C, below.

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

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

3. The Expedited Appeal Process

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

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

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

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

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

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

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

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

C. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED

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

1. Reconsideration of an Appeal Decision

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

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

2. External Review

If you disagree with the denial of your appeal you may be entitled seek external review through an Independent Review Organization (IRO). However, this right does not apply if your Plan is a grandfathered health plan under the Patient Protection and Affordable Care Act. Contact your Plan sponsor to find out whether your Plan is a grandfathered health plan.

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

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

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

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

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

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

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

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

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

   Medical Judgment. A "medical judgment" includes, but is not limited to, the following types of decisions: (i) whether the service is Medically Necessary; (ii) whether the health care facility, level of care, or service is appropriate for treatment of the Subscriber's condition; (iii) whether the service is likely to be effective, or more effective than an alternative service, in treating a Subscriber's condition; or (iv) whether the service is Experimental, Unproven, or Investigational. A medical judgement does not include a decision that is based on an interpretation of the law, or the benefits or wording of your Plan, without consideration of your clinical condition or what is best for you medically.

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

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

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

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

3. Alternative Dispute Resolution

You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.

4. Legal Action
You may be able to bring legal action under Section 502(a) of the Employee Retirement Income Security Act (ERISA). This may be done when your Plan is governed by ERISA.

Please note that any legal action under sections 502(c) of ERISA must be brought within the time period sated in Section *C. LEGAL ACTIONS*. Please note that government plans are not subject to ERISA.

D. THE FORMAL COMPLAINT PROCESS

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

HPHC Member Service Department
HPHC Insurance Company, Inc.
1 Wellness Way
Canton, MA 02021
Telephone: 1-888-333-4742
Fax: 1–617–509–3085
www.harvardpilgrim.org

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

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VII. Eligibility and Enrollment

Important Notice:

- Your membership starts the date your Plan Sponsor enrolls you in the Plan.
- Your employer may notify Harvard Pilgrim of enrollment changes retroactively. This means we may not have up to date membership status.

A. ELIGIBILITY

A Subscriber under the Plan must at all times:

1. be enrolled in Medicare Parts A and B and pay any premium required.
2. be enrolled through an Plan Sponsor that has entered into an agreement with HPHC Insurance Company, Inc. for enrollment in the Plan.
3. be a resident of the United States or one of its territories.
4. be a person for whom Medicare is primary to health benefits sponsored by the Plan Sponsor. In general, these are:
   a. retired employees of the Plan Sponsor who are eligible for Medicare based on age or disability.
   b. active or retired employees of the Plan Sponsor who:
      - (i) are Medicare eligible based on end stage renal disease (also known as "ESRD" or "permanent kidney failure") and
      - (ii) have passed the 30-month "coordination period" that begins when an individual becomes Medicare eligible based on ESRD.
   c. active employees of an Plan Sponsor with fewer than 20 employees (as defined by Medicare regulations).
5. not be enrolled in a Medicare Advantage or Medicare Part C plan.

HPHC must receive the administration fees amount for your coverage from the Plan Sponsor.

The Plan does not offer dependent coverage.

Spousal enrollment may be permitted by the Plan Sponsor. A dependent spouse who meets the eligibility requirements may enroll in the Plan under a separate Contract.

HPHC must receive notice from the Plan Sponsor using Plan enrollment forms or in a manner otherwise agreed to in writing by HPHC and the Plan Sponsor.

HPHC must receive proper notice from the Plan Sponsor for your enrollment in, or termination from, the Plan no more than 60 days after such change is to be effective, unless otherwise required by law.

See your Plan Sponsor for information, effective dates or coverage, and Plan enrollment forms.

Please Note: *If you are re-employed by the Plan Sponsor on a part time basis after retirement, the Plan Sponsor must assume primary coverage for you (and your spouse) if the amount of work performed would be sufficient, based on hours, productivity or other criteria established by the Plan Sponsor, to entitle an employee to coverage under the Plan Sponsor's health plan for active employees.*

You (and your spouse) may not be deemed "retired" and are not eligible for enrollment in the Plan. The only exceptions apply to (1) persons with ESRD and (2) persons eligible for Medicare based on age employed by Plan Sponsors with 19 employees or less in accordance with the requirements of 42 CFR Section 411.170.

B. ENROLLMENT

1. During the period established by HPHC and the Plan Sponsor, an eligible person may enroll by submitting completed application forms supplied by HPHC.

2. Subscribers or applicants will complete and submit Plan enrollment forms and such other information as HPHC may reasonably request.

   Subscribers and applicants agree that all information contained in the enrollment form or other forms or statements submitted are true, correct, and complete.

   All rights to benefits are subject to the condition that all information provided to HPHC is true, correct, and complete.

3. By enrolling in the Plan, all Subscribers legally capable of contracting and the legal representatives of all Subscribers incapable of contracting, agree to all the terms, conditions, and provisions in this Handbook, including any amendments.

C. EFFECTIVE DATE OF ENROLLMENT

Subject to administration fee payments and HPHC's receipt and acceptance of the completed enrollment form within 60 days of the enrollment date, an eligible individual who meets the requirements may be enrolled on any one of the following dates:

1. The date the person becomes enrolled in Medicare Parts A and B;
2. The date an eligible person loses eligibility for the Plan Sponsor's health coverage due to retirement;
3. The date the person loses eligibility for the Plan Sponsor's health coverage through their spouse's employment. This may be due to the spouse's:
   - death,
   - loss of employment,
   - reduction in hours,
   - divorce,
   - leave of absence, or
   - retirement;
4. The date an active employee enrolled in Medicare Parts A and B for ESRD completes the 30-month coordination period during which the Plan Sponsor health plan is the primary payer to Medicare; or
5. The Employer's Anniversary Date.

Important Note: Except as otherwise provided by law, you are eligible for coverage under this Benefit Handbook as of the effective date unless you are a Hospital inpatient on that date. If you are a Hospital inpatient on the effective date, coverage will begin on your discharge date.

D. CHANGE IN STATUS

You must inform your Plan Sponsor and us of all changes that affect eligibility.

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

E. IDENTIFICATION CARD

You will receive a Plan identification card. This card must be presented with your Medicare card whenever you receive health care services.

This card is not a guarantee of benefits. You must be a current Subscriber on whose behalf the Plan has received all applicable premium payments.

In addition, the health care services received must be Covered Services.

Fraudulent use of an identification card can result in your immediate termination.

VIII. Termination of Subscriber's Coverage

Please Note: Plan Sponsors have up to 60 days to notify us of enrollment changes. As a result, the information we have may not be current. Your Plan Sponsor can confirm membership status.

A. TERMINATION BY THE SUBSCRIBER

You may end your membership under this Plan. You will need your Plan Sponsor's approval. An Enrollment/Change form must be completed. We must receive the form from the Plan Sponsor within 60 days of the date you want to end your membership.

B. TERMINATION FOR LOSS OF ELIGIBILITY

Your Plan coverage will end if the Plan Sponsor contract with HPHC is terminated.

Your coverage will also end under this Plan if you do not meet any of the eligibility requirements.

You will be notified in writing if coverage ends for loss of eligibility. HPHC or the Plan Sponsor will inform you in writing.

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

C. TERMINATION FOR NON-PAYMENT BY THE PLAN SPONSOR

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

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

D. TERMINATION FOR CAUSE

HPHC may end your coverage for any of the following causes:

- Misrepresenting a material fact on your application.
- Committing, or attempting to commit, fraud to get benefits that you are not eligible for under the EOC.
- Getting or attempting to get benefits under the EOC for a person who is not a Subscriber.

Termination for providing false information or fraud to the Plan may go back to your effective date or the date of the misrepresentation or fraud as determined by the Plan.

E. TERMINATIONS FOR OTHER REASONS

We may end your coverage under the Plan for any of the following other reasons:

- If you commit acts or physical or verbal abuse which pose a threat to Providers or other Subscribers and which are unrelated to your physical or mental condition. HPHC will give you at least 31 days notice before the date of termination.
- The termination or non-renewal of the Employer Agreement under which the you are enrolled.

F. CONTINUATION OF COVERAGE REQUIRED BY LAW

If you lose Plan Sponsor eligibility and the Plan Sponsor has 20 or more employees, you may be able to continue group coverage under Federal law. This law is known as the Consolidated Omnibus Budget Reconciliation Act (COBRA). Contact your Plan Sponsor for more information if your coverage ends due to:

- bankruptcy; or

- loss of dependency status, such as divorce.

Continuation of coverage cannot go beyond the time period allowed under federal law.

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H. REINSTATEMENT

Your coverage will not be reinstated automatically if it is terminated. Reapplication is necessary.

IX. When You Have Other Coverage

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

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

Nothing in this section should be interpreted as:

- providing coverage for any service or supply that is not expressly covered under the EOC; or
- increasing the level of coverage provided.

A. COORDINATION OF BENEFITS (COB)

Medicare Enhance benefits are in addition to benefits provided under the Medicare program. No benefits will be provided that duplicate Medicare benefits.

To the extent that you also have health benefits coverage provided by another source, the Plan will coordinate coverage with the other payer, according to Massachusetts Coordination of Benefits regulations.

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

- car insurance,
- medical payment policies,
- homeowners insurance,
- 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 equal to less than $100 per day.

Coordination of benefits will be based on the reasonable and customary charge. This applies for any service that is covered at least in part by any of the plans involved.

If benefits are provided in the form of services the reasonable value of these services will be used as the basis for coordination. This also applies if a provider of services is paid under a capitation arrangement.

No duplication in coverage of services will occur among plans.

For prescription drug claims, we will coordinate benefits pursuant to our secondary payor allowed amount in all cases.

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

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

The benefits of secondary plan(s):

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

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

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

2. Active Employee or Retired or Laid-Off Employee
The benefits of a plan, which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined first. The benefits of a plan, which covers that person as a laid-off or retired employee (or as that employee's dependent) are determined second.

If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

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

a. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.

b. The start of a new plan does not include: (a) a change in the amount or scope of a plan's benefits; (b) a change in the entity which pays, provides or administers the plan's benefits; or (c) a change from one type of plan to another (such as, from a single Employer plan to that of a multiple employer plan).

c. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available, the date the person first became a Subscriber of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

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

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

B. SUBROGATION

If you have an injury or illness legally caused by a third party, we have a right to be reimbursed by the third party for claims we pay for Covered Services you need. This is called subrogation.

Specifically:

- HPHC will be subrogated and succeed to all your rights to recover against such third party (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
  - your own auto insurance carrier; in cases of uninsured or underinsured motorist coverage.
- HPHC will also be entitled to recover from you 100% of the value of services provided or paid for by HPHC when you have been, or could be, reimbursed for the cost of care by another party. HPHC's recovery will be made from any recovery you receive 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 you in seeking recovery from other persons or organizations.

- HPHC's right to 100% recovery shall apply even if a recovery you receive for the illness or injury is designated or described as being for injuries other than health care expenses.
- HPHC will have the right to take legal action, with or without your 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.

C. MOTOR VEHICLE ACCIDENTS

When you are involved in a motor vehicle accident, HPHC will coordinate benefits with your car insurance company. If you are involved in a motor vehicle accident, notify the attending physician(s) that the injuries are accident related.

You must also notify HPHC of the accident, the name and address of your car insurance carrier, and such other information as HPHC may reasonably request. You agree to complete the questionnaire provided by the Plan to obtain information regarding the accident.

D. DOUBLE COVERAGE

1. Worker's Compensation/Government Programs

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

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

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

2. Other Government Programs

Except as otherwise provided by applicable law that would require the Plan to be the primary payer, the benefits under this EOC will not duplicate any benefits to which you are entitled or for which you are eligible under any government program. If the Plan has duplicated such benefits, all sums payable under such programs for benefits provided by the Plan are payable to and may be retained by the Plan.

3. Subscriber Cooperation

You agree to cooperate with the Plan in exercising its rights of subrogation and coordination of benefits under this EOC. 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 benefits 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 the Plan's rights to subrogation or coordination of benefits.

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

4. Assignment

Coverage under this EOC is not assignable by you without the written consent of the Plan.

X. Miscellaneous Provisions

A. COMMENCEMENT AND DURATION OF BENEFITS

1. Except when you are hospitalized on the date of enrollment, all benefits under the Plan begin at 12:01 AM on the enrollment effective date.
2. If you are a Hospital inpatient on the enrollment effective date, your coverage will begin on your discharge date.
3. No benefits will be provided for services rendered prior to the effective date or after coverage has ended.
4. In counting the number of days of inpatient care benefits under the Plan, the admission date will be counted but not the discharge date.
5. If you stay in a Hospital, Skilled Nursing Facility, or other facility, for your convenience after the discharge hour, you will be responsible for any additional charge.

B. RELATIONSHIP TO MEDICARE COVERAGE

As described in Section *III. Covered Benefits*, the Plan covers the Medicare Deductible and Coinsurance amounts for all services covered by Medicare Parts A and B.

If a benefit is added to the Medicare program, it will be added to the Plan on the effective date of the benefit. This is subject to the terms of the Employer Agreement between HPHC and the Plan Sponsor.

We reserve the right to discuss with Medicare whether a Medicare coverage decision has been properly made for any reason, including, but not limited to, suspected fraud. However, the Plan is not required to do so in any case.

The decision by Medicare to cover, or not to cover, a product or service, is solely up to Medicare. The Plan will not do a utilization review of any charge for which Medicare has made to provide coverage.

C. LEGAL ACTIONS

You have two years to bring legal action against HPHC. This time period starts with the initial denial of any benefit.

D. PROVIDER MALPRACTICE

The Plan will not be liable to you for the part any Provider, Hospital, or other institution or person providing health care services or supplies to you that is responsible for:

- injuries,
- loss, or
- damage resulting from:
  - negligence;
  - misfeasance;
  - malfeasance;
  - nonfeasance; or
  - malpractice.

E. ACCESS TO INFORMATION

You agree that we may have access to the following (except where restricted by law):

- all health records and medical data from Providers of Covered Benefits.
- information concerning health coverage or claims from all providers of:
  - car insurance.
  - medical payment policies.

- home-owners' insurance.
- all types of health benefit plans.

We will comply with all laws that restrict access to special types of medical information. This includes, but is not limited to, data and records for:

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

F. CONSENT TO DISCLOSURE OF MENTAL HEALTH INFORMATION

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 the Medical Necessity of mental health services will be made in consultation with a Licensed Mental Health Professional.

G. NOTICE

Mailings are sent to your last address that we have on file. They may include:

- notices;
- plan documents;
- invoices; and
- activity statements.

Be sure to let us know of an address change. This ensures mailings go to the right address.

We are not responsible for mail you don't receive, if you have not sent an address change.

Notice to HPHC should be sent to:

HPHC Member Services Department
1 Wellness Way
Canton, MA 02021

See Section *VI. Appeals and Complaints* for the addresses and phone numbers to file an appeal.

H. TERMINATION AND MODIFICATION OF THIS HANDBOOK

We may amend this EOC.

We will provide 60 days written notice to your Plan Sponsor. Your consent is not required.

Amendments do not require your consent. You will be given written notice of any material changes in covered benefits.

This EOC is the entire contract between you and the Plan. HPHC's responsibilities to you are only as stated in the EOC.

The EOC can only be modified in writing by an authorized Plan officer. No other action by us will waive or alter any part of the EOC. This includes non-enforcement of any benefit.

HPHC may terminate this EOC by giving your Plan Sponsor written notice at least 60 days before the Contract Anniversary Date or as otherwise stated in an agreement between the Plan and your Employer.

I. IN THE EVENT OF A MAJOR DISASTER

We will try to provide or arrange for services in the case of a major disaster. This might include:

- war,
- riot,
- epidemic,
- public emergency, or
- natural disaster.

Other causes include:

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

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

J. UTILIZATION REVIEW PROCEDURES

We may conduct utilization review of any product or service covered under the Plan that is not covered by Medicare. This includes a product or service which Medicare coverage has ended for any reason.

The goal of such review is to evaluate the Medical Necessity of selected health care services. It is also to assure your care is clinically appropriate and cost-effective. We use the following utilization review procedures:

- **Concurrent utilization review of admissions to Hospitals and extended care facilities, and skilled home health services**

  We review ongoing admissions for certain services. These services may be at:

  - Hospitals, including acute care Hospitals;
  - rehabilitation Hospitals;
  - Skilled Nursing Facilities; and
  - skilled home health providers.

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

  For either a decision to approve or to deny additional services, we will call your Provider within 24 hours of the decision. We will send you and you Provider a written or electronic notice within one working day.

- **Retrospective utilization review**

  We may review services in situations where coverage is requested for services that, in the Plan's judgment, may not be Medically Necessary.

To find the status of a clinical review decision call Member Services at **(888) 333-4742**.

For an adverse decision involving clinical review, your Provider may discuss your case with a physician reviewer.

Your Provider may also ask us to reconsider our decision. We will reconsider a decision within one working day of your Provider's request. If the decision is not reversed, you may appeal.

Your appeal rights are described in section *VI. Appeals and Complaints*. Your right to appeal does not depend on making a request to reconsider our decision.

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

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

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

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

L. PROCESS TO DEVELOP CLINICAL GUIDELINES AND UTILIZATION REVIEW CRITERIA

We use clinical review criteria and guidelines to make fair and consistent utilization management decisions. They are developed in according to NCQA standards.

Guidelines are reviewed (revised, if needed) at least annually. Review may occur more often to include updates in practice standards. This process applies to criteria for both physical and mental health services.

As an example, we use the nationally recognized InterQual criteria to review:

- elective surgical day procedures; and
- services provided in acute care Hospitals.

InterQual criteria are developed from current national standards of medical practice. Physicians and clinicians in academic medicine and all areas of active clinical practice provide input. InterQual criteria are reviewed and revised annually.

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

M. NEW TO MARKET DRUGS

New to market prescription drugs are reviewed by the Plan prior to coverage. This ensures that the drug is safe and effective.

New to market drugs are reviewed by HPHC's:

- Medical Policy Department;
- New Technology Assessment Committee or Pharmacy Services Department; and
- the Pharmacy and Therapeutics Committee.

The review will take place within the first 180 days of the drug entering the market. Coverage for a new to market drug may apply Prior Approval and coverage limitations.

Please Note: Not all of our Plans provide coverage for outpatient prescription drugs through HPHC. Plan's that do not have coverage for outpatient prescription drugs, cover only Medical Drugs. If your Plan covers outpatient prescription drugs with us, see your prescription drug brochure for more details.

XI. SUBSCRIBER RIGHTS & RESPONSIBILITIES

You have a right to receive information about:

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

You have a right:

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

You have a responsibility:

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

HPHC Insurance Company, Inc.

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