Harvard Pilgrim Health Care

Benefit Handbook

HMO HSA

MASSACHUSETTS

EFFECTIVE DATE: 01/01/2025
FORM #2545_11

INTRODUCTION

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

The Plan is designed to meet Internal Revenue Service rules for a "High Deductible Health Plan." You may be eligible for a Health Savings Account, (HSA) with this High Deductible Health Plan. An HSA may be used to pay for:

The words "we," "us," and "our" used in this Handbook refer to Harvard Pilgrim Health Care. (HPHC) The words "you" or "your" we are referring to Members as defined in the Glossary.

We have a network of Primary Care Providers (PCPs), specialists, and other providers who will provide or arrange for the service you receive. You choose a PCP for yourself and each of your family members when you join the Plan.

Your Covered Benefits are described in this Handbook, the Schedule of Benefits, the Prescription Drug Brochure and any riders or amendments to those documents. Services under the Plan must be provided or arranged by your PCP, except as described in section *I.D.1. Your PCP Manages Your Health Care*.

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.

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

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

- benefits,
- Member Cost Sharing,
- claims history,
- Deductible status, and
- Prior Approvals and Referrals.

You can also learn how your Plan covers preventive care and conditions such as asthma, diabetes, COPD and high blood pressure.

You can use the cost transparency tool to compare cost and quality on many types of services, including surgical procedures and office visits. This tool provides estimated costs only. Your Member Cost Sharing may be different.

To use the tools and resources online, visit **www.harvardpilgrim.org** and select the Member Login button. First time users must create an account and then log in. After you log in, click on the "Tools and Resources" link from your Member dashboard. Look for the Estimate My Cost Link to get to the cost transparency tool.

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 Member 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 certain 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 any questions, call Member Services at **1-888-333-4742** if you have any questions. Member Services staff can help you with questions about the following:

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

We can help with questions from non-English speaking Members. We offer language interpretation services in more than 180 languages.

Deaf and hard-of-hearing Members who use a Teletypewriter (TTY) may communicate with the Member Services at **711** for TTY service.

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

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

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

Health Policy Commission
Office of Patient Protection
50 Milk Street, 8th Floor
Boston, MA 02109
Telephone: 1-800-436-7757
Fax: 1-617-624-5046
HPC-OPP@state.ma.us
http://www.masshpc.gov/OPP

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

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

Medical Necessity Guidelines. We use evidence based clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. To get Medical Necessity Guidelines, you or your Provider may call Member Services at **1-888-333-4742** or go to **www.harvardpilgrim.org**.

Exclusions or Limitations for Preexisting Conditions. The Plan has no pre-existing 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) ប្រសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាកម្មបកប្រែ ជូនលោកអ្នកដោយ គិតថ្លៃ។ 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. How the Plan Works

This section describes:

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

A. HOW TO USE THIS BENEFIT HANDBOOK

1. Why This Benefit Handbook Is Important

This Benefit Handbook, the Schedule of Benefits, the Prescription Drug Brochure and any applicable riders and amendments make up the Evidence of Coverage (EOC). The EOC is the legal agreement stating the terms of the Plan. The EOC also incorporates by reference an Employer Agreement issued to your Employer, The Employer Agreement includes information on Dependent eligibility. Please contact your Employer for more information on eligibility.

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

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

You can view your EOC documents online with **your secure online account** at **www.harvardpilgrim.org**.

2. Words With Special Meaning

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

3. How To Find What You Need To Know

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

We put the most important information first. For example, section *I. How the Plan Works* explains important requirements for coverage.

Benefit details are described in section *III. Covered Benefits* and are in your Schedule of Benefits. Please 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.

B. HOW TO USE YOUR PROVIDER DIRECTORY

The Provider Directory identifies the Plan's PCPs, specialists, hospitals and other providers you must use for most services. Providers are listed by:

- state and town,
- specialty, and
- languages spoken.

You can view the Provider Directory online at **www.harvardpilgrim.org**. Call Member Services at **1-888-333-4742** to get a free copy of the Provider Directory.

You can search the online Provider Directory for Plan Providers by:

- name,
- gender,
- specialty,
- hospital affiliations,
- languages spoken, and
- office locations.

You can also get information about which Plan Providers are accepting new patients. The online directory is updated according to state and Federal laws. As a result, it is more current than the paper directory.

A physician profiling site is maintained by the Commonwealth of Massachusetts Board of Registration in Medicine. You may access the site at **www.mass.gov/orgs/board-of-registration-in-medicine**.

Please Note: Plan Providers are contracted to be part of our network Contracts can be terminated either by a provider or by us. A Plan Provider may also leave the network to retire, relocate or for other reasons. This means that we cannot guarantee that your Plan Provider will be in the network for the duration of your membership.

If your PCP leaves the network, we will make every effort to give you at least 30 days notice. We will help you find a new Plan Provider. Under certain circumstances you may be eligible for transition services if your provider leaves the network. Please see section *I.F. SERVICES PROVIDED BY A DISENROLLED OR NON-PLAN PROVIDER* for details.

C. MEMBER OBLIGATIONS

1. Choose a Primary Care Provider (PCP)

Under this Plan you must choose a Primary Care Provider (PCP) for yourself and each covered person in your family. You may choose a different PCP for each family member. We will assign a PCP if:

- you do not choose a PCP when you first enroll, or
- the PCP you select is not available.

A PCP may be a physician, a physician assistant or a nurse practitioner. A PCP may specialize in one or more of the following:

- internal medicine,
- adult medicine,
- adolescent medicine,
- geriatric medicine,
- pediatrics,
- family practice, or
- gynecology and reproductive health.

PCP's are listed in the Provider Directory on our website.You may call Member Services to confirm that the PCP you choose is available.

We suggest calling your PCP for an appointment if you have not seen him/her before. **Please do not wait until you are sick.** Your PCP can take better care of you when he or she knows your health history.

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

2. Obtain Referrals to Specialists

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

If you need to see a specialist, you must contact your PCP for a Referral before your appointment. In most cases, you will be referred to a Plan Provider who:

- is affiliated with the same hospital as your PCP, or
- has a working relationship with your PCP.

Referrals to Plan Providers must be in writing.

3. Show Your Identification Card

Please show your identification (ID) card every time you request health services. If you do not show your ID card, the Provider may not bill us for Covered Benefits. You may be responsible for the cost of the service. You can order a new ID card online Log in to**www.harvardpilgrim.org** or call the Member Services.

4. Share Costs

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

- Copayments
- Coinsurance
- Deductibles

Your Plan has an Out-of-Pocket Maximum. This limits the amount of Member Cost Sharing you will be required to pay. Your specific Member Cost Sharing is listed in your Schedule of Benefits. See section *I.E. MEMBER COST SHARING* for more information.

5. Your Plan Does Not Pay for All Health Services

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

D. HOW TO OBTAIN CARE

IMPORTANT POINTS TO REMEMBER

1) You and each Member of your family must select a PCP.
2) To receive Covered Benefits you must use Plan Providers, except as noted below.
3) If you need care from a specialist, you must contact your PCP for a Referral. See *I.D.8. Services That Do Not Require a Referral* for exceptions.
4) In the event of a Medical Emergency, you should go to the nearest emergency facility or call 911 (or other local emergency number). You do not need a Referral for Medical Emergency Services.

1. Your PCP Manages Your Health Care

When you need care, call your PCP. Most services must be provided or arranged by your PCP. The only exceptions are:

- Care in a Medical Emergency.
- Care when you are temporarily traveling outside of the state you live in. See section *I.D.7. Coverage*

for Services When You Are Temporarily Traveling Outside of the State Where You Live.

- Mental health care. See section *III. Covered Benefits, Mental Health and Substance Use Disorder Treatment* for more information .
- Special services that do not require a Referral that are listed in section *I.D.8. Services That Do Not Require a Referral*.

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

You may change your PCP at any time. Choose a new PCP from the Provider Directory. You can change your PCP online. Go to **your secure online account** or call Member Services. The change is effective immediately. If you choose a new PCP, you cannot use the Referrals from your prior PCP. Your new PCP will need provide new Referrals.

2. Referrals for Hospital and Specialty Care

When you need hospital or specialty care, you must call your PCP first, Your PCP will arrange your care. Your PCP generally uses one hospital for inpatient care. This is where you will go for care. There is an exception if going to a different hospital is Medically Necessary.

You may need specialty care. Your PCP will refer you to a Plan Provider who uses the same hospital your PCP uses. This helps your PCP coordinate and maintain the quality of your care. Please ask your PCP about his/her Referral network.

If the services you need are not available in your PCP's referral network, your PCP may refer you to any Plan Provider. We can help you or your PCP find a Plan Provider. Call Member Services for help finding a medical, mental health or substance use disorder treatment provider. If there is no Plan Provider who can meet your medical needs, we will help you find a Non-Plan Provider. Prior Approval will be required in order to receive services from a Non-Plan Provider.

Plan Providers with recognized expertise in specialty pediatrics are covered with a Referral from your PCP.

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

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

You will be directed to a Center of Excellence for certain specialized services. See section *I.D.5. Centers of Excellence* for more information.

You do not need to ask your PCP to receive some specialty services. See section *I.D.8. Services That Do Not Require a Referral*.

3. Using Plan Providers

Under this Plan, you must get Covered Benefits from a Plan Provider Covered Benefits from a provider who is not a Plan Provider are covered only if one of the following exceptions applies:

1) The service was received in a Medical Emergency. See section *I.D.6. Medical Emergency Services* for information.
2) The service was received (i) while you were outside of the state where you live, and (ii) coverage included under the temporary travel benefit. See section *I.D.7. Coverage for Services When You Are Temporarily Traveling Outside of the State Where You Live* for more information.
3) There is no Plan Provider who has the professional expertise needed to provide the Medically Necessary Covered Benefit. Unless 1) or 2) above applies,, services by a Non-Plan Provider must be approved by us in advance .
4) An exception applies as described in section *I.F. SERVICES PROVIDED BY A DISENROLLED OR NON-PLAN PROVIDER* because: (i) your physician is disenrolled as a Plan Provider; or (ii) you are a new Plan Member.

Please Note: A Surprise Bill is an unexpected bill received from a Non-Plan Provider, that you did not knowingly select, who provided services to you while you were receiving covered services from a Plan Provider or facility. If you receive a Surprise Bill, you are only responsible for the applicable Member Cost Sharing that would apply if the covered service was provided by a Plan Provider, unless you had a reasonable opportunity to choose to have the service performed by a Plan Provider.

To check a providers status, see the Provider Directory online at **www.harvardpilgrim.org** or call our Member Services at **1-888-333-4742**.

4. Flex Providers
Some Plans may include Flex Providers. A Flex Provider is a Plan Provider that provides certain outpatient services with lower Member Cost Sharing. Your costs will be lower if you choose to go to a Flex Provider for these services.

✔ FOR EXAMPLE: If your Plan includes Flex Providers and you go to an outpatient surgical center designated as a Flex Provider, your Member Cost Sharing will be less than if you went to a hospital surgical center that is not a Flex Provider.

If your Plan includes Flex Providers, your Schedule of Benefits will list the Member Cost Sharing amounts for both Plan Providers and Flex Providers under the applicable outpatient Covered Benefits.

If your Plan includes Flex Providers, they will be listed in your Provider Directory. For a complete list of Plan Providers, please see your Provider Directory which may be found at **www.harvardpilgrim.org**.

5. Centers of Excellence
Plan Providers with special training, experience, facilities or protocols for certain specialized services are designated as "Centers of Excellence." Certain specialized services are only covered when received from a Centers of Excellence. We choose Centers of Excellence based on the findings of recognized specialty organizations or government agencies such as Medicare.

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

- Weight loss surgery (bariatric surgery)

Important Notice: There is no coverage for the service listed above unless it is received from a Center of Excellence.

A list of Centers of Excellence may be found in the Provider Directory. See your Provider Directory online at **www.harvardpilgrim.org** or call Member Services at **1-888-333-4742**.

We may change the list of services that must be received from a Center of Excellence with 30 days' notice.

- Services may be added to the list if we determine that significant improvements in the quality of care may be gained by having care at a Center of Excellence.
- Services may be removed from the list if we determine that the care advantages of a Center of Excellence no longer exist.

6. Medical Emergency Services
In a Medical Emergency, including an emergency related to a substance use disorder or mental health condition, you should go to the nearest emergency facility or call 911 (or other local emergency number). A Referral from your PCP is not needed. See your Schedule of Benefits for your Member Cost Sharing. If you are admitted to the hospital, you must call the Plan at **1-888-333-4742** within 48 hours or as soon as you can. This telephone number is on your ID card. If an attending emergency physician contacts us or your PCP, then no further notice is needed. Your PCP will help to arrange for any follow-up care you may need. See the *Glossary* for more information on Medical Emergency Services.

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

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

If you are admitted to the hospital, call the Plan at **1-888-333-4742** within 48 hours, or as soon as you can. This telephone number is on your ID card. If an attending emergency physician contacts us or your PCP, then no further notice is needed. Your PCP will help to arrange for any follow-up care you may need.

You must file a claim whenever you obtain services from a Non-Plan Provider. See section *V. Reimbursement and Claims Procedures* . Member Cost Sharing amounts will apply as listed in your Schedule of Benefits.

8. Services That Do Not Require a Referral
In most cases you need a Referral from your PCP to get care from any other Plan Provider. However, the services listed below do not require a referral when received from a Plan Provider. Plan Providers are listed in the Provider Directory. We urge you to keep your PCP informed about care you get without a referral. This ensures your PCP is aware of your

medical situation and keeps your medical records up-to-date.

i. Family Planning Services:

- Contraceptive monitoring
- Family planning consultation, including pregnancy testing
- Tubal ligation (if a covered benefit - Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.)
- Voluntary termination of pregnancy (if a covered benefit - Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.

ii. Outpatient Maternity Services

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

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

iii. Gynecological Services

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

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

iv. Dental Services:

- Emergency Dental Care
- Extraction of teeth impacted in bone
- Pediatric dental services (if a covered benefit - Please see your Schedule of Benefits and any associated riders to determine if your Plan provides coverage for this benefit.)

v. Other Services:

- Acupuncture treatment (if a covered benefit - Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.)
- Nutritional counseling
- Spinal manipulative therapy
- Routine eye examination
- Urgent Care services

E. MEMBER COST SHARING

Member Cost Sharing may include Copayments, Coinsurance and/or Deductible amounts. See your Schedule of Benefits for your specific Cost Sharing amounts. There may be two types of office visit cost sharing that apply to your Plan:

- a lower cost sharing known as "Level 1" and
- a higher cost sharing known as "Level 2."

Please Note: If you receive a Surprise Bill, you are only responsible for the Member Cost Sharing that would apply if the covered service was provided by a Plan Provider.

1. Copayment

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

Your Plan may have other Copayment amounts. See your Schedule of Benefits for more information on your specific Copayments.

2. Deductible

A Deductible is a specific dollar amount that is paid by a Member for Covered Benefits received each Plan Year or Calendar Year. Please see your Schedule of Benefits to see which type of year 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.

Your Plan will have one of the following types of Deductibles:

Individual Deductible An Individual Deductible will apply when you have Individual Coverage. Once you have met the individual Deductible, you will have no additional Deductible costs for the rest of the Plan Year

or Calendar Year. Note: An individual Deductible may also apply if you have Family Coverage. See Family Deductible with an embedded individual Deductible below.

Family Deductible A family Deductible applies when you have Family Coverage. This Deductible may be met by all family Members combined. For example, a family of four meets a $4,000 family Deductible as follows:

- one covered family Member incurs $3,000 in covered medical expenses, and
- another covered family Member incurs $1,000 in covered medical expenses.

In this example, the family Deductible is met for the entire family for the rest of that Plan Year or Calendar Year.

Family Deductible with an embedded individual Deductible A family Deductible with an embedded individual Deductible applies when you have Family Coverage. This Deductible can be met in one of two ways:

a. A Member of a covered family meets an individual Deductible. In this instance, that Member has no additional Deductible costs for the rest of the Plan Year or Calendar Year.

b. Any number of Members in a covered family collectively meet the family Deductible. In this instance, all Members of a covered family have no additional Deductible costs for Covered Benefits for the remainder of the Plan Year or Calendar Year. No one family member may contribute more than the individual Deductible amount to the family Deductible.

An embedded individual Deductible cannot be less than the minimum family Deductible required for a High Deductible Health Plan.

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

A Member may change from Family Coverage to Individual Coverage or from Individual Coverage to Family Coverage within a Plan Year or Calendar Year. In either case, costs the Member paid toward the Deductible under the prior coverage will apply toward the Deductible limit under their new coverage. If the previously paid Deductible amount is more than the new Deductible limit, the Member or family will need to pay the Copayment or Coinsurance amounts listed on the new Schedule of Benefits.

3. Coinsurance

After the your Deductible is met, you may have to pay Coinsurance, Coinsurance is a percentage of the Allowed Amount or the Recognized Amount, if applicable. For Plan Providers, the Allowed Amount is based on the contracted rate between HPHC and the Provider. Coinsurance amounts are listed on your Schedule of Benefits.

4. Out-of-Pocket Maximum

Your Plan has an Out-of-Pocket Maximum. This is the total amount of Member Cost Sharing you must pay in a Plan Year or Calendar Year. Member Cost Sharing includes any Copayments, Deductible and Coinsurance payments.

Once the Out-of-Pocket Maximum is reached, there is no additional Member Cost Sharing for the rest of the year.HPHC will pay 100% of the Allowed Amount for the remainder of the Plan Year or Calendar Year.

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

Individual Out-of-Pocket Maximum An individual Out-of-Pocket Maximum applies when you have Individual Coverage. Once you meet the individual Out-of-Pocket Maximum, you will have no additional Member Cost Sharing for the rest of the Plan Year or Calendar Year. Note: An individual Out-of-Pocket Maximum may also apply if you have Family Coverage. See Family Out-of-Pocket Maximum below.

Family Out-of-Pocket Maximum A family Out-of-Pocket Maximum applies when you have Family Coverage. A family Out-of-Pocket Maximum can be met by all Members of the family combined. For example, a family of four meets a $10,000 family Out-of-Pocket Maximum as follows:

- one covered family Member pays $5,000 in Member Cost Sharing; and.
- another family Member pays $3,000 in Member Cost Sharing; and
- another covered family Member pays $2,000 in Member Cost Sharing.

In this example, the $10,000 family Out-of-Pocket Maximum is met for the entire family for the rest of the Plan Year or Calendar Year.

Family Out-of-Pocket Maximum with an embedded individual Out-of-Pocket Maximum This family Out-of-Pocket Maximum may apply when you have Family Coverage. It can be met in one of two ways:

a. A Member of a covered family meets an individual Out-of-Pocket Maximum. In this case, the Member has no additional Member Cost Sharing for the rest of the Plan Year or Calendar Year.

b. Any number of Members in a covered family collectively meet the family Out-of-Pocket Maximum. In this case, all Members of the covered family have no additional Member Cost Sharing for the rest of the Plan Year or Calendar Year. Note: No one family member may contribute more than the individual embedded Out-of-Pocket Maximum amount toward the family Out-of-Pocket Maximum.

Please see your Schedule of Benefits to determine which Out-of-Pocket Maximum applies to your Plan.

A Member may change from Family Coverage to Individual Coverage or from Individual Coverage to Family Coverage within a Plan Year or Calendar Year. In either case, costs the Member paid toward the Out-of-Pocket Maximum limit under their new coverage. If the incurred Out-of-Pocket Maximum amount paid is greater than the new Out-of-Pocket Maximum limit, the Member will have no additional cost sharing for that Plan Year or Calendar Year.

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

1. Disenrollment of Primary Care Provider (PCP)

If your PCP is disenrolled as a Plan Provider , we will do our best to notify you in writing at least 30 days prior to the date of disenrollment. That notice will explain how to select a new PCP. If disenrollment was not related to fraud or quality of care, you may be able to continue to receive Covered Benefits from the disenrolled PCP. Coverage will continue, for at least 30 days after the disenrollment date. The terms of this Handbook and your Schedule of Benefits apply.

2. Disenrollment of other Plan Providers (other than your PCP)

When a provider you are receiving services from is disenrolled as a Plan Provider, you may be able to continue to receive Covered Benefits from that provider.

If disenrollment was not related to fraud or quality of care, you may be eligible to continue coverage from the disenrollment date or the date of disenrollment member notice (whichever is later). Only the following are eligible for this coverage:

a. **Active Course of Treatment**

Except for pregnancy and terminal illness as described below, if you are undergoing an active course of treatment for an illness, injury or condition, we may approve additional coverage through the active course of treatment or up to 90 days, (whichever is shorter). An active course of treatment includes when a member has a "serious and complex condition", is currently undergoing a course of institutional or inpatient care, or has scheduled nonelective surgery including any related postoperative care.

The term "serious and complex condition" is an acute illness that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or is a chronic illness that is (a) life-threatening, degenerative, potentially disabling, or congenital; and (b) requires specialized medical care over a prolonged period of time.

b. **Pregnancy**

If you are pregnant, you may continue to receive coverage for services from your disenrolled provider. Coverage will be through delivery and up to 6 weeks of postpartum visits immediately following childbirth.

c. **Terminal Illness**

If you have a terminal illness, you may continue to receive coverage for services from the disenrolled provider until death.

3. New Membership

If you are a new Member, we will provide coverage for services from a physician who is not a Plan Provider. The terms of this Handbook and your Schedule of Benefits apply. This will be provided for up to 30 days from your effective date of coverage if :

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

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

4. Conditions for Coverage of Services by a Disenrolled or Non-Plan Provider

Services received from a disenrolled or Non-Plan Provider as described above, are only covered when the physician agrees to:

- accept reimbursement from us at the rates applicable prior to notice of disenrollment as payment in full.
- not to impose Member Cost Sharing in an amount that would exceed the amount that could have been imposed if the he/she had not been disenrolled.
- adhere to the quality assurance standards of the Plan.
- provide us with necessary medical information related to the care provided.
- adhere to our policies and procedures, including Referrals, obtaining Prior Approval and providing Covered Benefits pursuant to a treatment plan, if any, approved by us.

G. MEDICAL NECESSITY GUIDELINES

We use evidence based clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for your care. You or your Provider may obtain a copy of the Medical Necessity Guidelines applicable to a service or procedure for which coverage is requested. Medical Necessity Guidelines may be obtained by calling Member Services at **1-888-333-4742** or going to **www.harvardpilgrim.org**.

H. PROVIDER FEES FOR SPECIAL SERVICES (CONCIERGE SERVICES)

Certain physician practices charge extra fees for special services or amenities. Examples of such special physician services might include:

- telephone access to a physician 24-hours a day.
- waiting room amenities.
- assistance with transportation to medical appointments.
- guaranteed same day or next day appointments when not Medically Necessary.
- providing a physician to accompany a patient to an appointment with a specialist. Such services are not covered by the Plan.

Such services are not covered by the Plan. The Plan does not cover fees for any service not included as a Covered Benefit under your Plan.

In considering arrangements with physicians for special services, you should understand exactly what services are to be provided. You will need to decide if these services are worth the fee you must pay. For example, the Plan does not require participating providers to be available by telephone 24-hours a day. However, the Plan does require PCPs to provide both an answering service that can be contacted 24-hours a day and prompt appointments when Medically Necessary.

I. BUNDLED PAYMENT ARRANGEMENTS

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

J. CARE MANAGEMENT PROGRAMS

The Plan provides care management programs for Members with certain illnesses and injuries. These programs are designed to encourage the use of the most appropriate and cost-effective treatment and to provide support for the Member's care.

Care management may include programs for medical and behavioral health care including, but not limited to:

- cancer;
- heart, lung and kidney diseases;
- severe traumatic injuries;
- behavioral health disorders;
- substance use disorders;
- high risk pregnancies and newborn care.

The Plan may work with certain providers to establish care management programs. The Plan or providers affiliated with the care management program may and contact Members that may be candidates for its programs. The Plan or providers may also contact Members to:

- assist with enrollment.

- develop treatment plans.
- establish goals.
- determine alternatives to a member's current treatment plan.

Member Cost Sharing may apply to. Covered Benefits provided through a care management program.

II. Glossary

This section lists words with special meaning within the Handbook.

Glossary Term	Definition
1 . Activities of Daily Living	
	The basic functions of daily life include bathing, dressing, and mobility, including, but not limited to, transferring from bed to chair and back, walking, sleeping, eating, taking medications and using the toilet.
2 . Acute Treatment Services	
	24-hour medically supervised addiction treatment for adults or adolescents provided in a medically managed or medically monitored inpatient facility, as defined by the Massachusetts Department of Public Health. Acute Treatment Services provide evaluation and withdrawal management and may include biopsychological assessment, individual and group counseling, psychoeducational groups and discharge planning.
3 . Allowed Amount	
	The Allowed Amount is the maximum amount the Plan will pay for Covered Benefits minus any applicable Member Cost Sharing. The Allowed Amount depends upon whether a Covered Benefit is provided by a Plan Provider or a Non-Plan Provider, as follows: 1. Plan Providers. If a Covered Benefit is provided by a Plan Provider, the Allowed Amount is the contracted rate HPHC has agreed to pay Plan Providers. The Plan Providers are not permitted to charge the Member any amount for Covered Benefits, except the applicable Member Cost Sharing amount for the service, in addition to the Allowed Amount. 2. Non-Plan Providers. Most services that are Covered Benefits under your Plan must be provided by a Plan Provider to be covered by HPHC. However, there are exceptions. These include: (i) care in a Medical Emergency; and (ii) care while traveling outside of the state where you live. If services provided by a Non-Plan Provider are Covered Benefits under your Plan, the Allowed Amount for such services depends upon where the Member receives the service, as explained below. a. If a Member receives Covered Benefits from a Non-Plan Provider in the states of Massachusetts, New Hampshire, Maine, Rhode Island, or Vermont, the Allowed Amount is defined as follows: The Allowed Amount is the lower of the Provider's charge or a rate determined as described below: An amount that is consistent, in the judgment of the Plan, with the normal range of charges by health care Providers for the same, or similar, products or services provided to a Member. If the Plan has appropriate data for the area, the Plan will determine the normal range of charges in the geographic area where the product or services were provided to the Member. If the Plan does not have data to reasonably determine the normal range of charges where the products or services were provided, the Plan will utilize the normal range of charges in Boston, Massachusetts. Where services are provided by non-physicians but the data on provider charges available to the Plan is based on charges for services by physicians, the Plan will, in its discretion, make reasonable reductions in its determination of the allowable charge for such non-physician Providers. b. If a Member receives Covered Benefits from a Non-Plan Provider outside of Massachusetts, New Hampshire, Maine, Rhode Island, or Vermont, the Allowed Amount is defined as follows:

Glossary Term	Definition
Allowed Amount (Continued)	
	The Allowed Amount is the lower of the Provider's charge or a rate determined as described below: The Allowed Amount is determined based on 150% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market. When a rate is not published by CMS for the service, we use other industry standard methodologies to determine the Allowed Amount for the service as follows: For services other than Pharmaceutical Products, we use a methodology called a relative value scale, which is based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by Optuminsight, Inc. If the Optuminsight, Inc. relative value scale becomes no longer available, a comparable scale will be used. For Pharmaceutical Products, we use industry standard methodologies that are similar to the pricing methodology used by CMS and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource. When a rate is not published by CMS for the service and no industry standard methodology applies to the service, or the provider does not submit sufficient information on the claim to pay it under CMS published rates or an industry standard methodology, the Allowed Amount will be 50% of the provider's billed charge, except that the Allowed Amount for certain mental health and substance use disorder treatment will be 80% of the billed charge. Pricing of the Allowed Amount will be conducted by UnitedHealthcare, Inc. United Healthcare, updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data. As stated above, the Allowed Amount is the maximum amount the Plan will pay for Covered Benefits minus any applicable Member Cost Sharing. Most Non-Plan Providers are permitted to charge amounts for Covered Benefits in excess of the Allowed Amount. In that event, the Plan is responsible for payment of the Allowed Amount, minus any applicable Member Cost Sharing. The Member is responsible for paying the applicable Member Cost Sharing amount and any additional amount charged by the Non-Plan Provider above the Allowed Amount.
4 . Anniversary Date	
	The date agreed to by HPHC and your Employer Group upon which the yearly Employer Group premium rate is adjusted and benefit changes normally become effective. The EOC and the Employer Group agreement will terminate unless renewed on the Anniversary Date. **For Example:** If your Anniversary Date is January 1st, this is the date when the Plan goes into effect and begins to pay for Covered Benefits.
5 . 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.

Glossary Term	Definition
6 . Benefit Limit	
	The day, visit or dollar limit maximum that applies to certain Covered Benefits, up to the Allowed Amount, or Recognized Amount, if applicable. Once the Benefit Limit has been reached, no more benefits will be paid for such services or supplies. If you exceed the Benefit Limit, you are responsible for all charges incurred. The Benefit Limits applicable to your Plan are listed in your Schedule of Benefits. **For Example:** If your Plan offers 30 visits per Plan Year or Calendar Year for physical therapy services, once you reach your 30 visit limit for that Plan Year or Calendar Year, no additional benefits for that service will be covered by the Plan.
7 . Calendar Year	
	The one-year period beginning on January 1 for which benefits are purchased and administered. Benefits for which limited yearly coverage is provided renew at the beginning of the Calendar Year. Benefits for which limited coverage is provided every two years renew at the beginning of every second Calendar Year. Benefits under your Plan are administered on either a Plan Year or Calendar Year basis. Please see your Schedule of Benefits to determine which type of year your Plan utilizes.
8 . Centers of Excellence	
	Certain specialized services are only covered when received from designated providers with special training, experience, facilities or protocols for the service. Centers of Excellence are selected by us based on the findings of recognized specialty organizations or government agencies such as Medicare.
9 . Clinical Stabilization Services	
	24-hour clinically managed post detoxification treatment for adults or adolescents, as defined by the Massachusetts Department of Public Health. Clinical Stabilization Services usually follow Acute Treatment Services for substance use disorders. Clinical Stabilization Services may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others and after care planning, for individuals beginning to engage in recovery from addiction.
10 . Coinsurance	
	A percentage of the Allowed Amount, or Recognized Amount, if applicable, for certain Covered Benefits that must be paid by the Member. Coinsurance amounts applicable to your Plan are stated in your Schedule of Benefits. **For Example:** If the Coinsurance for a service is 20%, you pay 20% of the Allowed Amount while we pay the remaining 80%.
11 . Copayment	
	A fixed dollar amount you must pay for certain Covered Benefits. The Copayment is usually due at the time services are rendered or when billed by the provider. **For Example:** If your Plan has a $20 Copayment for outpatient visits, you'll pay $20 at the time of the visit or when you are billed by the provider.
12 . Cosmetic Services	
	Cosmetic Services are surgery, procedures or treatments that are performed primarily to reshape or improve the individual's appearance.
13 . Covered Benefit(s)	
	The products and services that a Member is eligible to receive, or obtain payment for, under the Plan.

Glossary Term	Definition
14 . Custodial Care	
	Services provided to a person for the primary purpose of meeting non-medical personal needs (e.g., bathing, dressing, preparing meals, including special diets, taking medication, assisting with mobility).
15 . Deductible	
	A specific dollar amount that is payable by a Member for Covered Benefits received each Plan Year or Calendar Year before any benefits subject to the Deductible are payable by the Plan. There may be an individual Deductible and a family Deductible, and you may have different Deductibles that apply to different Covered Benefits under your Plan. If a family Deductible applies to your Plan, it will be stated in the Schedule of Benefits. **For Example:** If your Plan has a $500 Deductible and you have a claim with the Allowed Amount of $1,000, you will be responsible for the first $500 to satisfy your Deductible requirement before the Plan begins to pay benefits.
16 . Dental Care	
	Any service provided by a licensed dentist involving the diagnosis or treatment of any disease, pain, injury, deformity or other condition of the human teeth, alveolar process, gums, jaw or associated structures of the mouth. However, surgery performed by an oral maxillofacial surgeon to correct positioning of the bones of the jaw (orthognathic surgery) is not considered Dental Care within the meaning of this definition.
17 . Dependent	
	A Member of the Subscriber's family who (1) meets the eligibility requirements for coverage through a Subscriber and (2) is enrolled in the Plan.
18 . Employer Group or Employer	
	An organization that has contracted with us to provide health care coverage for its employees under the Plan.
19 . Enrollment Area	
	The geographic area in which you must live in order to be eligible to enroll as a Member under the Plan. The Enrollment Area includes the states of Maine, Massachusetts, New Hampshire and Rhode Island, and certain areas in Connecticut, New York and Vermont.
20 . Evidence of Coverage (EOC)	
	The legal documents, including the Benefit Handbook, Schedule of Benefits, Prescription Drug Brochure, and any applicable riders and amendments which describe the services covered by the Plan, and other terms and conditions of coverage.
21 . Experimental, Unproven, or Investigational	
	Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests, will be deemed Experimental, Unproven, or Investigational by us under this Benefit Handbook for use in the diagnosis or treatment of a particular medical condition if any the following is true: (a) The product or service is not recognized in accordance with generally accepted medical standards as being safe and effective for the use in the evaluation or treatment of the condition in question. In determining whether a service has been recognized as safe or effective in accordance with generally accepted evidence-based medical standards, primary reliance will be placed upon data from published reports in authoritative medical or scientific publications that are subject to established peer review by qualified medical or scientific experts prior to publication. In the absence of any such reports, it will generally be determined a service, procedure, device or drug is not safe and effective for the use in question Please Note: Autologous bone marrow transplants for the treatment of breast cancer, as required by law, are not considered Experimental or Unproven when they satisfy the criteria

Glossary Term	Definition
Experimental, Unproven, or Investigational (Continued)	
	identified by the Massachusetts Department of Public Health. (b) In the case of a drug, the drug has not been approved by the United States Food and Drug Administration (FDA) (this does not include off-label uses of FDA approved drugs) or if approved for lawful marketing by the FDA and reliable scientific evidence does not support that the treatment is effective in improving health outcomes or that appropriate patient selection has not been determined. (c) For purposes of the treatment of infertility only, the service, procedure, drug or device has not been recognized as a "non-experimental infertility procedure" under the Massachusetts Infertility Benefit Regulations at 211 CMR Section 37.00 et. seq.
22 . Family Coverage	
	Coverage for a Member and one or more Dependents.
23 . Flex Provider	
	An outpatient provider that provides certain Covered Benefits with lower Member Cost Sharing. When you receive certain Covered Benefits from a Flex Provider you will pay a lower Member Cost Sharing amount than if you received the same Covered Benefits from a provider that is not a Flex Provider. If your Plan includes Flex Providers, they will be listed in your Provider Directory. For a complete list of Plan Providers, please see your Provider Directory which may be found at **www.harvardpilgrim.org**.
24 . Habilitation Services	
	Health care services that help a person keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapies and speech-language services.
25 . Harvard Pilgrim Health Care, Inc. (HPHC)	
	Harvard Pilgrim Health Care, Inc. is a Massachusetts corporation that is licensed as a Health Maintenance Organization (HMO) in the state of Massachusetts. HPHC provides or arranges for health care benefits to Members through a network of Primary Care Providers, specialists and other providers.
26 . Health Savings Account or HSA	
	A tax-exempt trust or custodial account, similar to an individual retirement account (IRA), but established to pay qualified medical expenses. In order to establish a Health Savings Account an individual must (1) be covered under a High Deductible Health Plan during the months in which contributions are made to the account, (2) not be covered by any other health plan that is not a High Deductible Health Plan (with certain limited exceptions established by law), (3) not be entitled to Medicare benefits, and (4) not be claimed as a dependent on another person's tax return. Members should consult a qualified tax advisor before establishing a Health Savings Account.
27 . High Deductible Health Plan	
	A health care plan that meets the requirements of Section 223 of the Internal Revenue Code with respect to Deductibles and Out-of-Pocket Maximums. A person who is enrolled in a High Deductible Health Plan and meets other requirements stated in that law may establish a Health Savings Account (or HSA) for the purpose of paying qualified medical expenses.
28 . Individual Coverage	
	Coverage for a Subscriber only. No coverage for Dependents is provided.

Glossary Term	Definition
29 . 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 the Plan.
30 . Medical Drugs	
	A prescription drug that is administered to you either (1) in a doctor's office or other outpatient medical facility, or (2) at home while you are receiving home health care services or receiving drugs administered by home infusion services. Medical Drugs cannot be self-administered. The words "cannot be self-administered" mean that the active participation of skilled medical personnel is always required to take the drug. When a Member is receiving drugs in the home, the words "cannot be self-administered" will also include circumstances in which a family member or friend is trained to administer the drug and ongoing supervision by skilled medical personnel is required.
31 . Medical Emergency	
	A medical condition, whether physical or behavioral health (including a condition resulting from a substance use disorder), manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the Member or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part. With respect to a pregnant woman who is having contractions, Medical Emergency also means that there is inadequate time to effect a safe transfer to another hospital before delivery or that transfer may pose a threat to the health or safety of the woman or the unborn child. Examples of Medical Emergencies are: heart attack or suspected heart attack, stroke, shock, major blood loss, choking, severe head trauma, loss of consciousness, seizures and convulsions.

Glossary Term	Definition
32 . Medically Necessary or Medical Necessity	
	Those health care services that are consistent with generally accepted principles of professional medical practice as determined by whether: (a) the service is the most appropriate supply or level of service for the Member's condition, considering the potential benefit and harm to the individual; (b) the service is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; and, (c) for services and interventions that are not widely used, the use of the service for the Member's condition is based on scientific evidence. To determine coverage of Medically Necessary services, we use Medical Necessity Guidelines (MNG) created using clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of the Medical Necessity Guideline(s) applicable to a service or procedure for which coverage is requested by going online or calling Member Services at **1-888-333-4742**.
33 . Medical Emergency Services	
	Services provided during a Medical Emergency, including: • A medical screening examination (as required under section 1867 of the Social Security Act or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital, or an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Medical Emergency, and • Further medical examination and treatment, within the capabilities of the staff and facilities available at the hospital or independent freestanding emergency department, as applicable, as are required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further exam or treatment is provided). • Items and services, otherwise covered under the Plan, that are provided by a Non-Plan Provider or facility (regardless of the department of the hospital in which the items and services are provided) after the Member is stabilized and as part of an inpatient stay or outpatient services that are connected to the original Medical Emergency, unless each of the following conditions are met: a. The Provider or facility, as described above, determines the Member is able to travel using non-medical transportation or non-emergency medical transportation. b. The Provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law. c. The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law. d. Any other conditions as specified by the Secretary.
34 . Member	
	Any Subscriber or Dependent covered under the Plan.

Glossary Term	Definition
35 . Member Cost Sharing	
	The responsibility of Members to assume a share of the cost of the benefits provided under the Plan. Member Cost Sharing may include Copayments, Coinsurance and Deductibles. Please refer to your Schedule of Benefits for the specific Member Cost Sharing that applies to your Plan. There may be two types of office visit cost sharing that apply to your Plan: a lower cost sharing known as "Level 1" and a higher cost sharing known as "Level 2."
36 . Network	
	Providers of health care services, including but not limited to, physicians, hospitals and other health care facilities that are under contract with us to provide services to Members.
37 . Non-Plan Provider	
	Providers of health care services that are not under contract with us to provide care to Members.
38 . Out-of-Network Rate	
	With respect to a Surprise Bill, the total amount paid by the Plan to a Non-Plan Provider for Covered Benefits under section 2799A-1 and 2799A-2 of the Public Service Act and their implementing regulations for: (1) Emergency Medical Services, (2) non-emergency ancillary services, (3) non-emergency, non-ancillary services, and (4) air ambulance services. The amount is based on: (1) Applicable state law, (2) an All Payer Model Agreement if adopted, (3) the initial payment made by us or the amount subsequently agreed to by the Non-Plan Provider and us, or (4) the amount determined by Independent Dispute Resolution between us and the Non-Plan Provider.
39 . Out-of-Pocket Maximum	
	An Out-of-Pocket Maximum is a limit on the amount of Copayments, Coinsurance and Deductibles that you must pay for Covered Benefits in a Plan Year or Calendar Year. The Out-of-Pocket Maximum is specified in your Schedule of Benefits. **Please Note:** Charges above the Allowed Amount never apply to the Out-of-Pocket Maximum. **For Example:** If your plan has an individual Out-of-Pocket Maximum of $1,000, this is the most Member Cost Sharing you will pay for out-of-pocket costs for that Plan Year or Calendar Year. As an example, the Out-of-Pocket Maximum can be reached by the following: $500 in Deductible expenses, $400 in Coinsurance expenses and $100 in Copayment expenses.
40 . Physical Functional Impairment	
	A condition in which the normal or proper action of a body part is damaged, and affects the ability to participate in Activities of Daily Living. Physical Functional Impairments include, but are not limited to, problems with ambulation, communication, respiration, swallowing, vision, or skin integrity. A physical condition may impact an individual's emotional well-being or mental health. However such impact is not considered in determining whether or not a Physical Functional Impairment exists. Only the physical consequences of a condition are considered.
41 . Plan	
	This package of health care benefits offered by Harvard Pilgrim Health Care.

Glossary Term	Definition
42 . Plan Provider	
	Providers of health care services in the Service Area that are under contract to provide care to Members of your Plan. Care must be provided within the lawful scope of the Provider's license. Plan Providers include, but are not limited to physicians, podiatrists, psychologists, psychiatrists, nurse practitioners, advanced practice registered nurses, physician's assistants, psychiatric social workers, certified psychiatric nurses, psychotherapists, licensed independent clinical social workers, licensed nurse mental health clinical specialist, nurse midwives, nurse anesthetists, acupuncturists, licensed mental health counselors, level I licensed alcohol and drug counselors, optometrists, and early intervention specialists who are credentialed and certified by the Massachusetts Department of Public Health. Plan Providers are listed in the Provider Directory.
43 . Plan Year	
	The one-year period for which benefits are purchased and administered. Benefits for which limited yearly coverage is provided renew at the beginning of the Plan Year. Benefits for which limited coverage is provided every two years renew at the beginning of every second Plan Year. Generally, the Plan Year begins on the Plan's Anniversary Date. Benefits under your Plan are administered on either a Plan Year or Calendar Year basis. Please see your Schedule of Benefits to determine which type of year your Plan utilizes. **For Example:** A Plan Year could begin on April 1st and end on March 31st or begin on January 1st and end on December 31st.
44 . Premium	
	A payment made to us for health coverage under the Plan.
45 . Primary Care Provider (PCP)	
	A Plan Provider designated to help you maintain your health and to provide and authorize your medical care under the Plan. A PCP may be a physician, a physician assistant or a nurse practitioner specializing in one or more of the following specialties: internal medicine, adult medicine, adolescent medicine, geriatric medicine, pediatrics, family practice, or gynecology and reproductive health. A PCP may designate other Plan Providers to provide or authorize a Member's care.
46 . Prior Approval (also known as Prior Authorization)	
	A program to verify that certain Covered Benefits are, and continue to be, Medically Necessary and provided in an appropriate and cost-effective manner.
47 . Provider Directory	
	A directory that identifies Plan Providers. We may revise the Provider Directory from time to time without notice to Members. The most current listing of Plan Providers is available on **www.harvardpilgrim.org**.
48 . Recognized Amount	
	With respect to a Surprise Bill, the amount on which a Copayment, Coinsurance or Deductible is based for Medical Emergency Services and certain non-emergency Covered Benefits when provided by Non-Plan Providers. The amount under sections 2799A-1 and 2799A-2 of the Public Service Act and their implementing regulations is based on: (1) Applicable state law, (2) an All Payer Model Agreement if adopted, or (3) the lesser of the amount billed by the Provider or the qualifying payment amount as determined under applicable law. Member Cost Sharing based on the Recognized Amount may be higher or lower than Member Cost Sharing based on the Allowed Amount.

Glossary Term	Definition
49 . Referral	
	An instruction from your PCP that gives you the ability to see another Plan Provider for services that may be out of your PCP's scope of practice. **For Example:** If you need to visit a specialist, such as a dermatologist or cardiologist, you must contact your PCP first. Your PCP will refer you to a specialist who is a Plan Provider. Your PCP will generally refer you to a specialist with whom he or she is affiliated or has a working relationship.
50 . Rehabilitation Services	
	Rehabilitation Services are treatments for disease or injury that restore or move an individual toward functional capabilities prior to disease or injury. For treatment of congenital anomalies with significant functional impairment, Rehabilitation Services improve functional capabilities to or toward normal function for age appropriate skills. Only the following are covered: cardiac rehabilitation therapy; occupational therapy; physical therapy; pulmonary rehabilitation therapy; speech therapy; or an organized program of these services when rendered by a health care professional licensed to perform these therapies.
51 . Service Area	
	The geographic area where Plan Providers are available to manage a Member's care.
52 . Skilled Nursing Facility	
	An inpatient extended care facility, or part of one, that is operating pursuant to law and provides skilled nursing services.
53 . Subscriber	
	The person who meets the Subscriber eligibility requirements described in this Benefit Handbook and is enrolled in the Plan.
54 . Surgery - Outpatient	
	A surgery or procedure in a day surgery department, ambulatory surgery department or outpatient surgery center that requires operating room, anesthesia and recovery room services.
55 . Surprise Bill	
	An unexpected bill you may receive if: (1) you obtain services from a Non-Plan Provider in an emergency, (2) you obtain services from a Non-Plan Provider while you were receiving a service from a Plan Provider or facility, and you did not knowingly select the Non-Plan Provider, (3) you obtain air ambulance services from a Non-Plan Provider, or (4) you obtain services from a Non-Plan Provider during a service previously approved or authorized by HPHC where you did not knowingly select a Non-Plan Provider.
56 . 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.
57 . Urgent Care	
	Medically Necessary services for a condition that requires prompt medical attention but is not a Medical Emergency.

III. Covered Benefits

This Section contains detailed information on the benefits covered under your Plan. Member Cost Sharing information and any applicable benefit limitations that apply to your Plan are listed in your Schedule of Benefits. Benefits are administered on a Plan Year or Calendar Year basis. Please see your Schedule of Benefits to see which type of year your Plan utilizes.

Basic Requirements for Coverage

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

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

Benefit	Description
58 . Acupuncture Treatment	
	The Plan may cover acupuncture treatment including, electro-acupuncture, that is provided for the treatment of neuromusculoskeletal pain. **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.
59 . Ambulance and Medical Transport	
	Emergency Ambulance Transport If you have a Medical Emergency (including an emergency related to a substance use disorder or mental health condition), your Plan covers ambulance transport (ground and air) to the nearest hospital that can provide you with Medically Necessary care. **Non-Emergency Medical Transport** You're also covered for non-emergency medical transport, including but not limited to ambulance and wheelchair vans, between hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary. Services must be arranged by a Plan Provider.

Benefit	Description
60 . Autism Spectrum Disorders Treatment	
	Coverage is provided for the diagnosis and treatment of Autism Spectrum Disorders, as defined below. Covered Benefits include the following: • Diagnosis of Autism Spectrum Disorders. This includes Medically Necessary assessments, evaluations, including neuropsychological evaluations, genetic testing or other tests to diagnose whether an individual has one of the Autism Spectrum Disorders. • Professional services by Plan Providers. This includes care by physicians, Licensed Mental Health Professionals, speech therapists, occupational therapists, and physical therapists. • Rehabilitation and Habilitation Services, including, but not limited to, applied behavior analysis supervised by a board certified behavior analyst as defined by law. • Prescription drug coverage. Please see your Prescription Drug Brochure for information on this benefit. Autism Spectrum Disorders include any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. These include Autistic Disorder; Asperger's Disorder; and Pervasive Developmental Disorders Not Otherwise Specified. Applied behavior analysis is defined by Massachusetts law as the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior. It includes the use of direct observation, measurement and functional analysis of the relationship between environment and behavior. There is no coverage for services provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor.
61 . Bariatric Surgery	
	The Plan covers the surgical treatment of obesity and morbid obesity (bariatric surgery). Services are covered in accordance with the patient qualification and treatment standards set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons. Coverage may be limited or excluded under your Plan unless services are performed at a designated Center of Excellence. Please see the section *I.D.5. Centers of Excellence* for important information concerning your coverage for this service. **Important Notice:** We use clinical guidelines to evaluate whether bariatric surgery is Medically Necessary. If you are planning to receive bariatric surgery services we recommend that you review the current Medical Necessity Guidelines. To obtain a copy, please call Member Services at **1-888-333-4742**.
62 . Cardiac Rehabilitation Therapy	
	The Plan covers cardiac rehabilitation as required by Massachusetts law. Coverage includes only Medically Necessary services for Members with established coronary artery disease or unusual and serious risk factors for such disease.
63 . Chemotherapy and Radiation Therapy	
	The Plan covers outpatient chemotherapy administration and radiation therapy at a hospital or other outpatient medical facility. Covered Benefits include the facility charge, the charge for related supplies and equipment, and physician services for anesthesiologists, pathologists and radiologists.

Benefit	Description
64 . Clinical Trials for the Treatment of Cancer or Other Life-Threatening Diseases	
	The Plan covers services for Members enrolled in a qualified clinical trial of a treatment for any form of cancer or other life-threatening disease under the terms and conditions provided for under Massachusetts and federal law. All of the requirements for coverage under the Plan apply to coverage under this benefit. The following services are covered under this benefit: (1) all services that are Medically Necessary for treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the Plan; and (2) the reasonable cost of an investigational drug or device that has been approved for use in the clinical trial to the extent it is not paid for by its manufacturer, distributor or provider.
65 . COVID-19 Services	
	The Plan covers vaccines, testing and treatment for COVID-19 as required by Massachusetts law. Vaccines are covered in full with no Member Cost Sharing. Testing and treatment are covered with no Member Cost Sharing after the Deducible has been met Services are covered with no Member Cost Sharing and without the use of Prior Approval processes when Medically Necessary and provided by either Plan or Non-Plan Providers. The following services are covered: • **COVID-19 Vaccines** • **COVID-19 Testing** – 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 in order to support treatment for COVID-19, or for a Member 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 Treatment** – 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, Member Cost Sharing may apply to covered services related to treatment of reactions to the COVID-19 vaccine.
66 . Dental Services	
	Important Notice: The Plan does not provide dental insurance. It covers only the limited Dental Care described below. No other Dental Care is covered. **Cleft Palate:** For coverage of orthodontic and dental care related to the treatment of cleft lip or cleft palate for children up to the age of 18, please see section *III. Covered Benefits*, *Reconstructive Surgery,* for information on this benefit. **Emergency Dental Care:** The Plan covers emergency Dental Care needed due to an injury to sound, natural teeth. All services, except for suture removal, must be received within three days of injury. Only the following services are covered: • Extraction of the teeth damaged in the injury when needed to avoid infection • Reimplantation and stabilization of dislodged teeth

Benefit	Description
Dental Services (Continued)	
	• Repositioning and stabilization of partly dislodged teeth • Suturing and suture removal • Medication received from the provider **Extraction of Teeth Impacted in Bone:** The Plan may cover extraction of teeth impacted in bone. If covered under your Plan, only the following services are covered: • Extraction of teeth impacted in bone • Pre-operative and post-operative care, immediately following the procedure • Anesthesia • Bitewing x-rays **Please Note:** Your Plan may provide coverage for pediatric dental services. Please see your Schedule of Benefits and any associated riders to determine if your Plan provides coverage for this benefit.
67 . Diabetes Services and Supplies	
	Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care: The Plan covers outpatient self-management education and training for the treatment of diabetes, including medical nutrition therapy services, used to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes. Services must be provided on an individual basis and be provided by a Plan Provider. Benefits also include medical eye exams (dilated retinal exams) and preventive foot care. Diabetes equipment and supplies are also covered. Some equipment and supplies listed below may be furnished by a Durable Medical Equipment (DME) provider or a pharmacy. Your Member Cost Sharing is based on who furnishes the equipment and/or supplies. The following items are covered: **Diabetes Equipment (covered under your DME benefit):** • Blood glucose monitors • Continuous glucose monitors • Dosage gauges • Injectors • Insulin pumps (including supplies) and infusion devices • Lancet devices • Therapeutic molded shoes and inserts • Visual magnifying aids • Voice synthesizers Please see the "Durable Medical Equipment (DME)" benefit for more information. **Pharmacy Supplies (covered at a pharmacy):** • Certain blood glucose monitors

Benefit	Description
Diabetes Services and Supplies (Continued)	
	• Certain insulin pumps (including supplies) and infusion devices • Blood glucose strips • Flash glucose monitors (including supplies) • Insulin, insulin needles and syringes • Lancets • Oral agents for controlling blood sugar • Urine and ketone test strips Please see the "Drug Coverage" benefit for more information. For coverage of pharmacy items listed above, you must get a prescription from your Plan Provider and present it at a participating pharmacy. You can find participating pharmacies by logging into **your secure online account** at **www.harvardpilgrim.org** or by calling Member Services at **1-888-333-4742**.
68 . Dialysis	
	The Plan covers dialysis on an inpatient, outpatient or at home basis. When federal law permits Medicare to be the primary payer, you must apply for Medicare and also pay any Medicare premium. When Medicare is primary (or would be primary if the Member were timely enrolled) under federal law, the Plan will cover only those costs that exceed what would be payable by Medicare. Coverage for dialysis in the home includes non-durable medical supplies, and drugs and equipment necessary for dialysis. We must approve dialysis services if you are temporarily traveling outside of the state where you live. We will cover dialysis services for up to 30 days of travel per Plan Year or Calendar Year. You must make arrangements in advance with your Plan Provider.
69 . Drug Coverage	
	1) Drug Coverage under this Benefit Handbook a. **Medical Drugs:** Drugs Received During Outpatient or Home Care. A Medical Drug is administered to you either (1) in a doctor's office or other outpatient medical facility, or (2) at home while you are receiving home care services or receiving drugs administered by home infusion services. Medical Drugs cannot be self-administered. The words "cannot be self-administered" mean that the active participation of skilled medical personnel is always required to take the drug. When a Member is receiving drugs in the home, the words "cannot be self-administered" will also include circumstances in which a family member or friend is trained to administer the drug and ongoing supervision by skilled medical personnel is required. An example of a drug that cannot be self-administered is a drug that must be administered intravenously. Examples of drugs that can be self-administered are drugs that can be taken in pill form and drugs that are typically self-injected by the patient. See your Schedule of Benefits for your Medical Drug Member Cost Sharing. b. **Drugs and supplies required by law:** Some drugs or supplies required by law may only be available through a pharmacy. Coverage is provided for: • certain diabetes supplies. See the "Diabetes Services and Supplies" benefit for details.

Benefit	Description
Drug Coverage (Continued)	
	• syringes and needles you purchase at a pharmacy. See the "Hypodermic Syringes and Needles" benefit for details. • certain prescribed self-administered anticancer medications used to kill or slow the growth of cancerous cells are covered with no Member Cost Sharing after the Deductible has been met. • long-term antibiotic therapy for a Member diagnosed with Lyme disease as required by law. Please note: the plan will provide coverage for a long-term antibiotic drug, including an experimental drug, for an off-label use in the treatment of Lyme disease if the drug has been approved by the United States Food and Drug Administration. No coverage is provided under this Benefit Handbook for (1) drugs that have not been approved by the United States Food and Drug Administration; (2) drugs the Plan excludes or limits, including, but not limited to, drugs for cosmetic purposes; and (3) any drug that is obtained at an outpatient pharmacy except as explained above. **2) Outpatient Prescription Drug Coverage** In addition to the coverage provided under this Benefit Handbook, you also have HPHC's outpatient prescription drug rider. That rider covers most prescription drugs purchased at an outpatient pharmacy. See the Prescription Drug Brochure for more information. See your ID card for your Member Cost Sharing.
70 . Durable Medical Equipment (DME)	
	The Plan covers DME when Medically Necessary and ordered by a Plan Provider. We will rent or buy all equipment. The cost of the repair and maintenance of covered equipment is also covered. In order to be covered, all equipment must be: • Able to withstand repeated use; • Not generally useful in the absence of disease or injury; • Normally used in the treatment of an illness or injury or for the rehabilitation of an abnormal body part; and • Suitable for home use. Coverage is only available for: • The least costly equipment adequate to allow you to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports; and • One item of each type of equipment. No back-up items or items that serve a duplicate purpose are covered. For example, the Plan covers a manual or an electric wheelchair, not both. Covered equipment and supplies include: • Canes • Certain diabetes supplies and equipment (See the "Diabetes Services and Supplies" benefit for details) • Certain types of braces • Crutches • Hospital beds

Benefit	Description
Durable Medical Equipment (DME) (Continued)	
	• Oxygen and oxygen equipment • Respiratory equipment • Walkers • Wheelchairs Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan.
71 . Early Intervention Services	
	The Plan covers early intervention services provided for Members until three years of age. Covered Benefits include: • Nursing care • Physical, speech, and occupational therapy • Psychological counseling • Screening and assessment of the need for services
72 . Emergency Room Care	
	If you have a Medical Emergency, you are covered for care in a hospital emergency room. Please remember the following: • If you need follow-up care after you are treated in an emergency room, you must call your PCP. Your PCP will provide or arrange for the care you need. • If you are hospitalized, you must call the Plan at **1-888-333-4742** within 48 hours or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to the Plan or PCP by an attending emergency physician no further notice is required.
73 . Family Planning Services	
	The Plan covers family planning services, including the following: • Contraceptive monitoring • Family planning consultation • Pregnancy testing • Genetic counseling • FDA approved birth control drugs, implants or devices. • Professional services relating to the injection of birth control drugs and the insertion or removal of birth control implants or devices. **Please Note:** An exclusion for contraceptives may apply when coverage is provided by a religious diocese, as allowed by law. Please see your Schedule of Benefits. "Your Plan does not cover contraceptive methods" will display under "Preventive Services and Tests" when contraceptives are excluded from coverage.

Benefit	Description
74 . Fertility Services	
	This fertility benefit applies to members who do not meet the definition of infertility under Massachusetts law (M.G.L. c. 175, section 47H and 211 C.M.R. 37.09). This benefit is meant to support inclusive family expansion for people across sexual orientation and gender identity spectra, including those without coparenting partners. Fertility services may be considered Medically Necessary without a diagnosis of infertility. The Plan covers fertility services when determined to be Medically Necessary. Only the following fertility services are covered: • Intra-cytoplasmic sperm injection (ICSI) • Intrauterine Insemination (IUI) • Donor sperm • Donor egg procedures, including related egg and inseminated egg procurement, processing and cryopreservation up to a maximum of 24 months. • In-Vitro Fertilization (IVF) • Reciprocal In-Vitro Fertilization (IVF) Please Note: No coverage is provided for reciprocal IVF services for non-Members. • Laboratory testing, including blood testing, sperm testing, and ultrasound related to the covered fertility services listed above. • Preimplantation genetic testing (PGT) Please see section, *Infertility Services and Treatment* for information on other services related to Assistive Reproductive Technology procedures covered under the Plan. **Important Notice:** We use evidence based clinical criteria to evaluate whether the use of fertility services is Medically Necessary. If you are planning to receive fertility services we recommend that you review the current Medical Necessity Guidelines online at **www.harvardpilgrim.org**. To obtain a copy, call Member Services at **1-888-333-4742**. **Please Note:** An exclusion for Fertility Services may apply when your coverage is provided by a religious diocese that is excluding coverage for Infertility Treatment, as allowed by law. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.
75 . Gender Affirming Services	
	The Plan covers gender affirming services to the extent Medically Necessary and in accordance with clinical guidelines. HPHC consults up-to-date medical standards set forth by nationally recognized medical experts in the transgender field, including but not limited to those issued by the World Professional Association for Transgender Health (WPATH), to develop clinical guidelines and determine Medical Necessity. When a Member meets Medical Necessity Guidelines, coverage includes: • Surgery • Related physician and behavioral health visits • outpatient prescription drugs Procedures required in preparation for, as a component of, as a follow-up to, or as a revision to a covered treatment are also covered. **Important Notice:** We use clinical criteria/guidelines to evaluate whether gender affirming services are Medically Necessary. If you are planning to

Benefit	Description
Gender Affirming Services (Continued)	
	receive gender affirming services, you should review the current Medical Necessity Guidelines that identify covered services under this benefit. To obtain a copy, call Member Services at **1-888-333-4742** or go to our website at **www.harvardpilgrim.org**. Benefits for gender affirming services are in addition to other benefits provided under the Plan. HPHC does not consider gender affirming services to be reconstructive surgery to correct a Physical Functional Impairment or Cosmetic Services. Coverage for reconstructive surgery or Cosmetic Services is limited to the services described under the Reconstructive Surgery benefit in this Benefit Handbook.
76 . Hearing Aids	
	The Plan covers hearing aids up to the limit listed in your Schedule of Benefits. A hearing aid is defined as any instrument or device, excluding a surgical implant, designed, intended or offered for the purpose of improving a person's hearing. The Plan will pay the full cost of each medically necessary hearing aid up to the limit listed in your Schedule of Benefits, minus any applicable Member Cost Sharing. If you purchase a hearing aid that is more expensive than the limit listed in your Schedule of Benefits, you will be responsible for the additional cost. No back-up hearing aids that serve a duplicate purpose are covered. Covered services and supplies related to your hearing aid are not subject to the dollar limit listed in your Schedule of Benefits. Covered Benefits include the following: • One hearing aid per hearing impaired ear • Except for batteries, any necessary parts, attachments or accessories, including ear moldings; and • Services provided by a licensed audiologist, hearing instrument specialist or licensed physician that are necessary to assess, select, fit, adjust or service the hearing aid.
77 . Home Health Care	
	If you are homebound for medical reasons, you are covered for home health care services listed below. To be eligible for home health care, your Plan Provider must determine that skilled nursing care or physical therapy is an essential part of active treatment. There must also be a defined medical goal that your Plan Provider expects you will meet. When you qualify for home health care services as stated above, the Plan covers the following services when Medically Necessary: • Durable medical equipment and supplies (must be a component of the home health care being provided) • Medical and surgical supplies • Medical social services • Nutritional counseling • Occupational therapy • Palliative care • Physical therapy • Services of a home health aide • Skilled nursing care • Speech therapy

Benefit	Description
78 . Hospice Services	
	The Plan covers hospice services for terminally ill Members who need the skills of qualified technical or professional health personnel for palliative care. Care may be provided at home or on an inpatient basis. Inpatient respite care is covered for the purpose of relieving the primary caregiver and may be provided up to 5 days every 3 months not to exceed 14 days per Plan Year or Calendar Year. Inpatient care is also covered in an acute hospital or extended care facility when it is Medically Necessary to control pain and manage acute and severe clinical problems that cannot be managed in a home setting. Covered Benefits include: • Care to relieve pain • Counseling • Drugs that cannot be self-administered • Durable medical equipment appliances • Home health aide services • Medical supplies • Nursing care • Physician services • Occupational therapy • Physical therapy • Speech therapy • Respiratory therapy • Respite care • Social services
79 . Hospital – Inpatient Services	
	The Plan covers acute hospital care including, but not limited to, the following inpatient services: • Semi-private room and board • Doctor visits, including consultation with specialists • Palliative care • Medications • Laboratory, radiology and other diagnostic services • Intensive care • Surgery, including related services • Anesthesia, including the services of a nurse-anesthetist • Radiation therapy • Physical therapy • Occupational therapy • Speech therapy In order to be eligible for coverage, the following service must be received at a Center of Excellence: • Weight loss surgery (bariatric surgery) Please see section *I.D.5. Centers of Excellence* for more information.

Benefit	Description
80 . House Calls	
	The Plan covers house calls.
81 . Human Organ Transplant Services	
	The Plan covers human organ transplants, including bone marrow transplants for a Member with metastasized breast cancer in accordance with the criteria of the Massachusetts Department of Public Health. The Plan covers the following services when the recipient is a Member of the Plan: • Care for the recipient • Donor search costs through established organ donor registries • Donor costs that are not covered by the donor's health plan If a Member is a donor for a recipient who is not a Member, then the Plan will cover the donor costs for the Member, when they are not covered by the recipient's health plan.
82 . Hypodermic Syringes and Needles	
	The Plan covers hypodermic syringes and needles to the extent Medically Necessary, as required by Massachusetts law. You must get a prescription from your PCP or Plan Provider and present it at a participating pharmacy for coverage. You can get more information on participating pharmacies by logging into **your secure online account** at **www.harvardpilgrim.org** or by calling Member Services at **1-888-333-4742**.
83 . Infertility Services and Treatment	
	Infertility is defined as the inability of a woman aged 35 or younger to conceive or produce conception during a period of one year. In the case of a woman over age 35, the time period is reduced to 6 months. If a woman conceives but is unable to carry the pregnancy to live birth, the time she attempted to conceive prior to that pregnancy is included in the one year or 6 month period, as applicable. The Plan covers the following diagnostic services for infertility: • Consultation • Evaluation • Laboratory tests • Preimplantation genetic testing (PGT) When the Member meets Medical Necessity Guidelines, the Plan covers the following infertility treatment: • Therapeutic artificial insemination (AI), including related sperm procurement and banking • Donor egg procedures, including related egg and inseminated egg procurement, processing and banking • Donor oocyte (DO/IVF) • Donor embryo/frozen embryo transfer (DO/FET) • Frozen embryo transfer (FET) • Assisted hatching • Gamete intrafallopian transfer (GIFT) • Intra-cytoplasmic sperm injection (ICSI) • Intra-uterine insemination (IUI) • In-vitro fertilization and embryo transfer (IVF)

Benefit	Description
Infertility Services and Treatment (Continued)	
	• Zygote intrafallopian transfer (ZIFT) • Miscrosurgical epididiymal sperm aspiration (MESA) • Testicular sperm extraction (TESE) • Sperm collection, freezing and up to one year of storage is also covered for male Members in active infertility treatment. • Cryopreservation of eggs, sperm, and embryos. **Important Notice:** We use evidence based clinical criteria to evaluate whether the use of infertility treatment is Medically Necessary. Infertility treatments evolve and new treatments may be developed. If you are planning to receive infertility treatment we recommend that you review the current Medical Necessity Guidelines online at **www.harvardpilgrim.org**. To obtain a copy, call Member Services at **1-888-333-4742**. **Please Note:** An exclusion for Infertility Services and Treatment may apply when coverage is provided by a religious diocese, as allowed by law. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.
84 . Laboratory, Radiology and Other Diagnostic Services	
	The Plan covers laboratory and radiology services (including Advanced Radiology), and other diagnostic services on an outpatient basis. The term "Advanced Radiology" means CT scans, PET Scans, MRI and MRA, and nuclear medicine services. Coverage includes: • The facility charge and the charge for supplies and equipment • The charges of anesthesiologists, pathologists and radiologists In addition, the Plan covers the following: • Human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish bone marrow transplant donor suitability (including testing for A, B, or DR antigens, or any combination, consistent with rules, regulations and criteria established by the Department of Public Health). • Diagnostic screenings and tests as required by law including: hereditary and metabolic screening at birth; tuberculin tests; lead screenings; hematocrit, hemoglobin or other appropriate blood tests, human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish bone marrow transplant donor suitability, and urinalysis. • Screening and diagnostic mammograms.
85 . Low Protein Foods	
	The Plan covers food products modified to be low-protein ordered for the treatment of inherited diseases of amino acids and organic acid to the extent required by Massachusetts law.

Benefit	Description
86 . Maternity Care	
	The Plan covers the following maternity services: • Routine outpatient prenatal care, including evaluation and progress screening, physical exams, recording of weight and blood pressure monitoring • Prenatal genetic testing (office visits require a referral) • Delivery, including a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean section. Any decision to shorten the inpatient stay for the mother and her newborn child will be made by the attending physician and the mother. If early discharge is decided, the mother will be entitled to a minimum of one home visit. • Newborn care. Coverage is limited to routine nursery charges for a healthy newborn unless the child is enrolled in the Plan. Please see section *VII.E. ADDING A DEPENDENT* for more enrollment information. • Routine outpatient postpartum care for the mother up to six weeks after delivery. The plan may reimburse you up to the Benefit Limit stated in your Schedule of Benefits for fees paid for one childbirth course (or refresher course) for each pregnancy. Members are expected to attend childbirth classes recommended by their physician, nurse midwife or health care facility. You will receive reimbursement for the course following completion unless delivery occurs before the course ends. To request reimbursement, you will need to complete a reimbursement form and provide the Plan with proof of payment. Please submit your documents along with the reimbursement form to the following address: **Harvard Pilgrim Health Care** **P.O. Box 9185** **Quincy, MA 02269** To obtain a reimbursement form, please contact our Member Services Departmentcustomer service at **1-888-333-4742** or visit HPHC online at **www.harvardpilgrim.org**.
87 . Medical Formulas	
	The Plan covers the following to the extent required by Massachusetts law: • Non-prescription enteral formulas for home use for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction and inherited diseases of amino acids and organic acids. • Prescription formulas for the treatment of phenylketonuria, tyrosinemia, homocystrinuria, maple syrup urine disease, propionic acidemia or methylmalonic acidemia in infants and children or to protect the unborn fetuses of pregnant women with phenylketonuria.

Benefit	Description
88 . Mental Health and Substance Use Disorder Treatment	
	The Plan covers both inpatient and outpatient mental health and substance use disorder treatment to the extent Medically Necessary as outlined below. As used in this section the term "mental health" includes the Medically Necessary treatment of substance use disorders. For coverage of mental health and substance use disorder treatment, you should obtain care from a Plan Provider. (The exceptions to this rule are listed in section *I.D.3. Using Plan Providers*. In a Medical Emergency you do not need to use a Plan Provider. You should go to the nearest emergency facility or call 911 or your local emergency number. A Referral from your PCP is not needed. See your Schedule of Benefits for your Member Cost Sharing. If you are admitted to the hospital, you must call the Plan at **1-888-333-4742** within 48 hours or as soon as you can. This telephone number is on your ID card. If an attending emergency physician contacts us or your PCP, then no further notice is needed. See the *Glossary* for more information on Medical Emergency Services. **Please Note:** Prior Approval is not required to obtain substance use disorder treatment from a Plan Provider. In addition, when services are obtained from a Plan Provider, the Plan will not deny coverage for the first 14 days of (1) Acute Treatment Services or (2) Clinical Stabilization Services for the treatment of substance use disorders so long as the Plan receives notice from the Plan Provider within 48 hours of admission. The terms "Acute Treatment Services" and "Clinical Stabilization Services" are defined in the Glossary at Section II of this Benefit Handbook. Services beyond the 14 day period may be subject to concurrent review as described in section *X.L. UTILIZATION REVIEW PROCEDURES* of this Handbook. The Plan requires consent to the disclosure of information regarding services for mental disorders to the same extent it requires consent for disclosure of information for other medical conditions. Any determination of Medical Necessity for mental health care will be made in consultation with a Licensed Mental Health Professional. **Minimum Requirements for Covered Providers** To be eligible for coverage under this benefit, all services must be provided either (1) at the office of a Licensed Mental Health Professional, or (2) at a facility licensed or approved by the health department or mental health department of the state in which the service is provided. (In Massachusetts those departments are the Department of Public Health and the Department of Mental Health, respectively.) To qualify, a facility must be both licensed as, and function primarily as, a health or mental health and substance use disorder treatment facility. A facility that is also licensed as an educational or recreational institution will not meet this requirement unless the predominate purpose of the facility is the provision of mental health and substance use disorder treatment. In addition to numbers (1) and (2) above, services to treat child-adolescent mental health disorders may be provided in the least restrictive clinically appropriate setting. This may include the Member's home or a program in another community-based setting. Please see below for additional information on services to treat child-adolescent mental health disorders. To qualify for coverage, all services rendered outside of a state licensed or approved facility must be provided by an independently Licensed Mental Health Professional. If a provider of intermediate care or outpatient services to treat child-adolescent mental health disorders is not independently licensed at the Masters/PhD/MD level, then the supervisor – who must be a Masters

Benefit	Description
Mental Health and Substance Use Disorder Treatment (Continued)	
	Level independently Licensed Mental Health Professional – must sign off on the treatment plan whenever the child's or adolescent's condition changes. For services provided in Massachusetts, a Licensed Mental Health Professional must be one of the following types of providers: a licensed physician who specializes in the practice of psychiatry; a licensed psychologist; a licensed independent clinical social worker; a licensed 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 the Plan. **Coverage for Massachusetts Parity Conditions including Child-Adolescent Mental Health Disorders** Under Massachusetts law, services for three categories of conditions must be covered to the same extent as medical services for physical illnesses. These three categories are (1) services for "biologically-based mental disorders," (2) services required as a result of rape, and (3) services for child-adolescent mental health disorders. Further information on the coverage provided for these conditions can be found below. 1) **Services Required to Treat Biologically-Based Mental Disorders** The Plan covers services required to treat biologically based mental disorders. Biologically-based mental disorders are (1) schizophrenia, (2) schizoaffective disorders, (3) major depressive disorder, (4) bipolar disorder, (5) paranoia and other psychotic disorders; (6) obsessive-compulsive disorder; (7) panic disorder, (8) delirium and dementia, (9) affective disorders, (10) eating disorders, (11) post-traumatic stress disorders, (12) substance use disorders, and (13) autism. 2) **Services Required as a Result of Rape** The Plan covers services required to diagnose and treat rape-related mental or emotional disorders for victims of rape or victims of an assault with the attempt to commit rape. 3) **Services for Child-Adolescent Mental Health Disorders** The Plan covers services on a non-discriminatory basis for the diagnosis and treatment of child-adolescent mental health disorders that substantially interfere with or substantially limit the functioning and social interactions of a child or adolescent through the age of 18. Substantial interference with, or limitation of, function must be documented by the Member's PCP, primary pediatrician or HPHC Licensed Mental Health Professional, or when evidenced by conduct including, but not limited to: • the inability to attend school as a result of the disorder, • the need for hospitalization as a result of the disorder, or

Benefit	Description
Mental Health and Substance Use Disorder Treatment (Continued)	
	• a pattern of conduct or behavior caused by the disorder that poses a serious danger to self or others. Child-adolescent mental health services shall take place in the least restrictive clinically appropriate setting and shall consist of a range of inpatient, intermediate, and outpatient services that shall permit Medically Necessary, active care expected to lead to improvement of the condition in a reasonable period of time. The covered services may be provided to the child, the child's parent(s), and/or other appropriate caregivers. Coverage under this subsection shall continue after the child's 19th birthday until either the course of treatment specified in the child's treatment plan is completed or coverage under this Handbook is terminated, whichever comes first. If treatment of a 19 year old, as specified in his or her treatment plan, has not been completed at the time coverage under this Handbook is terminated, such treatment may be continued under a replacement plan issued by HPHC. **Medically Necessary Emergency Services Programs** Under Massachusetts law, 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 youth: (ii) mobile crisis intervention services for adults; (iii) emergency services provider community-based locations; and (iv) 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 for adults and youth, and community crisis stabilization services for adults and youth. CBHCs will also provide community-based Mobile Crisis Intervention (MCI) for both youths and adults. **Coverage for Other Conditions** In addition to the coverage discussed above, the Plan will provide coverage for the care of all other conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. Services for all other conditions not identified above will be covered to the extent Medically Necessary. **Mental Health and Substance Use Disorder Treatment** Subject to the Member Cost Sharing and any benefit limits stated in your Schedule of Benefits, the Plan provides coverage for the following Medically Necessary mental health and substance use disorder treatments: 1) **Inpatient Services** • Hospitalization, including detoxification 2) **Intermediate Care Services** • Acute residential treatment (including detoxification) • Intensive Outpatient Programs (IOPs) and Partial Hospitalization Programs (PHPs)

Benefit	Description
Mental Health and Substance Use Disorder Treatment (Continued)	

	• Mobile Crisis Intervention (MCI)
	  • Adult Mobile Crisis Intervention (AMCI) – provides 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.
	  • Youth Mobile Crisis Intervention (YMCI) - provides crisis assessment and crisis stabilization intervention to youth under the age of 21. Each YMCI encounter, including ongoing coordination following the crisis assessment and stabilization intervention, may last up to seven days.
	3) **Intermediate Care Services for children and adolescents**
	• Community-based acute treatment (CBAT) – intensive therapeutic services provided in a staff-secure setting on a 24-hour basis, with sufficient staffing to ensure safety, while providing intensive therapeutic services including but not limited to: daily medication monitoring; psychiatric assessment; nursing availability; specialing (as needed); individual group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from inpatient services.
	• Intensive community-based acute treatment (ICBAT) – provides the same services as CBAT but at a higher intensity, including more frequent psychiatric and psychopharmacological evaluation and treatment and more intensive staffing and service delivery. ICBAT programs have the capability to admit children and adolescents with more acute symptoms than those admitted to CBAT. ICBAT programs are able to treat Children and adolescents with clinical presentations similar to those referred to inpatient mental health services but who are able to be cared for safely in an unlocked setting. Children and adolescents may be admitted to an ICBAT directly from the community as an alternative to inpatient hospitalization. ICBAT is not used as a step-down placement following discharge from a locked, 24-hour setting.
	4) **Outpatient Services**
	• Annual mental health wellness examination performed by a Licensed Mental Health Professional or by a PCP 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.
	• Care by a Licensed Mental Health Professional (including online counseling through secure digital messaging)
	• Crisis intervention services
	• Crisis stabilization and in-home family stabilization
	• Detoxification
	• Medication management
	• Methadone maintenance
	• Psychological testing and neuropsychological assessment.
	5) **Outpatient Services for children and adolescents**

Benefit	Description
Mental Health and Substance Use Disorder Treatment (Continued)	

	• Treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS) including, but not limited to, the use of intravenous immunoglobulin therapy (IVIG).
	• Intensive care coordination (ICC) – a collaborative service that provides targeted case management services to children and adolescents with a serious emotional disturbance, including individuals with co-occurring conditions, in order to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality, cost effective outcomes. This service includes an assessment, the development of an individualized care plan, referrals to appropriate levels of care, monitoring of goals, and coordinating with other services and social supports and with state agencies, as indicated. The service shall be based upon a system of care philosophy and the individualized care plan shall be tailored to meet the needs of the individual. The service is delivered in office, home or other settings and shall include both face-to-face and telephonic meetings, as indicated and as clinically appropriate.
	• In-home behavioral services (IHBS) - a combination of behavior management therapy and behavior management monitoring. Services shall be available, when indicated, where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. In-home behavioral services include:
	  • *Behavior management monitoring* of a child's behavior, the implementations of a behavior plan and reinforcing implementation of a behavior plan by the child's parent or other care giver.
	  • *Behavioral management therapy* that addresses challenging behaviors that interfere with a child's successful functioning. That therapy shall include a functional behavioral assessment and observation of the youth in the home and/or community setting, development of a behavior plan, and supervision and coordination of interventions to address specific behavioral objectives or performance, including the development of a crisis-response strategy and may include short-term counseling and assistance.
	• In-home therapy (IHT) - therapeutic clinical intervention or ongoing therapeutic training and support. The intervention or support shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting.
	  • *Therapeutic clinical intervention* shall include: (i) a structured and consistent therapeutic relationship between a licensed clinician and a child and the child's family to treat the child's mental health needs, including improvement of the family's ability to provide effective support for the child and promotion of healthy functioning of the child within the family; (ii) the development of a treatment plan; and (iii) the use of established psychotherapeutic techniques, working with the family or a subset of the family to enhance problem solving, limit setting, communication, emotional support or other family or individual functions.
	  • *Ongoing therapeutic training and support* of a treatment plan pursuant to therapeutic clinical intervention that includes but is not limited to, teaching the child to understand, direct, interpret, manage and control feelings and emotional responses to situation

Benefit	Description
Mental Health and Substance Use Disorder Treatment (Continued)	
	and assisting the family in supporting the child and addressing the child's emotional and mental health needs. • Family support and training (FS&T) – services provided to a parent or other caregiver of a child to improve the capacity of the parent or caregiver to ameliorate or resolve the child's emotional or behavioral needs. Such services shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. Family support and training addresses one or more goals on the youth's behavioral health treatment plan and may include educating parents/caregivers about the youth's behavioral health needs and resiliency factors, teaching parents/caregivers how to navigate services on behalf of the child and how to identify formal and informal services and supports in their communities, including parent support and self-help groups. • Therapeutic mentoring (TM) services – services provided to a child designed to support age-appropriate social functioning or to ameliorate deficits in the child's age-appropriate social functioning resulting from a DSM diagnosis. Services may include supporting, coaching, and training the child in age-appropriate behaviors, interpersonal communication, problem solving, conflict resolution, and relating appropriately to other children and adolescents and to adults. Services shall be provided, when indicated, where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. Therapeutic mentoring is a skill building service addressing one or more goals on the youth's behavioral treatment plan. It may also be delivered in the community to allow the youth to practice desired skills in appropriate settings. Please refer to your Schedule of Benefits for the Member Cost Sharing amounts that apply to your "inpatient," "intermediate" and "outpatient" mental health and substance use disorder treatment services.
89 . Observation Services	
	The Plan covers observation services including short term treatment, assessment and reassessment for up to 48 hours in an acute care facility (i.e. hospital). Observation services determine if a Member needs to be admitted for additional treatment or if the Member is able to be discharged from the hospital.
90 . Ostomy Supplies	
	The Plan covers ostomy supplies up to the Benefit Limit listed in the Schedule of Benefits. Only the following supplies are covered: • Irrigation sleeves, bags and catheters • Pouches, face plates and belts • Skin barriers

Benefit	Description
91 . Palliative Care	
	The Plan covers palliative care in conjunction with inpatient, home health care, hospice and physician services. Member Cost Sharing for palliative care is included in the cost sharing associated with these services. Palliative care is a medical specialty that supports improved quality of life for Members with chronic or serious illness. Care is focused on providing relief from symptoms and the stress of illness. Palliative care can be provided at any stage of illness, along with treatment for your condition while remaining under the care of your regular provider. This care is offered alongside curative or other treatments you may be receiving. Palliative care may include physician services, nursing care, home health care, pain and symptom management, medication management, rehabilitation therapies (occupational, physical, speech and pulmonary), behavioral health services and durable medical equipment.
92 . Physician and Other Professional Office Visits	

	Physician services, including services of all covered medical professionals, can be obtained on an outpatient basis in a physician's office or a hospital. These services may include:
	
	• Routine physical examinations, including routine gynecological examination and annual cytological screenings
	• Follow-up care provided by an obstetrician or gynecologist for obstetrical or gynecological conditions identified during maternity care or annual gynecological visit
	• Psychiatric collaborative care in which a primary care team provides structured behavioral health care management to a Member. A primary care team includes a PCP and a care manager working in collaboration with a psychiatric consultant that provides regular consultations to the team to review the Member's clinical status and care and to make recommendations. **Please Note:** Not all PCP offices provide this service.
	• Immunizations, including childhood immunizations as recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention and the American Academy of Pediatrics
	• Well baby and well child care, including physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and developmental screening, and assessment at the following intervals:
	  • At least six visits per Plan Year or Calendar Year are covered for a child from birth to age one.
	  • At least three visits per Plan Year or Calendar Year are covered for a child from age one to age two.
	  • At least one visit per Plan Year or Calendar Year is covered for a child from age two to age six.
	• School, camp, sports and premarital examinations
	• Health education and nutritional counseling
	• Palliative care
	• Sickness and injury care
	• Vision and Hearing screenings
	• Medication management
	• Consultations concerning contraception and hormone replacement therapy
	• Chemotherapy

Benefit	Description
Physician and Other Professional Office Visits (Continued)	
	• Radiation therapy **Please Note:** Some Plans may cover certain preventive services and tests with no Member Cost Sharing. Please see your Schedule of Benefits for the coverage that applies to your Plan.
93 . Prosthetic Devices	
	The Plan covers prosthetic devices when ordered by a Plan Provider. The cost of the repair and maintenance of a covered device is also covered. In order to be covered, all devices must be able to withstand repeated use. Coverage is only available for: • The least costly prosthetic device adequate to allow you to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports; and • One item of each type of prosthetic device. No back-up items or items that serve a duplicate purpose are covered. Covered prostheses include: • Breast prostheses, including replacements and mastectomy bras • Prosthetic arms and legs (including myoelectric and bionic arms and legs) • Prosthetic eyes Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan.
94 . Reconstructive Surgery	
	The Plan covers reconstructive and restorative surgical procedures as follows: • Reconstructive surgery is covered when the surgery can reasonably be expected to improve or correct a Physical Functional Impairment resulting from an accidental injury, illness, congenital anomaly, birth injury or prior surgical procedure. If reconstructive surgery is performed to improve or correct a Physical Functional Impairment, as stated above, Cosmetic Services that are incidental to that surgery are also covered. After a Physical Functional Impairment is corrected, no further Cosmetic Services are covered by the Plan. • Restorative surgery is covered to repair or restore appearance damaged by an accidental injury. (For example, this benefit would cover repair of a facial deformity following an automobile accident.) Benefits are also provided for the following: • Post mastectomy care, including coverage for: – Prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient; – Reconstruction of the breast on which the mastectomy was performed; and – Surgery and reconstruction of the other breast to produce a symmetrical appearance. • Treatment of cleft lip and cleft palate for children up to the age of 18, including coverage for:

Benefit	Description
Reconstructive Surgery (Continued)	
	– Medical, dental, oral, and facial surgery, including surgery performed by oral and plastic surgeons, and surgical management and follow-up care related to such surgery; – Orthodontic treatment; – Preventative and restorative dentistry to ensure good health and adequate dental structures to support orthodontic treatment or prosthetic management therapy; – Speech therapy; – Audiology services; and – Nutrition services. • Treatment to correct or repair disturbances of body composition caused by HIV-associated lipodystrophy syndrome, including but not limited to coverage for: – Reconstructive surgery; – Restorative procedures; and – Dermal injections or fillers to treat facial lipoatrophy associated with HIV. Benefits include coverage for procedures that must be done in stages, as long as you are an active Member. Membership must be effective on all dates on which services are provided. There is no coverage for Cosmetic Services or surgery except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, (3) post-mastectomy care as described above, and (4) gender affirming procedures and related services. **Important Notice:** We use clinical guidelines to evaluate whether different types of reconstructive and restorative procedures are Medically Necessary. If you are planning to receive such treatment, you may review the current Medical Necessity Guidelines online at **www.harvardpilgrim.org**. To obtain a copy, call Member Services at **1-888-333-4742.**
95 . Rehabilitation Hospital Care	
	The Plan covers care in a facility licensed to provide rehabilitative care on an inpatient basis. Coverage is provided when you need daily Rehabilitation Services that must be provided in an inpatient setting. Rehabilitation Services include cardiac rehabilitation therapy, physical therapy, pulmonary rehabilitation therapy, occupational therapy and speech therapy. The Benefit Limit is listed in the Schedule of Benefits.
96 . Rehabilitation and Habilitation Services – Outpatient	
	The Plan covers the following outpatient Rehabilitation and Habilitation Services: • Occupational therapy • Physical therapy • Pulmonary rehabilitation therapy Outpatient Rehabilitation and Habilitation Services are covered up to the Benefit Limit listed in the Schedule of Benefits. Services are covered only: • If, in the opinion of your Plan Provider, there is likely to be significant improvement in your condition within the period of time benefits are covered; and

Benefit	Description
Rehabilitation and Habilitation Services – Outpatient (Continued)	
	• When needed to improve your ability to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports. Rehabilitation and Habilitation Services are also covered under your inpatient hospital and home health benefits. When such therapies are part of an approved home care treatment plan they are available as described in the section titled, "Home Health Care." **Please Note:** Outpatient physical and occupational therapies for children up to the age of 3 are covered to the extent Medically Necessary. The benefit limit stated in the Schedule of Benefits does not apply.
97 . Scopic Procedures – Outpatient Diagnostic	
	The Plan covers diagnostic scopic procedures and related services received on an outpatient basis. Diagnostic scopic procedures are those for visualization, biopsy and/or polyp removal. Scopic procedures are: • Colonoscopy • Endoscopy • Sigmoidoscopy
98 . Skilled Nursing Facility Care	
	The Plan covers care in a health care facility licensed to provide skilled nursing care on an inpatient basis. Coverage is provided only when you need daily skilled nursing care that must be provided in an inpatient setting. The Benefit Limit is listed in the Schedule of Benefits.
99 . Speech-Language and Hearing Services	
	The Plan covers diagnosis and treatment of speech, hearing and language disorders to the extent Medically Necessary by speech-language pathologists and audiologists.
100 . Spinal Manipulative Therapy (including care by a chiropractor)	
	The Plan may cover musculoskeletal adjustment or manipulation up to the Benefit Limit listed in the Schedule of Benefits.
101 . Surgery - Outpatient	
	The Plan covers outpatient surgery, including related services. Outpatient surgery is defined as any surgery or procedure in a day surgery department, ambulatory surgery department or outpatient surgery center. There are certain specialized services for which you will be directed to a Center of Excellence for care. See section *I.D.5. Centers of Excellence* for more information.

Benefit	Description
102 . Telemedicine Virtual Visit Services	
	The Plan covers Medically Necessary telemedicine virtual visit services for the purpose of evaluation, diagnosis, consultation, monitoring, or treatment of a Member's physical health, oral health, mental health or substance use disorder condition. Telemedicine virtual visit services include the use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology including: (a) interactive audio video technology; (b) remote patient monitoring devices; (c) audio-only telephone; (d) online adaptive interviews; and (e) telemonitoring. Your provider must be appropriately licensed in the state in which you are located when receiving telemedicine services. Member Cost Sharing for telemedicine virtual visit services will be the same or less then the Member Cost Sharing for the same type of service if it had been provided through an in-person consultation. Please refer to your Schedule of Benefits for specific information on Member Cost Sharing you may be required to pay.
103 . Temporomandibular Joint Dysfunction Services	
	The Plan covers medical treatment of Temporomandibular Joint Dysfunction (TMD). Only the following services are covered: • Consultation with a physician • Physical therapy, (subject to the visit limit for outpatient physical therapy listed in the Schedule of Benefits) • Surgery • X-rays **Important Notice:** No Dental Care is covered for the treatment of Temporomandibular Joint Dysfunction (TMD).
104 . Urgent Care Services	
	The Plan covers Urgent Care services you receive at (1) a convenience care clinic, (2) an urgent care center, including mobile urgent care providers, or (3) a hospital urgent care center. (1) **Convenience care clinics:** Convenience care clinics provide treatment for minor illnesses and injuries. They are usually staffed by non-physician providers, such as nurse practitioners, and are located in stores, supermarkets or pharmacies. To see a list of convenience care clinics covered by the Plan, please refer to your Provider Directory and search under "convenience care." (2) **Urgent care centers:** Urgent care centers provide treatment for illnesses and injuries that require urgent attention but are not life threatening. Urgent care centers are independently owned and operated centers that are considered standalone facilities, not departments of a hospital. They are staffed by doctors, nurse practitioners, and physician assistants. To see a list of urgent care centers covered by the Plan, please refer to your Provider Directory and search under "urgent care." **Please Note:** You may be eligible to receive mobile urgent care services in your home, at work or anywhere you require Urgent Care. Availability of mobile urgent care services will depend upon your location. Member Cost Sharing for mobile urgent care services will be the same as if the service was provided at an urgent care center. Please refer to your Schedule of Benefits for the specific Member Cost Sharing that applies to urgent care center services under your Plan. You can call Member Services at **1-888-333-4742** or go to, **www.harvardpilgrim.org** to see where these services are available.

Benefit	Description
Urgent Care Services (Continued)	
	(3) **Hospital urgent care centers:** Some hospitals provide treatment for urgent care services as part of the hospital's outpatient services. A hospital urgent care center may be located within a hospital, or at a satellite location separate from the hospital. These urgent care centers are owned and operated by the hospital and are considered a department of the hospital. They are staffed by doctors, nurse practitioners, and physician assistants and provide treatment for illnesses and injuries that require urgent attention but are not life threatening. Because the services provided are considered outpatient hospital services, only the hospitals are listed in the Provider Directory. These services may require higher Member Cost Sharing than urgent care services received at independent urgent care centers. **Please Note:** Hospital urgent care center services are treated differently than similar services received in a hospital emergency room. For information on services received in a hospital emergency room, please see the Emergency Room Care benefit above, and in your Schedule of Benefits. Please refer to your Schedule of Benefits for the Member Cost Sharing applicable to each type of Urgent Care service. Coverage for Urgent Care is provided for services that are required to prevent deterioration to your health 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 earaches • Treatment for minor sprains or strains You do not need to obtain a Referral from your PCP to be covered for Urgent Care. Whenever possible, you should contact your PCP prior to obtaining Urgent Care. Your PCP may be able to provide the services you require at a lower out-of-pocket cost. In addition, your PCP is responsible for coordinating your health care services and should know about the services you receive. **Important Notice:** Urgent Care is not emergency care. You should call 911 or go directly to a hospital emergency room if you suspect you are having a Medical Emergency. These include heart attack or suspected heart attack, shock, major blood loss, or loss of consciousness. Please see section *I.D.6. Medical Emergency Services* for more information.
105 . Vision Services	
	Routine Eye: The Plan covers routine eye examinations. **Vision Hardware for Special Conditions:** The Plan provides coverage for contact lenses or eyeglasses needed for the following conditions: • Keratoconus. One pair of contact lenses is covered per Plan Year or Calendar Year. The replacement of lenses, due to a change in the Member's condition, is limited to 3 per affected eye per Plan Year or Calendar Year. • Post cataract surgery with an intraocular lens implant (pseudophakes). Coverage is limited to $140 per surgery toward the purchase of eyeglass frames and lenses. The replacement of lenses due to a change in the Member's prescription of .50 diopters or more within 90 days of the surgery is also covered up to a limit of $140.

Benefit	Description
Vision Services (Continued)	
	• Post cataract surgery without lens implant (aphakes). One pair of eyeglass lenses or contact lenses is covered per Plan Year or Calendar Year. Coverage up to $50 per Plan Year or Calendar Year is also provided for the purchase of eyeglass frames. The replacement of lenses due to a change in the Member's condition is also covered. Replacement of lenses due to wear, damage, or loss, is limited to 3 per affected eye per Plan Year or Calendar Year. • Post retinal detachment surgery. For a Member who wore eyeglasses or contact lenses prior to retinal detachment surgery, the Plan covers the full cost of one lens per affected eye up to one Plan Year or Calendar Year after the date of surgery. For Members who have not previously worn eyeglasses or contact lenses, the Plan covers either (1) a pair of eyeglass lenses and up to $50 toward the purchase of the frames, or (2) a pair of contact lenses.
106 . Voluntary Sterilization	
	The Plan may cover voluntary sterilization, including tubal ligation and vasectomy. **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.
107 . Voluntary Termination of Pregnancy	
	The Plan covers voluntary termination of pregnancy and related services provided in conjunction with the covered termination procedure: 1) pre-pregnancy termination evaluation and examination; 2) pre-operative counseling; 3) ultrasounds; 4) laboratory services, including pregnancy testing, blood type, and Rh factor; 5) Rh (D) immune globulin (human); 6) anesthesia (general or local); 7) post-pregnancy termination care; 8) follow-up care; and 9) advice on contraception or referral to family planning services. Care related to a pregnancy is not covered under this benefit. **Please Note:** An exclusion for voluntary termination of pregnancy may apply when an employer is a church or church controlled organization, as allowed by law. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.
108 . Wellness Reimbursement Benefits	
	Members of small group plans, can receive reimbursement for certain fees paid when participating in fitness or weight management programs. Below is a description of those benefits. **Fitness** The Plan will reimburse you for monthly fees paid for an individual or family membership at a qualified fitness facility up to the Benefit Limit stated in your Schedule of Benefits. To be eligible for coverage, you must have (1) been enrolled as a Member of Harvard Pilgrim, and (2) belonged to the qualified fitness facility for at least four months during the calendar year for which reimbursement is sought. A qualified fitness facility is either (1) a facility providing cardiovascular and strength-training equipment for exercising and improving physical fitness, including private health clubs and fitness centers, YMCA's, YWCA's, Jewish Community Centers, municipal fitness centers; or (2) a studio, facility, or virtual platform with certified instructors providing yoga, pilates, Zumba, group aerobic classes, cycling or spinning classes, kickboxing, CrossFit, strength training, tennis, indoor rock climbing or personal training. No reimbursement is provided for initiation or termination fees.

Benefit	Description
Wellness Reimbursement Benefits (Continued)	
	The fitness benefit does not apply to any fees or costs that you pay for classes, lessons or training provided outside of a qualified fitness facility as described above. Facilities and services that are not covered include: country clubs, private tennis clubs, social clubs (such as ski, riding or hiking clubs), gymnastics facilities, pool-only facilities, sports teams or leagues, spas, instructional dance studios, martial arts schools, home gyms, or personal training sessions. **Weight Management Program** The Plan will reimburse you up to the Benefit Limit stated in your Schedule of Benefits for monthly fees paid for WW (Weight Watchers) digital, traditional meetings or Weight Watchers at Work programs. No coverage is provided for individual nutritional counseling sessions, pre-packaged meals, books, videos, scales or other items or supplies bought by the Member or any other items not included as part of a weight management class or weight management course. To request reimbursement for your fitness or weight management program, you will need to complete a reimbursement form and provide the Plan with proof of membership and proof of payment. Please submit your documents along with the reimbursement form to the following address: **Harvard Pilgrim Health Care** **P.O. Box 9185** **Quincy, MA 02269** To obtain a reimbursement form, please contact our Member Services Department at **1-888-333-4742** or visit HPHC online at **www.harvardpilgrim.org**. You also have the option to request reimbursement online. If you have a **secure online account**, you can complete an online reimbursement form and submit your documents online. For details on how to register for a **secure online account**, log on to **www.harvardpilgrim.org.**
109 . Wigs and Scalp Hair Prostheses	
	The Plan covers wigs and scalp hair prostheses when needed for hair loss suffered as a result of the treatment for any form of cancer or leukemia or for a certain pathologic 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.

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

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

IV. Exclusions

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

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

Exclusion	Description
1 . Alternative Treatments	
	1. Acupuncture care, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. 2. Acupuncture services that are outside the scope of standard acupuncture care. 3. Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for these benefits. 4. Aromatherapy, treatment with crystals and alternative medicine. 5. Any of the following types of programs: Health resorts, spas, recreational programs, camps, outdoor skills programs, therapeutic or educational boarding schools, educational programs for children in residential care, self-help programs, life skills programs, relaxation or lifestyle programs, and wilderness programs (therapeutic outdoor programs). 6. Massage therapy. 7. Myotherapy.
2 . Dental Services	
	1. Dental Care, except the specific dental services listed as Covered Benefits in this Benefit Handbook, your Schedule of Benefits and any associated riders. 2. Temporomandibular Joint Dysfunction (TMD) care, except for the specific medical treatments listed as Covered Benefits in this Benefit Handbook. 3. Extraction of teeth, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. 4. Pediatric dental care, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits and any associated riders to determine if your Plan provides coverage for this benefit.
3 . Durable Medical Equipment and Prosthetic Devices	
	1. Any devices or special equipment needed for sports or occupational purposes. 2. Any home adaptations, including, but not limited to home improvements and home adaptation equipment. 3. Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. 4. Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.

Exclusion	Description
4 . Experimental, Unproven, or Investigational Services	
	1. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.
5 . Foot Care	
	1. Foot orthotics, except for the treatment of severe diabetic foot disease or systemic circulatory disease. 2. Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members diagnosed with diabetes or systemic circulatory disease.
6 . Maternity Services	
	1. Delivery outside the Service Area after the 37th week of pregnancy, or after you have been told that you are at risk for early delivery. 2. Planned home births. 3. Routine pre-natal and post-partum care when you are traveling outside the Service Area. 4. Services provided by a doula.
7 . Mental Health and Substance Use Disorder Treatment	
	1. Educational services or testing, except services covered under the benefit for Early Intervention Services. No benefits are provided (1) for educational services intended to enhance educational achievement or developmental functioning, (2) to resolve problems of school performance, (3) for driver alcohol education, or (4) for community reinforcement approach and assertive continuing care. 2. Any of the following types of programs: programs in which the patient has a pre-defined duration of care without the Plan's ability to conduct concurrent determinations of continued medical necessity, programs that only provide meetings or activities not based on individualized treatment plans, programs that focus solely on interpersonal or other skills rather than directed toward symptom reduction and functional recovery related to specific mental health disorders, and tuition based programs that offer educational, vocational, recreational, or personal developmental activities. 3. Sensory integrative praxis tests. 4. Mental health and substance use disorder treatment that is (1) provided to Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health. 5. Services or supplies for the diagnosis or treatment of mental health and substance use disorders that, in the reasonable judgment of the Plan, are any of the following: • Not consistent with prevailing national standards of clinical practice for the treatment of such conditions. • Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome. • Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.

Exclusion	Description
8 . Physical Appearance	
	1. Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, (3) post-mastectomy care, and (4) gender affirming procedures and related services. 2. Electrolysis or laser hair removal, except for what is Medically Necessary as part of gender affirming services. 3. Hair removal or restoration, including, but not limited to transplantation or drug therapy. 4. Liposuction, except for what is Medically Necessary as part of gender affirming services, or removal of fat deposits considered undesirable. 5. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). 6. Skin abrasion procedures performed as a treatment for acne. 7. Treatments and procedures related to appearance including but not limited to, abdominoplasty; chemical peels; collagen injections; dermabrasion; implantations (e.g. cheek, calf, pectoral, gluteal); lip reduction/enhancement; panniculectomy; removal of redundant skin; and silicone injections (e.g. for breast enlargement), except for what is Medically Necessary as part of gender affirming services or another Covered Benefit. 8. Treatment for skin wrinkles and skin tags or any treatment to improve the appearance of the skin. 9. Treatment for spider veins. 10. Wigs and scalp hair prostheses when hair loss is due to male pattern baldness, female pattern baldness, or natural or premature aging.
9 . Procedures and Treatments	
	1. Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial X-ray. 2. Spinal manipulative therapy (including care by a chiropractor), except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. 3. Commercial diet plans, weight loss programs and any services in connection with such plans or programs, except as provided in this Benefit Handbook under Wellness Reimbursement Benefits. **Please Note:** Your employer may participate in other wellness and health improvement incentive programs offered by Harvard Pilgrim. Please review all your Plan documents for the amount of incentives, if any, available under your Plan. 4. If a service is listed as requiring that it be provided at a Center of Excellence, no coverage will be provided under this Handbook if that service is received from a provider that has not been designated as a Center of Excellence. Please see section *I.D.5. Centers of Excellence* for more information. 5. Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes,

Exclusion	Description
Procedures and Treatments (Continued)	
	and foods of any kind (including high protein foods and low carbohydrate foods). 6. Physical examinations and testing for insurance, licensing or employment. 7. Services for Members who are donors for non-Members, except as described under Human Organ Transplant Services. 8. Testing for central auditory processing. 9. Group diabetes training, educational programs or camps.
10 . Providers	
	1. Charges for services which were provided after the date on which your membership ends. 2. Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit under this Handbook. 3. Charges for missed appointments. 4. Concierge service fees. Please see section *I.H. PROVIDER FEES FOR SPECIAL SERVICES (CONCIERGE SERVICES)* for more information. 5. Follow-up care after an emergency room visit, unless provided or arranged by your PCP. 6. Inpatient charges after your hospital discharge. 7. Provider's charge to file a claim or to transcribe or copy your medical records. 8. Services or supplies provided by (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
11 . Reproduction	
	1. Any form of Surrogacy or services for a gestational carrier other than covered maternity services. 2. Infertility drugs if a Member is not in a Plan authorized cycle of infertility treatment. 3. Infertility drugs, if infertility services are not a Covered Benefit. 4. Infertility treatment for Members who are not medically infertile. 5. 6. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). 7. Sperm collection, freezing and storage except as described in section *III. Covered Benefits*, *"Infertility Services and Treatment"*. 8. Sperm identification when not Medically Necessary (e.g., gender identification). 9. The following fees: wait list fees, non-medical costs, shipping and handling charges etc.

Exclusion	Description
12 . Services Provided Under Another Plan	
	1. Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. 2. Costs for services for which payment is required to be made by a Workers' Compensation plan or an Employer under state or federal law.
13 . Telemedicine Services	
	1. Telemedicine services involving e-mail or fax. 2. Provider fees for technical costs for the provision of telemedicine services.
14 . Types of Care	
	1. Custodial Care. 2. Recovery programs including rest or domiciliary care, sober houses, transitional support services, and therapeutic communities. 3. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. 4. Pain management programs or clinics. 5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation, except as provided in this Benefit Handbook under Wellness Reimbursement Benefits. 6. Private duty nursing. 7. Sports medicine clinics. 8. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
15 . Vision and Hearing	
	1. Eyeglasses, contact lenses and fittings, except as listed in this Benefit Handbook. 2. Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD. 3. Over the counter hearing aids. 4. Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism. 5. Routine eye examinations, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.

Exclusion	Description
16 . All Other Exclusions	
	1. Any service or supply furnished in connection with a non-Covered Benefit. 2. Any service or supply (with the exception of contact lenses) purchased from the internet. 3. Any service, supply or medication when there is a less intensive Covered Benefit or more cost-effective alternative that can be safely and effectively provided, in accordance with applicable Medical Necessity Guidelines. 4. Any service, supply or medication that is required by a third party that is not otherwise Medically Necessary (examples of a third party are an employer, an insurance company, a school or court). 5. Beauty or barber service. 6. Diabetes equipment replacements when solely due to manufacturer warranty expiration. 7. Donated or banked breast milk. 8. Externally powered exoskeleton assistive devices and orthoses. 9. Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law and prescribed for Members who meet HPHC policies for enteral tube feedings. 10. Guest services. 11. Medical equipment, devices or supplies except as listed in this Benefit Handbook. 12. Medical services that are provided to Members who are confined or committed to jail, house of correction, prison, or custodial facility of the Department of Youth Services. 13. Reimbursement for travel expenses. 14. Services for non-Members. 15. Services for which no charge would be made in the absence of insurance. 16. Services for which no coverage is provided in this Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure. 17. Services provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor. 18. Services that are not Medically Necessary. 19. Services your PCP or a Plan Provider has not provided, arranged or approved except as described in the *Handbook* sections *"Your PCP Manages Your Health Care"* and *"Using Plan Providers"*. 20. Taxes or governmental assessments on services or supplies. 21. Transportation, except for emergency ambulance transport, and non-emergency medical transport needed for transfer between hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary. 22. Voice modification surgery, except when Medically Necessary for gender affirming services.

Exclusion	Description
All Other Exclusions (Continued)	
	23. The following products and services: • Air conditioners, air purifiers and filters, dehumidifiers and humidifiers. • Car seats. • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners. • Electric scooters. • Exercise equipment. • Home modifications including but not limited to elevators, handrails and ramps. • Hot tubs, jacuzzis, saunas or whirlpools. • Mattresses. • Medical alert systems. • Motorized beds. • Pillows. • Power-operated vehicles. • Stair lifts and stair glides. • Strollers. • Safety equipment. • Vehicle modifications including but not limited to van lifts. • Telephone. • Television.

V. Reimbursement and Claims Procedures

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

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

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

A. BILLING BY PROVIDERS

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

1) Bill us on a standard health care claim form (such as the CMS 1500 or the UB04 form); and

2) Send it to the address listed on the back of your Plan ID card.

If you receive a Surprise Bill, you are only responsible for the applicable Member Cost Sharing that would apply if the service was provided by a Plan Provider. HPHC will reimburse Non-Plan Providers at the Out-of-Network Rate unless otherwise agreed to by the Provider and HPHC. You will not be billed for any charges other than the applicable Member Cost Sharing based on the Recognized Amount. You are not responsible, and a Non-Plan Provider cannot bill you, for:

- Amounts in excess of your Member Cost Sharing, based on the Recognized Amount, for non-emergency ancillary Covered Benefits received at certain In-network facilities by a Non-Plan Provider.
- Amounts in excess of your Member Cost Sharing, based on the Recognized Amount, for non-emergency, non-ancillary Covered Benefits received at certain In-network facilities from a Non-Plan Provider who has not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act.
- Amounts in excess of your Member Cost Sharing, based on the Recognized Amount, for Covered Benefits that are Medically Emergency Services provided by a Non-Plan Provider.
- Amounts in excess of your applicable Member Cost Sharing, based on the rates that would apply if the service was provided by a Plan Provider, for Covered Benefits that are air ambulance services provided by a Non-Plan Provider.

If you have any questions, call Member Services at **1-877-907-4742**.

B. REIMBURSEMENT FOR BILLS YOU PAY

If you pay a provider who is not a Plan Provider for a Covered Benefit, we will reimburse you less your applicable Member Cost Sharing. Claim reimbursements must be submitted to the following addresses:

Pharmacy Claims:

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

All Other Claims:

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

To obtain reimbursement for a bill you have paid, other than for pharmacy items, you must submit an HPHC health care reimbursement claim form with the provider or facility information. A legible claim form from the provider or facility that provided your care may also be included but is not required. The form must include all the following information:

- The Member's full name and address
- The Member's date of birth
- The Member's Plan ID number (on the front of the Member's Plan ID card)
- The Member's signature
- The name and address of the person or facility providing the services for which a claim is made and their Tax Identification Number (TIN) or National Provider Identification (NPI) number
- The Member's diagnosis description, diagnosis code or ICD 10 code
- The date the service was rendered
- The CPT code (or a brief description of the illness or injury) for which payment is sought
- The amount of the provider's charge
- Proof that you have paid the bill
- Other insurance information

Important Notice: We may need more information for some claims. If you have any questions about claims, call Member Services at **1-877-907-4742**.

A health care reimbursement claim form can be obtained online at **www.harvardpilgrim.org** or by calling Member Services.

1. International Claims
If you are requesting reimbursement for services received while outside of the United States, you must submit an HPHC health care reimbursement claim form along with an itemized bill and proof of payment. We may also require you to provide additional documentation, including, but not limited to: (1) records from financial institutions clearly demonstrating that you have paid for the services that are the subject of the claim, (2) the source of funds used for payment; and (3) an English translated description of the services received.

2. Pharmacy Claims
To obtain reimbursement for pharmacy bills you have paid, you must submit a Prescription Claim Form. The form can be obtained online at **www.harvardpilgrim.org** or by calling Member Services at **1-877-907-4742**.

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

The following information must be on the Prescription Claim Form:

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

If you have a question regarding your reimbursement, you should contact Member Services at **1-877-907-4742**.

C. TIME LIMITS ON FILING CLAIMS

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

Failure to file claims in a timely manner as provided in this section may result in denial of benefits.

Claims will be reviewed within 45 days of the receipt, unless it is a Surprise Bill. A claim for a Surprise Bill will be reviewed within 30 days of receipt. If a claim cannot be paid within that time, HPHC will notify the provider in writing:

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

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

D. PAYMENT LIMITS

We limit the amount- we will pay for services that are not rendered by Plan Providers. The most we will pay for such services is the Allowed Amount, unless it is a Surprise Bill. You may have to pay the balance if the claim is for more than the Allowed Amount, unless it is a Surprise Bill

✔ FOR EXAMPLE: If the Allowed Amount is $1,000 and the applicable Member Cost Sharing for the service is 20% Coinsurance, the maximum amount we will pay is $800.

E. MISCELLANEOUS CLAIMS PROVISIONS

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

HPHC will have the right to require that a Member for whom a claim is made be examined by a physician as often as may be reasonably necessary to determine HPHC's liability for the payment of benefits under this Handbook. HPHC will also have a right, where not prohibited by law, to have an autopsy performed. Any such examination or autopsy will be conducted by a licensed physician chosen by HPHC and at its expense.

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

VI. Appeals and Complaints

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

A. ABOUT OUR APPEAL AND COMPLAINT PROCEDURES

What are "Appeals" and "Complaints"?

- An **appeal** may be filed when coverage is denied. This includes either:
  - the denial of a health service you requested; or
  - the denial of payment for a health service you already received.
- A **complaint** may be filed when you have an issue with our actions or our services. (For a denial of coverage, you file an appeal not a complaint.)

Please file appeals and complaints at the addresses or telephone numbers listed below.

1. Member Representation

You may authorize, in writing, an individual to represent you. Your representative may file an appeal or complaint and participate in any part of the appeal or complaint process for you. Any notice will be sent to your representative upon request.

Below are examples of who you might choose to represent you:

- guardian,
- conservator,
- agent under a power of attorney,
- health care agent under a health care proxy,
- family member, or
- any other person appointed in writing to represent you.

We may ask you to document that the person chosen meets one of the above criteria.

2. Report on Appeals and Complaints

We will file an annual report on appeals and complaints with the Office of Patient Protection. The report filed for the prior year will be available to you upon request. You can get it from the Member Services Department.

3. Membership Required for Coverage

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

B. HOW TO FILE AN APPEAL

Any appeal may be filed:

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

Appeals should be submitted to:

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

1. Time Limit for Filing Appeals

An appeal must be filed within 180 days of the date a service, or payment for a service, was denied.

2. Appeals Involving Medical Necessity Determinations

Special rights apply to appeals that involve a Medical Necessity determination. These appeals could involve a decision that a service:

- is not Medically Necessary.
- is not being provided in an appropriate health care setting or level of care.
- is not effective for treatment of the Member's condition.
- is Experimental, Unproven, or Investigational.

These include the right to appeal to an external review organization. These organizations are under contract with the Office of Patient Protection. The external review process is summarized below. See section *VI.E. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED*.

3. The Office of Patient Protection

The Office of Patient Protection is the agency that enforces Massachusetts laws concerning managed care grievance rights. They administer appeals to external review organizations. The Office of Patient Protection also:

- enforces health care standards for managed care organizations,
- answers questions of consumers about managed care, and
- monitors quality-related health insurance information relating to managed care practices.

The Office of Patient Protection can be reached at:

Health Policy Commission
Office of Patient Protection
50 Milk Street, 8th Floor
Boston, MA 02109
Telephone: 1-800-436-7757
Fax: 1-617-624-5046
HPC-OPP@state.ma.us
http://www.masshpc.gov/OPP

C. THE APPEAL PROCESS

After an appeal is filed, we assign an Appeals and Grievances Analyst. This analyst will be responsible for your appeal during the appeal process.

1. Acknowledgment of Appeals

Appeals will be acknowledged in writing within 15 days of receipt. This time limit may be extended by written mutual agreement between you and HPHC.

2. Release of Medical Records

Any appeal that requires the review of medical information must include a signed authorization. This allows Protected Health Information (PHI) to be released or obtained. This form must be signed and dated by you or your authorized representative. (Proof as the authorized representative, must also be provided). If authorization is not provided when the appeal is filed, a blank form will be sent to you or your representative. .

3. Time Limit for Processing Appeals

A written appeal decision will be sent to you by certified or registered mail. This will be sent within 30 days of receipt of the appeal. The time limit may be extended by mutual agreement between you and HPHC. The agreement must be made in writing. Any extension will not be more than 30 days from the date of the agreement. We may not extend the review period for an appeal if a service has been continued pending an appeal.

When the appeal requires review of medical information, the date of receipt will be the date a signed authorization to release or obtain PHI is received. No appeal will be deemed received until it is received at the appropriate address or phone number. The address and phone number are listed in section *VI.B. HOW TO FILE AN APPEAL*.

If we do not act on an appeal within 30 days, plus any extension of time as agreed in writing, the appeal will be deemed to be resolved in your favor.

4. Medical Records and Information

The Appeals and Grievances Analyst will work to get all relevant information, including medical records. There is limited time available for the processing of appeals. You may be asked to help obtain any missing information. The appeal time limit may be extended until the information can be obtained. If information is not received by the 15th day following the receipt of the authorization to release or obtain PHI, and no agreement can be reached on extending the appeal time limit, the appeal may be decided without the missing information.

5. The Appeal Process

We will review, research and decide an appeal within the applicable time limit. See section *3. Time Limit for Processing Appeals* above.

The Appeals and Grievances Analyst will investigate the appeal. The analyst will let you know if additional information is needed. This information may include:

- medical records,
- statements from doctors, and
- bills and receipts for services you received.

You may also provide us with any written comments, documents, records or other information related to the claim.

Appeals that involve Medical Necessity decisions will be reviewed by a health care professional. This reviewer will be a health care professional who:

- is in active practice.
- is in the same or similar specialty as the medical specialty that treats the condition in your appeal.
- was not involved in any prior decision on your appeal
- is not the subordinate of any person who took part in a prior decision about your appeal.

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

- the benefits, terms and conditions of coverage stated in your EOC,
- the views of medical professionals who have cared for you,

- the views of any specialist who has reviewed the appeal,
- any relevant records or other documents you provided, and
- any other relevant information available to us.

Our appeal decision will be sent to you in writing. The decision will:

- specify the information considered in your appeal;
- explain the basis for the decision; and
- point out the plan provisions that are the basis for the decision.

If coverage is denied based on Medical Necessity, the appeal decision will state:

- the specific information upon which the decision was based. This includes clinical practice and review criteria information relied on to make the decision.
- your presenting symptoms or condition, diagnosis and treatment interventions.
- the specific reasons the medical evidence fails to meet the relevant medical review criteria.
- any alternative treatment option we cover.

The decision will also include other options available for further review of the appeal. These options are described in section *VI.E. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED*.

No one involved in the initial decision to deny a claim will make a decision in the appeal process. You have the right to receive, free of charge, all documents, records, or other information related to the initial denial and appeal.

D. THE EXPEDITED APPEAL PROCESS

1. Expedited Appeals Process

You may obtain expedited review of certain types of appeals. An expedited appeal may be requested if we deny coverage for health services involving:

- continued hospital care,
- care that a physician certifies is required to prevent serious harm, or
- a Member with a terminal illness.

An expedited appeal will not be granted to review a termination or reduction in coverage resulting from:

- a benefit limit or cost sharing provision of this Handbook or
- the termination of membership.

Members may request an expedited appeal by phone or in writing at the following phone number or address:

HPHC Appeals and Grievances Department
Harvard Pilgrim Health Care
1 Wellness Way
Canton, MA 02021
Telephone: 1-888-333-4742
Fax: 1-617-509-3085

We will make a decision of an expedited appeal within 72 hours from receipt of the appeal. The time limit may differ as specified below. If we do not act on an expedited appeal within the time limits stated, plus any extension of time as agreed to in writing, the appeal will be deemed to be resolved in your favor. Our decision will be sent to you in writing.

You may file an expedited appeal with HPHC, while also filing a request for expedited external review with the Office of Patient Protection. The filings can be done at the same time. You do not have to wait until HPHC completes your expedited appeal to file for expedited external review. See section *VI.E. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED*, "External Review" for more information.

You may obtain an expedited appeal for the following reasons and procedures:

i. Hospital Discharge

If you are inpatient in a hospital, we will provide an expedited review. The review will be of any action by us to terminate or reduce coverage for continued hospital care based upon the Medical Necessity of the hospitalization or the services provided. This appeal will be decided prior to the termination or reduction of coverage for your hospital stay. Coverage for services will continue through the completion of the appeals process. We will provide you with written notice of the appeal decision before discharge from a hospital.

ii. Services or Durable Medical Equipment Required to Prevent Serious Harm

An expedited review will be provided for appeals for services or durable medical equipment that, if not immediately provided, could result in serious harm to you. “Serious harm” means circumstances that could:

a) jeopardize your life or health,

b) jeopardize your ability to regain maximum function, or

c) result in severe pain that cannot be adequately managed without the care or treatment requested.

An expedited review will be provided for appeals for coverage for denied services or durable medical equipment if the physician recommending the service or durable medical equipment provides us with a written certification stating that:

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

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

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

This certification must contain the name, address and phone number of the certifying physician and his or her signature. Certification may be delivered in person, by mail or by fax. These can be sent to the address or hone numbers listed above. Upon receipt of proper certification, HPHC will review the denial of coverage. HPHC will then provide you with notice of the decision within 48 hours. A decision may take place earlier than 48 hours for durable medical equipment if (1) a request for the early reversal is included in the certification and (2) the physician's certification includes specific facts that indicate a 48 hour delay will cause you immediate and severe harm.

iii. Member with a Terminal Illness

If you file an appeal of a denial of coverage and you have a terminal illness, we will make a decision within 5 business days of receipt of the appeal. A terminal illness is an illness that is likely to cause death within 6 months.

2. Continuation of Services Pending Expedited Appeal

You may file an expedited appeal related to termination or reduction of coverage for ongoing treatment. In this case, coverage will be continued through the completion of our expedited appeal process if:

- We authorized the service when it began.
- We did not terminate or reduce the service due to a benefit limit under your EOC.
- You are, and continue to be, a duly enrolled Member under this Handbook.
- The appeal is filed on a timely basis, based on the course of treatment.

3. Expedited Appeals Decision

We will notify you of the decision in writing. This will be by certified/registered mail or by any electronic means you agreed to. Notification will be made within 72 hours from receipt of your request for expedited review. When a decision is made to deny the coverage requested, it will include:

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

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

c) A statement that you may request a meeting with our review committee to reconsider the denial. The meeting will be held within 10 days of request. The treating physician may request that it be held earlier. In such event, the meeting will be held within 5 business days. At the meeting, you and the committee will review the information previously provided in response to your appeal. The review committee has the authority to approve or deny the appeal. The review committee's decision will be our final decision.

E. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED

If you disagree with the appeal decision, you may have options for further review. These options may include:

- reconsideration of appeals that involve a Medical Necessity decision (as described in *VI.B. HOW TO FILE AN APPEAL*),
- external review by an independent organization appointed by the Office of Patient Protection, or
- (3) legal action. Below is a summary of these options.

Below is a summary of these options.

1. Reconsideration by the Plan

If you disagree with a decision involving a Medical Necessity determination, you may request reconsideration. This can be done if there is additional clinical documentation that hasn't previously been reviewed by HPHC. You must request reconsideration within 15 days of the date of our denial letter.

Reconsideration is not available for the following types of appeals:

- Decisions involving a benefit limitation where the limit is stated in the EOC,
- Decisions involving excluded services, except Experimental, Unproven, or Investigational services, and

- Decisions concerning Member Cost-Sharing requirements

Our reconsideration process is voluntary and optional. You may request reconsideration before or after seeking any other dispute resolution process. The other processes are described below. The only exception is for appeals that have been accepted by the Office of Patient Protection for external review. For example, you may:

- request reconsideration of an appeal before seeking external review from the Office of Patient Protection.
- go directly to external review.
- request reconsideration, if the Office of Patient Protection has decided that an appeal is not eligible for external review.

We will not reconsider an appeal that has been accepted for external review by the Office of Patient Protection.

Reconsideration by HPHC will not affect your right to any other benefits. On reconsideration, HPHC will make an impartial evaluation of your appeal. This evaluation is based on the review criteria in "The Formal Appeal Process," above. It is also evaluated without deference to any prior decisions made on the claim. HPHC will provide you with a written decision of the review.

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

2. External Review

If you disagree with a final appeal decision involving a Medical Necessity determination, you may request external review by an independent organization. Independent organizations are under contract with the Office of Patient Protection. A written request for external review must be filed with the Office of Patient Protection. This must be done within 4 months of receipt of the written notice of our appeal decision. A copy of the external review form will be enclosed with your notice from us of the decision to deny your appeal.

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

a) The request must be submitted on the Office of Patient Protection's application form called, "Request for Independent External Review of a Health Insurance Grievance." A copy of this form is included with the denial letter. You may also get a form by:
   - calling Member Services at **1-888-333-4742**.
   - calling the Office of Patient Protection at **1-800-436-7757**.
   - downloading a copy from the Department's website at **http://www.masshpc.gov/OPP**.

b) The form must include your signature or the signature of your authorized representative, consenting to the release of medical information.

c) A copy of our final appeal decision must be enclosed.

d) A fee of $25 must be paid. The Office of Patient Protection may waive this fee for extreme financial hardship.

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

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

The Office of Patient Protection may be reached at:

Health Policy Commission
Office of Patient Protection
50 Milk Street, 8th Floor
Boston, MA 02109
Telephone: 1-800-436-7757
Fax: 1-617-624-5046
HPC-OPP@state.ma.us
http://www.masshpc.gov/OPP

The Office of Patient Protection may arrange for an expedited external review. If you are not receiving inpatient service, a request must include a written certification from a physician that a delay in providing or continuing the health services that are the subject

of the appeal decision would pose a serious and immediate threat to your health.

If the subject of an external review involves the termination of ongoing services, you may ask the external review panel to continue coverage for the service while the review is pending. Any request for continuation of coverage must be made before the end of the second business day following receipt of the final adverse decision.

The review panel may order the continuation of coverage if it finds termination of coverage may cause substantial harm to your health. The panel may also order the continuation of coverage for good cause. Any such continuation of coverage shall be at our expense regardless of the final external review determination.

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

3. Legal Action

You may also seek 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 section 502(c) of ERISA must be brought within the time period stated in section *X.B. LIMITATION ON LEGAL ACTIONS*. Please note that government plans are not subject to ERISA.

F. THE FORMAL COMPLAINT PROCEDURE

A complaint may be filed in person, by mail, by fax, electronically via the secure online member portal, or by phone at the addresses or telephone numbers listed below. An Appeals and Grievances Analyst will investigate each complaint and respond in writing.

For all complaints call or write to:

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

1. Documentation of Oral Complaints

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

2. Acknowledgment of Complaints

Written complaints will be acknowledged in writing within 15 days of receipt. This time limit may be extended by written mutual agreement between you and HPHC.

3. Release of Medical Records

Any complaint that requires the review of medical information must include a signed authorization. This allows PHI to be released or obtained. This form must be signed and dated by you or your authorized representative. (Proof of the authorized representative must also be provided). If authorization is not provided a blank form will be sent to you or your representative.

4. Time Limit for Responding to Complaints

A written response will be sent to you by certified or registered mail. This will be sent within 30 days of receipt of the complaint. This time limit may be extended by mutual agreement between you and HPHC. Any extension will not be more than 30 days from the date of the agreement. Any such agreement must be in writing.

When the complaint requires review of medical records, the date of receipt will be the date a signed authorization to release or obtain PHI is received. No complaint will be deemed received until it is received at the appropriate address or phone number. The address and phone number are listed in the section *VI.B. HOW TO FILE AN APPEAL*.

5. Medical Records and Information

The Appeals and Grievances Analyst will work to get all information, including medical records. There is limited time available for processing complaints. You may be asked to help obtain any missing information. The time limit for response may be extended until the information can be obtained. If information is not received by the 15th day following the receipt of the authorization to release or obtain PHI, and no agreement can be reached on extending the response time limit the Appeals and Grievances Analyst may respond to the complaint without the missing information.

VII. Eligibility

Important Notice:

- Your membership starts the date your Employer Group enrolls you in the Plan.
- Your employer determines Dependent eligibility and effective dates of coverage.
- Your employer may notify Harvard Pilgrim of enrollment changes retroactively. This means we may not have up to date membership status.

Only your Employer Group can confirm membership status.

This section describes requirements concerning eligibility under the Plan.

A. MEMBER ELIGIBILITY

1. Residence Requirement

You must live, and keep a permanent residence, in the Enrollment Area at least nine months of a year. Call Member Services with any questions.

2. Subscriber Eligibility

A Subscriber under this Plan must:

- be an employee of an Employer Group;
- meet eligibility guidelines agreed to by the Employer Group and us; and
- be enrolled through an Employer Group that is current with premium payments.

We can review an Employer Group's payroll and other records to confirm eligibility and premium payments.

3. Dependent Eligibility

To the extent allowed by law, employers may have:

- different coverage for Dependents, and
- different age limits for Dependent termination.

See your Employer Group for your Plan's Dependent eligibility rules.

Unless an employer has elected different types of coverage, a Dependent must be one of the following:

a) The Subscriber's legal spouse. This means the same-sex or opposite-sex spouse of the Subscriber. The Subscriber and spouse must be in a legally valid marriage or civil union in a jurisdiction where such marriage or civil union is legal.

Note: We recognize same-sex spouses and partners in a civil union. However, this is subject to the Employer's eligibility policies.

b) The Subscriber's former spouse. This applies until the earlier of:

- the Subscriber or the former spouse remarries, or
- their divorce judgment no longer requires the Subscriber to provide health coverage to the former spouse.

Please Note: There is no coverage for the former spouse after he/she remarries. When the Subscriber remarries, a former spouse may continue coverage through an individual contract. This applies if the provision of such coverage:

- is required by the divorce judgment, and
- the applicable premium for such coverage is paid to us.

c) A child (including an adopted child) of the Subscriber or Subscriber's spouse. Coverage is provided until the end of the month in which the child turns 26.

d) A child (including an adopted child) of the Subscriber or Subscriber's spouse, age 26 years or older. The child must meet each of these requirements:

- is currently disabled;
- lives either:
  - with the Subscriber or spouse,
  - in a licensed institution, or
  - in a group home; and
- remains financially dependent on the Subscriber.

e) An unmarried child up to the age of 19* years, when either the Subscriber or Subscriber's spouse is the court appointed legal guardian. You must submit proof of guardianship to us prior to enrollment.

f) The unmarried child of an enrolled Dependent child of the Subscriber (or the Subscriber's enrolled spouse) until:

- the child's parent is no longer an eligible Dependent; or
- the child reaches age 19*, whichever occurs first.

Note: The enrolled Dependent parent must have legal custody of the child.

We may require proof of eligibility.

B. EFFECTIVE DATE - NEW AND EXISTING DEPENDENTS

See your Employer Group for information on enrollment and effective dates of coverage. Also see section *VII.H. SPECIAL ENROLLMENT RIGHTS*.

C. EFFECTIVE DATE - ADOPTIVE DEPENDENTS

An adoptive child may be covered if:

- The child has been living with you and you have been receiving foster care payments. Coverage may begin on the date you file the petition to adopt.
- The child has not been living with you. Coverage may begin on the date a licensed adoption agency places the child in your home for adoption.

See section *VII.H. SPECIAL ENROLLMENT RIGHTS* for more information.

D. CHANGE IN STATUS

You must inform your Employer Group and us of all changes that affect eligibility. Changes include:

- address changes;
- marriage of a Dependent; and
- death of a Member.

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

E. ADDING A DEPENDENT

Contact your Employer to add a new Dependent to your Plan. If you already have family coverage, you may also call Member Services to add a newborn or newly adopted child.

Dependents of eligible employees who meet the eligibility guidelines listed in this Handbook and the Employer Agreement may be enrolled in the Plan. This can be done:

- using HPHC enrollment forms; or
- in a way we and your Employer Group agreed to in writing.

The Employer Group must provide proper notice of any Member's Plan enrollment or termination. We must receive this no more than 60 days after the change effective date (unless otherwise required by law).

F. NEWBORN COVERAGE

A newborn infant of a Member or a newborn infant of a Dependent of a Member may be covered under the Plan. Coverage is from the moment of birth as required by law. See section *VII.E. ADDING A DEPENDENT* for the enrollment process. Also see section *VII.H. SPECIAL ENROLLMENT RIGHTS* for additional rights upon the birth of a child.

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

Coverage starts on the day membership is effective, even if you are hospitalized. To obtain coverage, you must call both your PCP and the Plan. You must allow us to manage your care. This may include transfer to a Plan affiliated facility. All other terms and conditions of coverage under this Handbook will apply.

H. SPECIAL ENROLLMENT RIGHTS

You may decline enrollment for yourself and your Dependents (including your spouse) due to other health insurance coverage. You may be able to enroll yourself, along with your Dependents in this Plan at a later date. This my happen if eligibility under that other coverage is lost. This might also happen if the employer stops paying for the other coverage. Enrollment must be requested within 30 days after the other coverage ends (or after the employer stops paying for the other coverage).

You may be able to enroll with your Dependents, if you have a new Dependent. This may be the result of:

- marriage;
- birth;
- adoption; or
- placement for adoption.

Enrollment must be requested within 30 days after the marriage, birth, adoption or placement for adoption.

Special enrollment rights may also apply to persons who:

- lose coverage under Medicaid or the Children's Health Insurance Program (CHIP), or
- become eligible for state premium assistance under Medicaid or CHIP.

If loss of Medicaid or CHIP eligibility results in lost coverage, an employee or Dependent may be able to enroll in this Plan. Enrollment must be requested within 60 days after Medicaid or CHIP coverage ends.

An employee or Dependent may become eligible for group health plan premium assistance under Medicaid or CHIP. If premium assistance is approved, enrollment in this Plan must be requested within 60 days of the approval date.

VIII. Termination and Transfer to Other Coverage

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

A. TERMINATION BY THE SUBSCRIBER

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

B. TERMINATION FOR LOSS OF ELIGIBILITY

Your Plan coverage will end if the Employer Group contract you are covered under is terminated. Your coverage may also end if you do not meet any of the specified eligibility requirements. This includes a Member relocating outside the Enrollment Area.

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

C. TERMINATION FOR NON-PAYMENT BY THE EMPLOYER GROUP

Your Plan coverage will end if the Employer Group contract you are covered under is termed for non-payment.

We will notify you in writing, if your coverage is termed due to non-payment of premium. We will follow one of two options in this event:
1) continue your coverage up to the date you receive termination notice, or
2) offer temporary continued coverage and individual coverage, if you satisfy the state mandated eligibility criteria.

You may be eligible for continued enrollment under federal or state law. See section *VIII.E. CONTINUATION OF EMPLOYER GROUP COVERAGE REQUIRED BY LAW* for more information.

D. MEMBERSHIP TERMINATION FOR CAUSE

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

- Misrepresenting a material fact on your Member application.
- Committing, or attempting to commit, fraud to obtain benefits that you are not eligible for under your EOC.
- Getting or attempting to get benefits under the EOC for a person who is not a Member.
- Committing acts of physical or verbal abuse that pose a threat to providers, the Plan, or other Members, which are unrelated to your physical or mental condition.

Termination for providing false information will be effective immediately upon notice to you. It is a crime to knowingly provide false, incomplete or misleading information for the purpose of defrauding the company. Termination for the other causes will be effective 15 days after notice. We will refund premium paid for periods after the date of termination.

E. CONTINUATION OF EMPLOYER GROUP COVERAGE REQUIRED BY LAW

1. Massachusetts Law

If you lose Employer Group eligibility under a Massachusetts employer with 2 - 19 employees, you may be able to continue group coverage under the state's Small Group Continuation Coverage law. Under this law you have 60 days to elect coverage. You should contact your Employer Group or Member Services for more information. In addition, there are other state laws which may apply. You should contact your Employer Group for more information. Contact your employer if membership ends due to:

- plant closing or partial closings.
- loss of dependency status due to age or divorce or legal separation.
- separation from employment or reduction of work hours.

2. Federal Law

If you lose Employer Group eligibility and your employer 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 Employer Group for more information if your coverage ends due to:

- separation from employment;
- reduction of work hours; or
- loss of dependency status.

Continuation of coverage cannot go beyond the time period allowed under federal law. The size of your Employer Group determines whether you select continuation of coverage rights under state or federal law.

F. INDIVIDUAL HEALTH PLANS

We offer individual health plans for Massachusetts, Maine and New Hampshire residents. Coverage purchased as an individual may differ from the coverage under your previous Plan. You may enroll only in a plan offered in the state where you live. You must also satisfy all eligibility guidelines. Your state of residence will have specific rules about eligibility and coverage. If you have questions about individual health plan coverage please call the applicable number below.

1. Massachusetts Residents:
1-866-229-8821 - weekdays 8:30 a.m. -5:00 p.m.

2. Maine Residents:
1-855-354-4742- weekdays 8:30 a.m. - 5:00 p.m.

3. New Hampshire Residents
1-844-213-1591 - weekdays 8:30 a.m. -5:00 p.m.

G. MEMBERS ELIGIBLE FOR MEDICARE

You may become eligible for Medicare under conditions where federal law allows Medicare to be the primary payer for Medicare-covered services. If this happens, your membership may end and you may apply for coverage under an HPHC Medicare plan. You may contact Member Services at **1-888-333-4742** for more information.

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 a Member has 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 a Member's 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. BENEFITS IN THE EVENT OF OTHER INSURANCE

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

- motor vehicle insurance,
- medical payment policies,
- governmental benefits (including Medicare), and
- all Health Benefit Plans.

The term "Health Benefit Plan" means:

- all group HMO and other group prepaid health plans,
- Medical or Hospital Service Corporation plans,
- commercial health insurance, and
- self-insured health plans.

There is no coordination of benefits with Medicaid plans or with hospital indemnity benefits that are less than $100 per day.

Coordination of benefits will be based on the Allowed Amount, or Recognized Amount. 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.

A Member 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 covers the person as a Dependent are determined second.

2. Dependent Children

i. Dependent Child Whose Parents Are Not Separated or Divorced

The order of benefits is determined as follows:

1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined first. The benefits of the plan of the parent whose birthday falls later in that year are determined second.
2) Both parents may have the same birthday. The benefits of the plan that covered the parent longer are determined first. The benefits of the plan that covered the other parent for a shorter period of time are determined second.
3) The other plan may not have the rule described in (1) above. It may instead have a rule based on the gender of the parent. As a result, the plans may not agree on the order of benefits. In this case, the other plan will determine the order of benefits.

ii. Dependent Child/Separated or Divorced Parents

A court order may specify one of the parents as responsible for the health care benefits of the child.

Unless HPHC is aware of such court order, the order of benefits is determined as follows:

1) First the plan of the parent with custody of the child;
2) Then, the plan of the spouse of the parent with custody of the child;
3) Finally, the plan of the parent not having custody of the child.

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

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

5. 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 the employee, Member or Subscriber longer are determined first. The benefits of the plan that covered that person for the shorter time are determined second.

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. PAYMENT WHEN HPHC COVERAGE IS PRIMARY OR SECONDARY

When HPHC is primary,

- HPHC is responsible for processing and paying claims for Covered Benefits first.
- coverage will be provided to the full extent of benefits available under the EOC.

When HPHC is secondary,

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

C. WORKERS' 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 determination is made whether payment will be made by such program. If HPHC provides or pays for services for an illness or injury covered under 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.

D. SUBROGATION AND REIMBURSEMENT

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 a Member's 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
- the Member's own auto insurance carrier; in cases of uninsured or underinsured motorist coverage.

- HPHC will also be entitled to recover from a Member 100% of the value of services provided or paid for by HPHC when a Member has been, or could be, reimbursed for the cost of care by another party. HPHC's recovery will be made from any recovery the Member receives from an insurance company or any third party.
- HPHC's right to recover 100% of the value of services paid for or provided by HPHC is not subject to reduction for a pro rata share of any attorney's fees incurred by the Member in seeking recovery from other persons or organizations.
- HPHC's right to 100% recovery shall apply even if a recovery the Member receives for the illness or injury is designated or described as being for injuries other than health care expenses.
- HPHC will have the right to take legal action, with or without the Member's consent, against any party to secure recovery of the value of services provided or paid for by HPHC for which such party is, or may be, liable.

The subrogation and recovery provisions in this section apply whether or not the Member recovering money is a minor.

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 subrogation under this Handbook.

E. MEDICAL PAYMENT POLICIES

A Member may be entitled to coverage under the medical payment benefit of a boat, homeowners, hotel, restaurant, or other insurance policy, or the first $2,000 of Personal Injury Protection (PIP) coverage (or $8,000 for self-funded plans governed by ERISA). Such coverage shall become primary to the coverage under this Benefit Handbook for services rendered in connection with a covered loss under that policy.

A Member may be entitled to coverage under (1) a medical payment policy, or (2) Personal Injury Protection (PIP) coverage in excess of $2,000 (or $8,000 for self-funded plans governed by ERISA). Such coverage shall become secondary to the coverage under this Benefit Handbook for services rendered in connection with a covered loss under that policy. This shall be where, and only to the extent, the law requires the coverage under this Benefit Handbook to be primary.

The benefits under this Benefit Handbook shall not duplicate any benefits to which the Member is entitled under any medical payment policy or benefit. All sums payable for services provided under this Benefit Handbook to Members that are covered under any medical payment policy or benefit are payable to HPHC.

F. MEMBER COOPERATION

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

1) the provision of all information and documents requested by HPHC;
2) the execution of any instruments deemed necessary by HPHC to protect its rights;
3) the prompt assignment to HPHC of any monies received for services provided or paid for by HPHC; and
4) the prompt notification to HPHC of any instances that may give rise to HPHC's rights.

You further agree to do nothing to prejudice or interfere with HPHC's rights to subrogation or coordination of benefits.

If 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.

G. HPHC'S RIGHTS

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

H. MEDICARE ELIGIBILITY

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

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

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

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

Note: When Medicare is primary due to End Stage Renal Disease (or would be primary if the Member were timely enrolled), the Plan will pay for Medicare Part B services only to the extent payments would exceed what would be payable by Medicare. The Plan will estimate the amount that would be payable by Medicare and pay secondary benefits accordingly. The Plan may apply the same terms when Medicare is primary due to age or disability (or would be primary if the Member were timely enrolled).

X. Plan Provisions and Responsibilities

A. IF YOU DISAGREE WITH RECOMMENDED TREATMENT

Plan Providers are responsible for determining treatment appropriate to your care. You:

- may disagree with the treatment recommended by Plan Providers for personal or religious reasons.
- may demand or seek a treatment that Plan Providers judge to be incompatible with proper medical care.
- have the right to refuse the recommendations of Plan Providers.

In this case, HPHC shall have no further obligation to provide coverage for the care in question. If you obtain care from Non-Plan Providers because of the disagreement, HPHC has no obligation for the cost or outcome of such care. You have the right to appeal benefit denials.

B. LIMITATION ON LEGAL ACTIONS

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

C. 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:
  - motor vehicle 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.

D. SAFEGUARDING CONFIDENTIALITY

HPHC values your privacy rights. HPHC is committed to safeguarding protected health information (PHI) and personal information (PI). Our Privacy and Security policies include:

- how HPHC administers privacy and security programs;
- staff training; and
- how PHI and PI can be used and disclosed.

We may collect, use, and disclose financial and medical information about you when doing business with you or others. We follow our privacy policies and state and federal laws. Our business partners administer your health care coverage on our behalf. We require our partners to protect your information according to state and federal law.

For a copy of our Notice of Privacy Practices go to **www.harvardpilgrim.org** or call Member Services at **1-888-333-4742**.

E. NOTICE

Member mailings are sent to your last address that we have on file. Mailings 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, other than a request for Member appeal, should be sent to:

HPHC Member Services Department
1 Wellness Way
Canton, MA 02021

See section *VI. Appeals and Complaints* for the address and phone numbers to file an appeal.

F. MODIFICATION OF THIS HANDBOOK

We may amend the EOC. We will provide sixty (60) days written notice to your Employer Group. Member consent is not required.

The EOC is the entire contract between you and the Plan. HPHC's responsibilities to the Member are 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.

G. OUR RELATIONSHIP WITH PLAN PROVIDERS

Separate agreements govern our relationship with Plan Providers. Plan Providers:

- are independent contractors.
- may not modify the EOC.
- may not create any obligation for HPHC.

We are not liable for their statements about the EOC. This includes their employees or agents.

We may change our arrangements with service Providers, including the addition or removal of Providers, without notice to Members.

H. WELLNESS INCENTIVES

A Member may be able to receive incentives for taking part in health and wellness programs. Incentives may include reimbursement for certain fees you pay for taking part in:

- fitness programs;
- weight loss programs; or
- other wellness programs.

Receiving an incentive does not depend upon the outcome of the program. Go to **www.harvardpilgrim.org** for more information. See your EOC for any incentive amounts included with your Plan. For tax information, please consult with your employer or tax advisor.

I. IN THE EVENT OF A MAJOR DISASTER

We will try to provide or arrange for services in the case of a major disaster. This might include war, riot, epidemic, public emergency, or natural disaster. Other causes include:

- the partial or complete destruction of our facility(ies).
- 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. EVALUATION OF NEW TECHNOLOGY

We have a dedicated team of staff that evaluates new:

- diagnostics;
- testing;
- interventional treatment;
- therapeutics;
- medical/behavioral therapies;
- surgical procedures;
- medical devices and drugs; and
- new applications of the above.

The team manages an evidence-based evaluation process. This process recommends a status of (i) an accepted standard of care; or (ii) Experimental, Unproven, or Investigational. The team researches the safety and effectiveness of these new technologies by:

- reviewing published peer reviewed medical reports and literature,
- consulting with expert practitioners, and
- benchmarking.

The team makes recommendations to internal policy committees. These committees make final policy decisions for new technology coverage. The policy evaluation process includes:

- determining the FDA approval status of the device/product/drug in question;
- reviewing relevant clinical literature; and
- consulting actively practicing specialists about current practice standards.

K. GOVERNING LAW

This Evidence of Coverage is governed by Massachusetts law.

L. UTILIZATION REVIEW PROCEDURES

We use the following utilization review procedures to evaluate the Medical Necessity of certain services. We use clinical criteria to assure your care is clinically appropriate and cost-effective. This applies to both physical and mental health services.

- **Prospective Utilization Review (Prior Approval).** We review certain services before they are provided. This review determines if the proposed services meet Medical Necessity Guidelines. Services include:
  - elective inpatient admissions;
  - surgical day care;

- outpatient/ambulatory procedures; and
- Medical Drugs.

Prior Approval decisions are made within two working days of receiving all necessary information.

(1) For notice of a decision to approve an admission, procedure or service:
- we will send notice in the HPHC provider portal within 24 hours of the decision.
- will send written notice to you and the Provider within two working days.

(2) For notice of a decision to deny or reduce benefits ("an adverse determination");
- we will call your Provider within 24 hours of the decision.
- we will send you and your Provider written or electronic notice within one working day after the call.

Please Note: Prior Approval is not required to receive Acute Treatment Services or Clinical Stabilization Services from a Plan Provider. The terms "Acute Treatment Services" and "Clinical Stabilization Services" are defined in the Glossary.

- **Concurrent Utilization Review.** We review ongoing admissions for certain services. These reviews are to assure that the services provided meet Medical Necessity Guidelines. These services may be at:
  - hospitals, including acute care hospitals;
  - rehabilitation hospitals;
  - skilled nursing facilities;
  - skilled home health providers; and
  - behavioral health and substance use disorder treatment facilities.

  Concurrent review decisions are made within one working day of receiving 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 your provider written or electronic notice within one working day. For ongoing services, coverage will continue without liability to you until you are notified of an adverse determination. Concurrent review includes active case management and discharge planning. Your Provider may also request these services.
- **Retrospective Utilization Review.** We may review services that were provided before Prior Approval was obtained. This includes review of emergency medical admissions for appropriate level of care.

To find the status of a clinical review decision call Member Services at **1-888-333-4742**.

For an adverse determination 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 adverse determination 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.

M. QUALITY ASSURANCE PROGRAMS

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

- **Verifying Provider Credentials** - HPHC obtains, verifies and assesses Plan Provider qualifications to provide care or services. This involves gathering evidence of licensure, education, training and other experience and/or qualifications.
- **Verifying Facility Credentials** - HPHC reviews and confirms licensures and certifications based on facility type.
- **Quality of Care Complaints** – HPHC follows a process to investigate, resolve and monitor Member complaints about care provided by a Plan Provider.
- **Evidence Based Practice** – HPHC compiles Medical Necessity Guidelines. These guidelines are based on the most current evidence-based standards. They provide an analytical framework for clinicians to evaluate and treat common health conditions.
- **Performance monitoring** – HPHC collects data to measure outcomes. This data is related to the Health Care Effectiveness Data and Information Set (HEDIS). It is used to monitor health care quality across various domains of evidence-based care and practice.

- **Quality program evaluation**- Annually HPHC develops, plans and implements initiatives to improve clinical service and quality. The Quality Program is documented, tracked and evaluated against milestones and objectives. See and review the full program description at **https://www.harvardpilgrim.org/public/about-us/quality**.

N. 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. The process includes:

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

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

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

We use Medical Necessity Guidelines to make fair and consistent utilization management decisions. Medical Necessity Guidelines are developed 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.

For example, we use the nationally recognized InterQual criteria to review (i) elective surgical day procedures; and (ii) 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.

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

P. NON-ASSIGNMENT OF BENEFITS

You may not assign or transfer your rights to benefits, monies, claims or causes of action provided under this Plan to:

- any person;
- health care provider;
- company; or
- other organization.

You must have our written consent to assign any benefits, monies, claims, or causes of action that result from a benefits denial.

Q. 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 their introduction to the market. Coverage for a new to market drug may apply Prior Approval and coverage limitations.

R. DETERMINATION OF COVERED BENEFITS

We have the discretionary authority to:

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

Our decisions and interpretations are final and binding.

S. PAYMENT RECOVERY

We may determine that a mistake was made paying Plan benefits. We reserve the right to:

- recover such payments from the Provider or Member.
- offset later benefit payments to a Provider (regardless of payment source) or Member by any such overpayment amount.

XI. MEMBER 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 Plan 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.

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