Harvard Pilgrim Health Care *of New England*

Benefit Handbook

ELEVATEHEALTH℠ HMO HSA FOR INDIVIDUAL MEMBERS
NEW HAMPSHIRE
POLICY

Coverage under this Plan is provided in accordance with the New Hampshire Insurance law and under the jurisdiction of the New Hampshire Insurance Commissioner. Please read your Policy carefully. This is a legal document between you and Harvard Pilgrim Health Care of New England.

This policy may, at any time within 30 days after its receipt by the policyholder, be returned by delivering it or mailing it to the company or the agent through whom it was purchased. Immediately upon such delivery or mailing, the policy will be deemed void from the beginning, and any premium paid on it will be refunded.

Plan Coverage and Renewability: Coverage under this Policy is provided on a yearly basis from January 1st through December 31st and is guaranteed renewable. This Policy may only be cancelled, rescinded or non-renewed as allowed under state or federal law. You may renew this Policy by paying the renewal premium on the date your premium is due and you remain eligible for coverage.

Important Notice: This plan includes a limited provider network called the ElevateHealth Provider Network. This plan provides access to a network that is smaller than Harvard Pilgrim Health Care of New England's full provider network. In this plan, Members have access to network benefits only from the providers in the ElevateHealth Provider Network. Please consult the Provider Directory or visit the provider search tool at **www.harvardpilgrim.org** to determine which providers are included in the ElevateHealth Provider Network.

IMPORTANT INFORMATION: This policy reflects the known requirements for compliance under The Affordable Care Act as passed on March 23, 2010. As additional guidance is forthcoming from the US Department of Health and Human Services and the New Hampshire Insurance Department, those changes will be incorporated into your health insurance policy.

EFFECTIVE DATE: 01/01/2020
FORM #1723_04

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INTRODUCTION

Welcome to The ElevateHealth℠ HMO HSA for Individual Members offered by Harvard Pilgrim Health Care of New England, Inc. and thank you for choosing us to help meet your health care needs.

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

If you are receiving a cost share reduction subsidy from the Federal Government, your Plan may not be meet the requirements for a High Deductible Health Plan. Please refer to the cover of your Schedule of Benefits to determine if your Plan qualifies as a High Deductible Health Plan that can be paired with an HSA.

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

Your health care under the Plan is provided or arranged through our ElevateHealth Provider Network. The ElevateHealth Provider Network includes two groups of providers (1) Easy Access Providers and (2) Authorized Access Providers.

Easy Access Providers are the providers through which you will receive most of your care. Easy Access Providers include Primary Care Providers (PCPs), specialists and other providers. You must choose a PCP from the list of Easy Access Providers for yourself and each of your family members when you enroll in the Plan. Your PCP will provide or coordinate most of your care.

Authorized Access Providers include, but are not limited to physicians and hospitals who provide highly specialized care. You are required to obtain Prior Approval for any service received from an Authorized Access Provider to obtain coverage under the Plan. Authorized Access Providers are only available when there are no Easy Access Providers with the professional expertise needed to provide the required care.

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

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

You may also call the Member Services Department at **1-877-907-4742** if you have any questions. Member Services staff are available to help you with questions about the following:

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

We can usually accommodate questions from non-English speaking Members, as we offer language interpretation services in more than 120 languages.

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

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

Harvard Pilgrim Health Care of New England
Member Services Department
1600 Crown Colony Drive
Quincy, MA 02169
1-877-907-4742
Website: www.harvardpilgrim.org

Clinical Review Criteria

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

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 اَللُغة **العربية** ، خَدَمات اَلمُساعَدة اَللُغوية مُتَوفرة لك مَجانا. ً **إتصل على 1 888-333-4742**
(TTY: 711)

ខ្មែរ (Cambodian) ប្រសុំជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយ គិតគិតថ្លៃ។។ 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. ໂທ 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 Connecticut, 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. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

HPHC:

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

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

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (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 Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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TABLE OF CONTENTS

Benefit Handbook

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I. How the Plan Works

This section describes how to use your Benefit Handbook and how your coverage works under ElevateHealth℠ HMO HSA for Individual Members (the Plan or Policy).

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 amendments (collectively referred to as the Evidence of Coverage) make up the legal agreement stating the terms of the Plan and constitutes the entire contract of insurance under this Policy.

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

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

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

2. Words With Special Meaning

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

3. How To Find What You Need To Know

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

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

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

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

B. YOUR ELEVATEHEALTH NETWORK AND HOW TO USE YOUR PROVIDER DIRECTORY TO FIND CARE

Coverage under The ElevateHealth Plan is provided through a health maintenance organization. Except in limited circumstances discussed under section 7 below, Covered Benefits must be provided by Plan Providers. There are two types of providers under your Plan that make up the ElevateHealth Provider Network. These are (1) Easy Access Providers and (2) Authorized Access Providers. Easy Access Providers are providers where you will receive most of your care. They include Primary Care Providers, specialists and other inpatient and outpatient providers. Easy Access Providers are located in select counties in New Hampshire. Authorized Access Providers are made up of a limited number of specialists and facilities that are available for complex or specialty care where no Easy Access Provider is available to provide the Covered Benefits. Additional information about the ElevateHealth network is described later in this section.

The Provider Directory lists both Easy Access Providers and Authorized Access Providers. (Please see subsection below for information on Easy Access and Authorized Access Providers). It identifies Plan Providers by state and town, specialty, and languages spoken and whether or not they are an Authorized Access Provider. You may view the Provider Directory online at our website, **www.harvardpilgrim.org**. You may also obtain a copy of the Provider Directory, free of charge, by calling the Member Services Department at **1-877-907-4742.**

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

Please Note: Plan Providers participate through contractual arrangements that can be terminated either by a provider or by us. In addition, a provider may leave the ElevateHealth network because of retirement, relocation or other reasons. This means that we cannot guarantee that the physician you choose will continue

to participate in the ElevateHealth network for the duration of your membership. If your PCP leaves the ElevateHealth network for any reason, we will make every effort to notify you in advance and 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)

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

A PCP may be a (1) physician or (2) advanced practice registered nurse who is designated as an Easy Access Provider specializing in one or more of the following specialties: internal medicine, pediatrics or family practice. PCPs are listed in the Provider Directory. You can access our website at **www.harvardpilgrim.org** or call the Member Services Department at **1-877-907-4742** to confirm that the PCP you select is available.

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

You may change your PCP at any time. Just choose a new PCP who is an Easy Access Provider from the Provider Directory. You can change your PCP online by using **your secure online account** at **www.harvardpilgrim.org** or by calling the Member Services Department at **1-877-907-4742**. The change is effective immediately.

2. Obtain Referrals to Specialists

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

If you need to see a specialist, you must contact your PCP for a Referral prior to the appointment. In most cases, a Referral will be given to an Easy Access Provider. Referrals to Plan Providers must be given in writing.

3. Show Your Identification Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the Provider may not bill us for Covered Benefits, and you may be responsible for the cost of the service. You can order a new ID card online by using **your secure online account** at **www.harvardpilgrim.org** or by calling the Member Services Department at **1-877-907-4742**.

4. Share Costs

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

- Copayments
- Coinsurance
- Deductibles

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

5. Be Aware That Your Plan Does Not Pay for All Health Services

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

D. HOW TO OBTAIN CARE

IMPORTANT POINTS TO REMEMBER

1) You and each Member of your family must select a PCP from the list of Easy Access Providers. You can find an Easy Access Provider at www.harvardpilgrim.org/elevatehealth.
2) In order to receive Covered Benefits you must use Plan Providers, except as noted below.
3) In order to receive primary care services, including internal medicine, family practice, pediatrics, routine obstetrics and gynecology, or routine or preventive care you must obtain these services from an Easy Access Provider.
4) If you need care from a specialist, you must contact your PCP for a Referral to a specialist who is an Easy Access Provider. For exceptions, see *I.D.8. Services That Do Not Require a Referral* below.
5) In order to receive Covered Benefits from designated Authorized Access Providers, your PCP or specialist must obtain Prior Approval from the Plan. Prior Approval will be provided when it has been determined that no Easy Access Provider has the professional expertise needed to provide the required services.
6) In the event of a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. You do not need a Referral for Medical Emergency services.

1. Your PCP Manages Your Health Care

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

- Care in a Medical Emergency.
- Care when you are temporarily traveling outside of the state where you live as described below.
- Mental health care, which may be arranged by calling the Behavioral Health Access Center at **1-888-777-4742**. The telephone number for the Behavioral Health Access Center is also listed on your ID card. Please see section *III. Covered Benefits*, *Mental Health and Substance Use Disorder Treatment* for information on this benefit.
- Special services that do not require a Referral that are listed in section *I.D.8. Services That Do Not Require a Referral* below.

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

You may change your PCP at any time. Just choose a new PCP who is an Easy Access Provider from the Provider Directory. You can change your PCP online by using **your secure online account** at **www.harvardpilgrim.org** or by calling the Member Services Department at **1-877-907-4742**. The change is effective immediately. If you select a new PCP, all Referrals from your prior PCP become invalid. Your new PCP will need to assess your condition and provide new Referrals.

2. Referrals for Hospital and Specialty Care

When you need hospital or specialty care, you must first call your PCP, who will coordinate your care. This helps your PCP manage and maintain the quality of your care. When you need specialty care, your PCP will refer you to an Easy Access Provider. If you or your PCP has difficulty finding an Easy Access Provider who can provide the services you need, we will assist you. For help finding a medial provider, please call **1-877-907-4742**. For help finding a mental health care provider, please call **1–888–777–4742**. If no Easy Access Provider has the expertise needed to meet your medical needs, we will assist you in finding an appropriate Authorized Access Provider or Non-Plan Provider if needed. In these instances, Prior Approval will be required in order to receive services from an Authorized Access Provider or from a Non-Plan Provider.

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

Your PCP may authorize a standing Referral with an Easy Access Provider who is a specialist when:

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

There are certain specialized services for which you will be directed to a Center of Excellence for care. Please see section *I.D.5. Centers of Excellence* for more information.

Certain specialty services may be obtained without involving your PCP. For more information please see section *I.D.8. Services That Do Not Require a Referral*.

3. Using Plan Providers

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

1) The service was received in a Medical Emergency. Please see section *I.D.6. Medical Emergency Services* for information on your coverage in a Medical Emergency.
2) The service was received while you were outside of the state where you live and coverage is available under the benefit for temporary travel. Please see section *I.D.7. Coverage for Services When You Are Temporarily Traveling Outside of the State Where You Live* for information on this benefit.
3) No Plan Provider has the professional expertise needed to provide the required service. In this case, services by a Non-Plan Provider must be authorized in advance by us, unless one of the exceptions above applies.
4) Your physician is disenrolled as a Plan Provider and one of the exceptions stated in section *I.F. SERVICES PROVIDED BY A DISENROLLED OR NON-PLAN PROVIDER* applies. Please refer to that section for the details of these exceptions.

To find out if a provider is in the Plan network, see the Provider Directory. The Provider Directory is available online at **www.harvardpilgrim.org** or by calling our Member Services Department at **1-877-907-4742**.

4. Using Easy Access and Authorized Access Providers

In most cases, Covered Benefits must be received from a Plan Provider to be eligible for coverage. There are two types of providers under your Plan that make up the ElevateHealth Provider Network. These are (1) Easy Access Providers and (2) Authorized Access Providers.

Easy Access Providers are the providers through which you will receive most of your care. Easy Access Providers include Primary Care Providers (PCPs), specialists and other providers. You must choose a PCP from the list of Easy Access Providers for yourself and each of your family members when you enroll in the Plan. Your PCP will provide or coordinate most of your care. In order to receive primary care services, including internal medicine, family practice, pediatrics, routine obstetrics and gynecology, or routine or preventive care, you must obtain Covered Benefits from an Easy Access Provider.

Sometimes, however, your care may not be able to be provided by an Easy Access Provider and must be obtained from an Authorized Access Provider. Authorized Access Providers are physicians and hospitals who provide highly specialized care that is not available from Easy Access Providers. Your PCP or specialist is required to obtain Prior Approval from HPHC-NE before you receive services from an Authorized Access Provider. Prior Approval will be provided only when it has been determined that no Easy Access Provider has the professional expertise needed to provide the required services. HPHC-NE will not grant Prior Approval for an Authorized Access Provider for any primary care services, including internal medicine, family practice, pediatrics, routine obstetrics and gynecology, or routine or preventive care. These services may only be obtained from Easy Access Providers.

To obtain Prior Approval for certain services, your PCP or specialist should call: **1–800–708–4414.**

Please refer to your Provider Directory or view the directory online at **www.harvardpilgrim.org** for a list of providers in the ElevateHealth Provider Network.

5. Centers of Excellence

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

Centers of Excellence are selected by us based on the findings of recognized specialty organizations or government agencies such as Medicare.

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

- Weight loss surgery (bariatric surgery)

Important Notice: No coverage is provided for the service listed above unless it is received from a

Plan Provider that has been designated as a Center of Excellence. To verify a Provider's status, see the Provider Directory. The Provider Directory is available online at **www.harvardpilgrim.org** or call our Member Services Department at **1-877-907-4742**.

6. Medical Emergency Services

In a Medical Emergency, including an emergency 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. Your emergency room Member Cost Sharing is listed in your Schedule of Benefits. Please remember that if you are hospitalized, you must call the Plan at **1-877-907-4742** within 48 hours or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to the Plan or PCP by an attending emergency physician no further notice is required. Your PCP will help to arrange for any follow-up care you may need.

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

When you are temporarily traveling 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 hospitalized, you must call the Plan at **1-877-907-4742** within 48 hours, or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to the Plan or PCP by an attending emergency physician no further notice is required. Your PCP will help to arrange for any follow-up care you may need.

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

Please Note: We must have your current address on file in order to correctly process claims for care outside the Service Area. To change your address, please call our Member Services Department at **1-877-907-4742**.

8. Services That Do Not Require a Referral

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

i. Family Planning Services:

- Contraceptive monitoring
- Family planning consultation, including pregnancy testing
- Tubal ligation
- Voluntary termination of pregnancy

ii. Outpatient Maternity Services

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

iii. Gynecological Services

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

iv. Dental Services:

- Accidental injury dental care
- Pediatric dental services

v. Other Services:

- Acupuncture treatment for injury or illness
- Chiropractic care

- Routine eye examination
- Urgent Care Services

E. MEMBER COST SHARING

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

If a Provider is categorized as both a Level 1 Provider and a Level 2 Provider, the Level 1 Copayment applies. For example, if a Provider is both a PCP and a Cardiologist, you will be responsible for the Level 1 Copayment.

Your Plan may have other Copayment amounts. For more information about Copayments under your Plan, including your specific Copayment requirements, please refer to your Schedule of Benefits.

2. Deductible

A Deductible is a specific dollar amount that is payable by a Member for Covered Benefits received each Calendar Year before any benefits subject to the Deductible are payable by the Plan. Deductible amounts are incurred on the date of service. You may have different Deductibles that apply to different Covered Benefits under your Plan. Your Deductible is listed in your Schedule of Benefits.

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

Your Plan 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 amount, you will have no additional Deductible Member Cost Sharing for Covered Benefits for the remainder of the Calendar Year. An individual Deductible may also apply if you have Family Coverage that includes a family Deductible with an embedded individual Deductible. Please see additional information on Family Coverage Deductibles below.

Family Deductible A Family Deductible will apply when you have Family Coverage. If you have Family Coverage, the Deductible may be met by all Members of the family combined. For example, a family of four would meet a $4,000 family Deductible if one covered family Member incurs $3,000 in covered medical expenses and another covered family Member incurs $1,000 in covered medical expenses during the Calendar Year. At that point, the family Deductible would also be met for the entire family for that Calendar Year.

Family Deductible with embedded individual Deductibles A Family Deductible with embedded individual Deductibles may apply when you have Family Coverage. If your Family Coverage includes a family Deductible with an embedded individual Deductible, the Deductible can be satisfied in one of two ways:

a. If a Member of a covered family meets an individual Deductible, then that Member has no additional Deductible Member Cost Sharing for Covered Benefits for the remainder of the Calendar Year.

b. If any number of Members in a covered family collectively meet the family Deductible, then all Members of the covered family have no additional Deductible Member Cost Sharing for Covered Benefits for the remainder of the Calendar Year. No one family member may contribute more than the individual Deductible amount to the family Deductible.

An embedded individual Deductible may not be less than the applicable 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.

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

3. Coinsurance

After the appropriate Deductible amount is met, you may be responsible for paying a Coinsurance amount which is a percentage of the Allowed Amount. When using Plan Providers, the Allowed Amount is based on the contracted rate between HPHC-NE and the Provider. Coinsurance amounts are listed in your Schedule of Benefits.

4. Out-of-Pocket Maximum

Your coverage includes an Out-of-Pocket Maximum. An Out-of-Pocket Maximum is the total amount of Copayments, Deductible or Coinsurance payments for which a Member or a family is responsible in a Calendar Year. Once the Out-of-Pocket Maximum has been reached, no further Copayment, Deductible or Coinsurance amounts will be payable by the Member and HPHC-NE will pay 100% of the Allowed Amount for the remainder of the Calendar Year. Once a family Out-of-Pocket Maximum has been met in a Calendar Year, the Out-of-Pocket Maximum is deemed to have been met by all Members in a family for the remainder of the Calendar Year.

Certain expenses may not apply to the Out-of-Pocket Maximum. Charges above the Allowed Amount never apply to the Out-of-Pocket Maximum.

All Plans have one or more individual Out-of-Pocket Maximums or family Out-of-Pocket Maximums.

Individual Out-of-Pocket Maximums An Individual Out-of-Pocket Maximum will apply when you have Individual Coverage. Once you have met the individual Out-of-Pocket Maximum amount, you will have no additional Member Cost Sharing for Covered Benefits for the remainder of the Calendar Year. An individual Out-of-Pocket Maximum may also apply if you have Family Coverage that includes a family Out-of-Pocket Maximum with an embedded individual Out-of-Pocket Maximum. Please see additional information on Family Coverage Out-of-Pocket Maximums below.

Family Out-of-Pocket Maximums Family Out-of-Pocket Maximums will apply when you have Family Coverage. If you have Family Coverage, the Out-of-Pocket Maximum can be met by all Members of the family combined. For example, a family of four would meet a $10,000 family Out-of-Pocket Maximum if one covered family Member pays $5,000 in Member Cost Sharing, another family Member pays $3,000 in Member Cost Sharing and yet another covered family Member pays $2,000 in Member Cost Sharing during the Calendar Year. At that point, the family Out-of-Pocket Maximum would be met for the entire family for that Calendar Year.

Family Out-of-Pocket Maximums with embedded individual Out-of-Pocket Maximums Family Out-of-Pocket Maximums with embedded individual Out-of-Pocket Maximums may apply when you have Family Coverage. If your Family Coverage includes a family Out-of-Pocket Maximum with an embedded individual Out-of-Pocket Maximum, the Out-of-Pocket Maximum can be satisfied in one of two ways:

a. If a Member of a covered family meets an individual Out-of-Pocket Maximum, then that Member has no additional Member Cost Sharing for the remainder of the Calendar Year.

b. If any number of Members in a covered family collectively meet the family Out-of-Pocket Maximum, then all Members of the covered family have no additional Member Cost Sharing for the remainder of the Calendar Year. No one family member may contribute more than the individual 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.

If a Member changes to Family Coverage from Individual Coverage or to Individual Coverage from Family Coverage within a Calendar Year, expenses that Member incurred for Covered Benefits toward the Out-of-Pocket Maximum under the prior coverage will apply toward the Out-of-Pocket Maximum limit under their new coverage. If the incurred Out-of-Pocket Maximum amount is greater than the new Out-of-Pocket Maximum limit, the Member will have no additional cost sharing for that 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 for reasons unrelated to fraud or quality of care, we will use our best efforts to provide you with written notice at least 60 days prior to the date of your PCP's disenrollment. That notice will also explain the process for selecting a new PCP. You may be eligible to continue to receive coverage for services provided by the disenrolled PCP, under the terms of this Handbook and your Schedule of Benefits, for at least 30 days after the disenrollment date. If you are undergoing

an active course of treatment for an illness, injury or condition, we may authorize additional coverage through the acute phase of illness, or for up to 90 days (whichever is shorter).

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

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

G. CLINICAL REVIEW CRITERIA

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

H. PROVIDER FEES FOR SPECIAL SERVICES (CONCIERGE SERVICES)

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

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

I. BUNDLED PAYMENT ARRANGEMENTS

The Plan may participate in bundled payment arrangements with certain Providers under which a specific service or treatment is paid for based on a fixed sum for all of the Covered Benefits you receive. Member Cost Sharing for Covered Benefits under a bundled payment arrangement may be less than if the Covered Benefits were received without the bundled payment arrangement. Please refer to **www.harvardpilgrim.org** or call the Member Services Department at **1-877-907-4742** for a list of Providers who have bundled payment arrangements with Harvard Pilgrim and their corresponding services. We may revise the list of Providers or services who have bundled payment arrangements upon 30 days notice to Members.

J. COUNSELING PROGRAMS

Harvard Pilgrim offers certain counseling programs to Members receiving care covered under the Plan. These services may include telephone or video counseling sessions designed to treat depression, anxiety or stress that may accompany chronic conditions of life events. These counseling sessions may be available to you at lower Member Cost Sharing. Please log into your secure online account at **www.harvardpilgrim.org** or call the Member Services Department at **1–877–907–4742** for more information concerning these programs and their Member Cost Sharing obligations.

II. Glossary

This section lists words with special meaning within the Handbook.

Activities of Daily Living The basic functions of daily life include bathing, dressing, and mobility, including, but not limited to, transferring from bed to chair and back, walking, sleeping, eating, taking medications and using the toilet.

Allowed Amount The Allowed Amount is the maximum amount the Plan will pay for Covered Benefits minus any applicable Member Cost Sharing.

The Allowed Amount depends upon whether a Covered Benefit is provided by a Plan Provider or a Non-Plan Provider, as follows:

1. Plan Providers. If a Covered Benefit is provided by a Plan Provider, the Allowed Amount is the contracted rate HPHC-NE 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-NE. 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, Vermont or Connecticut, 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, Vermont or Connecticut, the Allowed Amount is defined as follows:

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

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

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

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

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

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

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

As stated above, the Allowed Amount is the maximum amount the Plan will pay for Covered Benefits minus any applicable Member Cost

Sharing. Most Non-Plan Providers are permitted to charge amounts for Covered Benefits in excess of the Allowed Amount. In that event, the Plan is responsible for payment of the Allowed Amount, minus any applicable Member Cost Sharing. The Member is responsible for paying the applicable Member Cost Sharing amount and any additional amount charged by the Non-Plan Provider.

Anniversary Date The date upon which the yearly premium rate is adjusted and benefit changes normally become effective. This Benefit Handbook, Schedule of Benefits and Prescription Drug Brochure, will terminate unless renewed on the Anniversary Date.

Authorized Access Provider Certain specialty health care providers who are participating in the Plan. Prior Approval is required from the Plan for services with these providers. Authorized Access Providers are listed in the Provider Directory.

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

Benefit Handbook (or Handbook) This document that describes the terms and conditions of the Plan, including but not limited to, Covered Benefits and exclusions from coverage.

Benefit Limit The day, visit or any other limit maximum that applies to certain Covered Benefits. Once the Benefit Limit has been reached, no more benefits will be paid for such services or supplies. If you exceed the Benefit Limit, you are responsible for all charges incurred. The Benefit Limits applicable to your Plan are listed in your Schedule of Benefits.

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

Calendar Year The one-year period beginning on January 1 for which benefits are purchased and administered. Benefits for which limited yearly coverage is provided renew at the beginning of the Calendar Year. Benefits for which limited coverage is provided every two years renew at the beginning of every second Calendar Year. Benefits under your Plan are administered on a Calendar Year basis.

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

Coinsurance A percentage of the Allowed Amount 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%.

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.

There may be two types of office visit Copayments that apply to your Plan: a lower Copayment known as "Level 1" and a higher Copayment known as "Level 2." Your specific Copayment amounts, and the services to which they apply, are listed in your Schedule of Benefits.

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

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

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

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

Deductible A specific dollar amount that is payable by the Member for Covered Benefits received each 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 your Schedule of Benefits.

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

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

Dependent A Member of the Subscriber's family who (1) meets the

eligibility requirements as described in section *VIII.A.2. Dependent Eligibility* for coverage through a Subscriber and (2) is enrolled in the Plan.

Easy Access Provider Designated providers in the ElevateHealth Plan who are the providers through which you will receive most of your care. Easy Access Providers include Primary Care Providers (PCPs), specialists and other providers.

ElevateHealth Provider Network A network of 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.

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 counties of: Belknap, Cheshire, Coos, Grafton, Hillsborough, Merrimack, Rockingham, Sullivan and Strafford. We may add or delete counties from the Enrollment Area from time to time.

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

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

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

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

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

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

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

Individual Coverage Coverage for a Subscriber only.

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

Medical Emergency A sudden and unexpected onset of a condition with symptoms of sufficient severity that a prudent person with average knowledge of health and medicine would reasonably expect that failure to obtain immediate medical attention could result in serious impairment to bodily functions, serious dysfunction of bodily organ or part, or could place the person's health in serious jeopardy.

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

Medically Necessary or Medical Necessity Those medical services which are provided to a Member for the purpose of preventing, stabilizing, diagnosing or treating an illness, injury or disease, or the symptoms thereof, in a manner that is (a)

consistent with generally accepted standards of medical practice, (b) clinically appropriate in terms of type, frequency, extent, location of service and duration, (c) demonstrated through scientific evidence to be effective in improving health outcomes, (d) representative of best practices in the medical profession, and (e) not primarily for the convenience of the enrollee or physician or other health care provider.

Member Any Subscriber or Dependent covered under the Plan.

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

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

Non-Plan Provider Providers of health care services that are not members of the ElevateHealth Plan.

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 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 Calendar Year. As an example, the Out-of-Pocket Maximum can be reached by the following: $500 in Deductible expenses, $400 in Coinsurance expenses and $100 in Copayment expenses.

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

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

Plan or Policy This package of health care benefits offered by Harvard Pilgrim Health Care of New England.

Plan Provider Providers of health care services in the Service Area that are under contract to provide care to Members of your Plan. Providers include, but are not limited to hospitals, skilled nursing facilities, and medical professionals including: physicians, psychiatrists, phychiatrist-supervised physician assistants, naturopaths, acupuncturists, nurse practitioners, advanced practice registered nurses, physician assistants, certified midwives, certified registered nurse anesthetists, and licensed mental health professionals including psychologists, clinical social workers, marriage and family therapists, psychiatric/mental health advanced practice registered nurses, alcohol and drug counselors, clinical mental health counselors, and pastoral psychotherapists (except when providing services to a Member of his church or congregation in the course of his or her duties as a pastor, minister or staff person). Providers are made up of two provider groups (1) Easy Access Providers, and (2) Authorized Access Providers. Providers are listed in the Provider Directory.

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

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. Prior Approval is required for the coverage of services by Authorized Access Providers. Prior Approval will only be provided when it has been determined that no Easy Access Provider has the professional expertise needed to provide the required service.

Primary Care Provider (PCP) An Easy Access Provider designated to help you maintain your health and to provide and authorize your medical care under the Plan. A PCP may be a (1) physician or a (2) advanced practice registered nurse specializing in one or more of the following specialties: internal medicine, pediatrics or family practice. A PCP may designate other Plan Providers to provide or authorize a Member's care.

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**.

Referral An instruction from your PCP that gives you the ability to see another Easy Access 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.

Rehabilitation Services Rehabilitation Services are treatments for a disease or injury that helps restore or move an individual toward functional capabilities he/she had prior to the 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.

Serious Mental Illness Serious Mental Illness means any of the following conditions: (a) schizophrenia and other psychotic disorders; (b) schizoaffective disorder; (c) bipolar disorders; (d) anorexia nervosa and bulimia nervosa; (e) major depressive disorder; (f) obsessive compulsive disorder; (g) panic disorder; (h) pervasive developmental disorder or autism; and (i) chronic post-traumatic stress disorder.

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

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

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

Surgery - Outpatient A surgery or procedure in a day surgery department, ambulatory surgery department or outpatient surgery center that requires operating room, anesthesia and recovery room services.

Surrogacy Any procedure in which a person serves as the gestational carrier of a child with the goal or intention of transferring custody of the child after birth to an individual (or individuals) who is (are) unable or unwilling to serve as the gestational carrier. This includes both procedures in which the gestational carrier is, and is not, genetically related to the child.

Urgent Care Medically Necessary services for a condition that requires prompt medical attention but is not a Medical Emergency.

III. Covered Benefits

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

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 *I.D.3. Using Plan Providers* for other exceptions that apply.

Benefit	Description
1 . Acupuncture Treatment for Injury or Illness	
	The Plan covers acupuncture treatment for illness or injury, including, electro-acupuncture, that is provided for the treatment of neuromusculoskeletal pain.
2 . Ambulance Transport	
	Emergency Ambulance Transport If you have a Medical Emergency, your Plan covers ambulance transport to the nearest hospital that can provide you with Medically Necessary care. **Non-Emergency Ambulance Transport** You're also covered for non-emergency ambulance transport between hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary. Services must be arranged by a Plan Provider.
3 . Autism Spectrum Disorders Treatment	
	The Plan covers the following services for the treatment of autism spectrum disorders to the extent required by New Hampshire law: • Services and treatment programs, including applied behavioral analysis, necessary to produce socially significant improvements in human behavior or to prevent loss of attained skill or function. To be covered by the Plan, applied behavior analysis must be provided by a person who is professionally certified by the National Behavior Analyst Certification Board or provides services under the supervision of a person professionally certified by the National Behavior Analyst Certification Board. • Direct or consultative services provided by a licensed Plan Provider including a licensed psychiatrist, licensed advanced practice registered nurse, licensed psychologist, or licensed clinical social worker. • Services provided by a licensed speech therapist, licensed occupational therapist, or licensed physical therapist. • Prescriptions drugs.

Benefit	Description
Autism Spectrum Disorders Treatment (Continued)	
	The Plan may require the submission of a treatment plan, including frequency and duration of treatment showing that the treatment is Medically Necessary and is consistent with nationally recognized treatment standards for autism spectrum disorders.
4 . 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 guidelines. To obtain a copy, please call **1-888-888-4742**.
5 . 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.
6 . Chiropractic Care	
	The Plan covers musculoskeletal adjustment or manipulation up to the Benefit Limit listed in the Schedule of Benefits.
7 . Clinical Trials for the Treatment of Cancer or Other Life-Threatening Diseases	
	The Plan covers services for Members enrolled in a qualified clinical trial for the treatment, prevention or detection of any form of cancer or other life-threatening disease under the terms and conditions provided for under New Hampshire and federal law. A qualified clinical trial means any trial approved by: (1) a New Hampshire institutional review board; (2) a federal agency including the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control and Prevention, and the Department of Health and Human Services; or (3) any other state or federal agency authorized by law to approve clinical trials. All of the requirements for coverage under the Plan apply to coverage under this benefit. Coverage is provided under this benefit for services that are Medically Necessary for the treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the Plan. Coverage is not provided for the following: (1) the investigational item, device or service itself; or (2) for services, tests or items that are provided solely to satisfy data collection and analysis for the clinical trial and that are not used for the direct clinical management of your condition.

Benefit	Description
8 . Dental Services	
	Important Notice: The Plan does not provide dental insurance. It covers only the limited Dental Care described below. No other Dental Care is covered. **Accidental Injury Dental Care:** The Plan provides coverage for Medically Necessary Dental Care resulting from an accidental injury to sound natural teeth and gums. Coverage for Dental Care is subject to all other terms and conditions of this Evidence of Coverage. Dental Care required as a result of normal activities of daily living or extraordinary use of the teeth is not considered by the Plan to have occurred as the result of an accident. No coverage is provided under the Plan for repairs to teeth that are damaged as a result of such activities. **Outpatient Surgery Expenses for Dental Care:** The Plan covers the expenses of a hospital or outpatient surgery and expenses for general anesthesia administered by a licensed anesthesiologist or certified registered nurse anesthetist for the performance of Dental Care if: • A Member is a child under the age of 13 who is determined by a licensed dentist and his or her PCP to have a dental condition that is so complex as to require the necessary dental procedures be performed in a hospital or surgical day care facility; or • A Member (of any age) is determined by his or her PCP to require dental treatment in a hospital or surgical day care facility due to exceptional medical circumstances or a developmental disability, which places the Member at serious risk. Your PCP must arrange for all hospital or outpatient surgery. The only expenses covered under this benefit are hospital charges, surgical day charges and anesthesia charges. **Pediatric Dental Care:** The Plan provides coverage for pediatric dental care for children until the end of the month in which the child turns 19. Please see the Pediatric Dental Benefit section of your Schedule of Benefits and Appendix B: Pediatric Dental Benefit (for children under the age of 19) later in this Benefit Handbook for details.
9 . Diabetes Services and Supplies	
	Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care: The Plan covers outpatient self-management education and training for the treatment of diabetes, including medical nutrition therapy services, used to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes. Services must be provided on an individual basis and be provided by a Plan Provider. Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care. The following items are also covered: **Diabetes Equipment:** • Blood glucose monitors • Dosage gauges • Injectors

Benefit	Description
Diabetes Services and Supplies (Continued)	
	• Insulin pumps (including supplies) and infusion devices • Lancet devices • Therapeutic molded shoes and inserts • Visual magnifying aids • Voice synthesizers **Pharmacy Supplies:** • Blood glucose strips • Flash glucose monitors (including supplies) • Insulin, insulin needles and syringes • Lancets • Oral agents for controlling blood sugar • Urine and ketone test strips For coverage of pharmacy items listed above, you must 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 the Member Services Department at **1-877-907-4742**.
10 . Dialysis	
	The Plan covers dialysis on an inpatient, outpatient or at home basis. When Medicare is the primary payer 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 Calendar Year. You must make arrangements in advance with your Plan Provider.
11 . Drug Coverage	
	You have limited coverage for drugs received during inpatient and outpatient treatment and also for certain medical supplies you purchase at a pharmacy under this Benefit Handbook. This coverage is described in Subsection 1, below. You also have coverage for outpatient prescription drugs you purchase at a pharmacy under the Plan's outpatient prescription drug coverage. Subsection 2, below, explains more about this coverage. **1. Your Coverage under this Benefit Handbook** This Benefit Handbook covers the following: a. Drugs Received During Inpatient Care. The drug is administered to you while you are an inpatient at a hospital, Skilled Nursing Facility or other medical facility at which Covered Benefits are provided to you on an inpatient basis; b. Drugs Received During Outpatient or Home Care. These drugs are known as "Medical Drugs." A Medical Drug is administered to you either (1) in a doctor's office or other outpatient medical facility, or (2) at home while you are receiving home care services or receiving drugs administered by home infusion services.

Benefit	Description
Drug Coverage (Continued)	
	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. c. Drugs and supplies required by law. Coverage is provided for (1) certain diabetes supplies you purchase at a pharmacy; and (2) certain orally administered medications for the treatment of cancer. There is no Member Cost Sharing for orally administered medications for the treatment of cancer after the Deductible has been met. Please see the benefit for "Diabetes Services and Supplies" for the details of that coverage. No coverage is provided under this Benefit Handbook for: (1) drugs that have not been approved by the United States Food and Drug Administration; (2) drugs the Plan excludes or limits, including, but not limited to, drugs for cosmetic purposes; and (3) any drug that is obtained at an outpatient pharmacy except covered diabetes supplies, as explained above. **2. Outpatient Prescription Drug Coverage** In addition to the coverage provided under this Benefit Handbook, you also have coverage for outpatient prescription drugs. Your Plan provides coverage for most prescription drugs purchased at an outpatient pharmacy. Your Member Cost Sharing for prescription drugs purchased at a pharmacy will be listed on your ID Card. Please see the Prescription Drug Brochure for a detailed explanation of your benefits.
12 . Durable Medical Equipment (DME)	
	The Plan covers DME when Medically Necessary and ordered by a Plan Provider. We will rent or buy all equipment. The cost of the repair and maintenance of covered equipment is also covered. In order to be covered, all equipment must be: • Able to withstand repeated use; • Not generally useful in the absence of disease or injury; • Normally used in the treatment of an illness or injury or for the rehabilitation of an abnormal body part ; and • Suitable for home use. Coverage is only available for: • The least costly equipment adequate to allow you to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports; and • One item of each type of equipment. No back-up items or items that serve a duplicate purpose are covered. For example, the Plan covers a manual or an electric wheelchair, not both. Covered equipment and supplies include:

Benefit	Description
Durable Medical Equipment (DME) (Continued)	
	• Canes • Certain types of braces • Crutches • Hospital beds • Oxygen and oxygen equipment • Respiratory equipment • Walkers • Wheelchairs Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan.
13 . Early Intervention Services	
	The Plan covers early intervention services for children with an identified developmental disability or delay. Coverage is provided for children from birth until three years of age. Coverage under this benefit is only available for services rendered by the following types of providers: • Occupational therapists • Physical therapists • Speech-language pathologists • Clinical social workers
14 . Emergency Room Care	
	If you have a Medical Emergency, you are covered for care in a hospital emergency room. Please remember the following: • If you need follow-up care after you are treated in an emergency room, you must call your PCP. Your PCP will provide or arrange for the care you need. • If you are hospitalized, you must call the Plan at **1-877-907-4742** 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. • Services provided in an emergency room for conditions that do not meet the definition of Medical Emergency may apply a higher Member Cost Sharing. Examples of non-Medical Emergency services may include follow-up care, treatment for earaches, rashes, or sore throats, or suture removal. Please refer to your Schedule of Benefits to determine the applicable Member Cost Sharing for services provided in an emergency room. **Please Note:** You may log into your secure online account for more information on lower cost options when you need Urgent Care. Whenever possible, you should also contact your PCP prior to obtaining Urgent Care, because your PCP may be able to provide the services you require at a lower out-of-pocket cost.

Benefit	Description
15 . Family Planning Services	
	The Plan covers family planning services, including the following: • Contraceptive monitoring • Family planning consultation • Pregnancy testing • Genetic counseling • FDA approved birth control drugs, implants or devices • Professional services relating to the injection of birth control drugs and the insertion or removal of birth control implants or devices.
16 . Hearing Aids	
	The Plan covers hearing aids to the extent required by New Hampshire law. A hearing aid is defined as any instrument or device designed, intended or offered for the purpose of improving a person's hearing. Coverage is only available for the least costly hearing aid when determined by a Provider to be Medically Necessary to correct a hearing impairment. The Plan will pay the Allowed Amount, minus any applicable Member Cost Sharing, for the least costly hearing aid. If you purchase a hearing aid that is more expensive than the least costly item adequate to correct a Medically Necessary hearing impairment, you will be responsible for any additional cost. Medically Necessary hearing impairments do not include special functions needed for occupational purposes or sports. No back-up hearing aids that serve a duplicate purpose are covered. Covered Benefits include the following: • One hearing aid per hearing impaired ear • Any parts, attachments or accessories, including ear moldings • Services necessary to assess, select, fit or service the hearing aid that are provided by a licensed audiologist, hearing instrument specialist or licensed physician
17 . Home Health Care	
	If you are homebound for medical reasons, you are covered for home health care services listed below. To be eligible for home health care, your Plan Provider must determine that skilled nursing care or physical therapy is an essential part of active treatment. There must also be a defined medical goal that your Plan Provider expects you will meet in a reasonable period of time. When you qualify for home health care services as stated above, the Plan covers the following services: • 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
Home Health Care (Continued)	
	Medically Necessary prenatal and postpartum homemaker services are covered when on the recommendation of her attending healthcare provider, a woman is confined to bed rest or her normal functions of daily life (including walking, speaking, sleeping, eating, drinking and using the toilet) are restricted.
18 . Hospice Services	
	The Plan covers hospice services for terminally ill Members who need the skills of qualified technical or professional health personnel for palliative care. Care may be provided at home or on an inpatient basis. Inpatient respite care is covered for the purpose of relieving the primary caregiver and may be provided up to 5 days every 3 months not to exceed 14 days per Calendar Year. Inpatient care is also covered in an acute hospital or extended care facility when it is Medically Necessary to control pain and manage acute and severe clinical problems that cannot be managed in a home setting. Covered Benefits include: • Care to relieve pain • Counseling • Drugs that cannot be self-administered • Durable medical equipment appliances • Home health aide services • Medical supplies • Nursing care • Physician services • Occupational therapy • Physical therapy • Speech therapy • Respiratory therapy • Respite care • Social services
19 . Hospital – Inpatient Services	
	The Plan covers acute hospital care including, but not limited to, the following inpatient services: • Semi-private room and board • Doctor visits, including consultation with specialists • Medications • Laboratory, 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:

Benefit	Description
Hospital – Inpatient Services (Continued)	
	• Weight loss surgery (bariatric surgery) Please see the *I.D.5. Centers of Excellence* section for more information.
20 . House Calls	
	The Plan covers house calls.
21 . Human Organ Transplant Services	
	The Plan covers human organ transplants, including bone marrow transplants for a Member with metastasized breast cancer in accordance with the criteria of the National Cancer Institute. The Plan covers the following services when the recipient is a Member of the Plan: • Care for the recipient • Donor search costs through established organ donor registries • Donor costs that are not covered by the donor's health plan If a Member is a donor for a recipient who is not a Member, then the Plan will cover the donor costs for the Member when they are not covered by the recipient's health plan.
22 . Infertility Services and Treatment	
	The Plan covers the following diagnostic services for infertility: • Consultation • Evaluation • Laboratory tests **Please Note:** The Plan does not cover infertility treatment such as intra-cytoplasmic sperm injection (ICSI), intra-uterine insemination (IUI), and in-vitro fertilization (IVF), but coverage is provided for Medically Necessary services to treat underlying medical conditions that may cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency).
23 . 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 also covers the following: • Human leukocyte antigen testing or histocompatibility locus antigen testing for A, B or DR antigens. The Plan provides coverage up to $150 toward the cost of human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish bone marrow transplant donor suitability. Services are subject to the Deductible. Testing must be performed at a facility accredited by the American Association of Blood Banks or its successors. At the time of testing the Member must complete and sign an informed consent form that authorizes the results of the test to be used for participation in the National Marrow Donor Program. NH Law prohibits Providers to bill, charge, collect a deposit from, seek payment for or reimbursement from, or have recourse against a Member for any portion of the HLA laboratory fee expense.

Benefit	Description
Laboratory, Radiology and Other Diagnostic Services (Continued)	
	• Screening and diagnostic mammograms. This includes mammograms provided by breast tomosynthesis (3D mammographic imaging). • Blood lead testing
24 . Low Protein Foods	
	The Plan covers low protein foods for inherited diseases of amino and organic acids to the extent required by New Hampshire law.
25 . Maternity Care	
	The Plan covers the following maternity services: • Routine outpatient prenatal care, including evaluation and progress screening, physical exams, recording of weight and blood pressure monitoring. • Prenatal genetic testing (office visits require a referral). • Delivery, including a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean section. Any decision to shorten the inpatient stay for the mother and her newborn child will be made by the attending physician and the mother. • Services by a certified midwife provided in a licensed health care facility or at a home. • Newborn care up to 31 days after birth. Coverage beyond 31 days will only be provided if the newborn is enrolled as a Dependent. Please see the section *VII. Eligibility* for information on adding new Dependents. • Routine outpatient postpartum care for the mother, up to six weeks after delivery. • Prenatal homemaker services (cooking, cleaning, laundry, shopping and other light housekeeping) for a woman who (1) is confined to bed rest or (2) whose normal functions of daily life (including walking, speaking, sleeping, eating, drinking and using the toilet) are restricted. Services must be Medically Necessary, as determined by your attending Plan Provider, who shall consult with the Plan case manager, when applicable. • A minimum of two postpartum homemaker visits, when Medically Necessary, as determined by your attending Plan Provider, who shall consult with the Plan case manager, when applicable.
26 . Medical Formulas	
	The Plan covers enteral formulas for inherited diseases of amino and organic acids and the treatment of impaired absorption of nutrients caused by disorders effecting the absorptive surface, functional length, or motility of the gastrointestinal tract to the extent required by New Hampshire law.

Benefit	Description
27 . Mental Health and Substance Use Disorder Treatment	
	Before you receive mental health and substance use disorder treatment, you should call the Behavioral Health Access Center at **1-888-777-4742**. The Behavioral Health Access Center phone line is staffed by licensed mental health clinicians. A clinician will assist you in finding appropriate mental health providers in the network and arranging the services you require. To be covered by the Plan, all mental health and substance use disorder treatment must be provided by contracted providers. The only exceptions apply to: (1) care required in a Medical Emergency, and (2) care when you are temporarily outside of the state where you live. These exceptions are described in the section *I. How the Plan Works*. **Coverage for New Hampshire Parity Conditions:** Under New Hampshire law, the Plan covers Medically Necessary treatment of Serious Mental Illness at the same level as for any other medical condition. Serious Mental Illnesses are the following diagnoses: schizophrenia and other psychotic disorders, schizoaffective disorder, bipolar disorder, anorexia nervosa and bulimia nervosa, major depressive disorder, panic disorder, pervasive developmental disorder or autism, chronic post-traumatic stress disorder and obsessive-compulsive disorder including pediatric autoimmune neuropsychiatric disorders (PANS/PANDAS). Treatment for PANS/PANDAS may include intravenous immunoglobulin therapy (IVIG) when ordered by a physician.. **Coverage for Other Conditions:** In addition to the coverage discussed above, the Plan will provide coverage for the care of all other conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. (The only exception is conditions for which only a "Z Code" designation applies, which means that the condition is not attributable to a mental disorder.) Services for all other conditions not identified above will be covered to the extent Medically Necessary. **Mental Health and Substance Use Disorder Treatment** The Plan provides coverage through the Behavioral Health Access Center for the following Medically Necessary mental health and substance use disorder treatment: a) Inpatient Services • Mental health services • Substance use disorder treatment • Detoxification services b) Partial Hospitalization Services • Partial hospitalization is an intensive outpatient program that provides coordinated services in a therapeutic setting. Partial hospitalization will only be covered if you and your doctor agree that this treatment is best for you. c) Outpatient Services • Care by a licensed mental health professional • Substance use disorder treatment • Detoxification services • Medication management • Methadone maintenance • Psychological testing

Benefit	Description
Mental Health and Substance Use Disorder Treatment (Continued)	
	• eVisits (email consultations between a patient and a licensed mental health professional when there is an established relationship) **Please Note:** A Member requesting mental health services will be referred for at least five (5) visits per Calendar Year to an HPHC-NE network mental health provider. The Plan will not review Medical Necessity of those five (5) visits.
28 . Oral Surgery	
	The Plan covers the following services when Medically Necessary: • Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia • Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part • Oral/surgical correction of accidental injuries as described in the "Dental Services" benefit. • Surgical services for the treatment of Temporomandibular Joint Dysfunction (TMD) as described in the "Temporomandibular Joint Dysfunction (TMD)" benefit. • Treatment of non-dental lesions, such as removal of tumors and biopsies • Incision and drainage of infection of soft tissue not including odontogenic cysts or abcesses
29 . 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.
30 . Ostomy Supplies	
	The Plan covers the following ostomy supplies: • Irrigation sleeves, bags and catheters • Pouches, face plates and belts • Skin barriers
31 . Physician and Other Professional Office Visits	
	Physician services, including services of all covered medical professionals, can be obtained on an outpatient basis at a physician's office or a hospital. These services may include: • Routine physical examinations, including routine gynecological examination • Follow-up care provided by an obstetrician or gynecologist for obstetrical or gynecological conditions identified during maternity care or annual gynecological visit • Immunizations, including childhood immunizations as recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention and the American Academy of Pediatrics • Well baby and well child care • Health education and nutritional counseling • Sickness and injury care • Palliative care

Benefit	Description
Physician and Other Professional Office Visits (Continued)	
	• Vision and Hearing screenings • Medication management • Chemotherapy • Radiation therapy • eVisits (email consultations between a patient and a physician or other medical professional when there is an established relationship)
32 . 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). A prosthetic device means an artificial limb device to replace, in whole or in part, an arm or leg. • Prosthetic eyes Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan.
33 . Reconstructive Surgery	
	The Plan covers reconstructive and restorative surgical procedures as follows: • Reconstructive surgery is covered when the surgery can reasonably be expected to improve or correct a Physical Functional Impairment resulting from an accidental injury, illness, congenital anomaly, birth injury or prior surgical procedure. If reconstructive surgery is performed to improve or correct a Physical Functional Impairment, as stated above, Cosmetic Services that are incidental to that surgery are also covered. After a Physical Functional Impairment is corrected, no further Cosmetic Services are covered by the Plan. • Restorative surgery is covered to repair or restore appearance damaged by an accidental injury. (For example, this benefit would cover repair of a facial deformity following an automobile accident.) Benefits are also provided for post mastectomy care, including coverage for: • Prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient; • Reconstruction of the breast on which the mastectomy was performed; and • Surgery and reconstruction of the other breast to produce a symmetrical appearance.

Benefit	Description
Reconstructive Surgery (Continued)	
	Benefits include coverage for procedures that must be done in stages, as long as you are an active member. Membership must be effective on all dates on which services are provided. There is no coverage for Cosmetic Services or surgery except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care as described above. **Important Notice:** We use clinical guidelines to evaluate whether different types of reconstructive and restorative procedures are Medically Necessary. If you are planning to receive such treatment, you may review the current guidelines. To obtain a copy, please call **1-888-888-4742 ext. 38732**.
34 . 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.
35 . Rehabilitation and Habilitation Services – Outpatient	
	The Plan covers the following outpatient Rehabilitation and Habilitation Services: • Cardiac rehabilitation therapy • Occupational therapy • Physical therapy • Pulmonary rehabilitation therapy • Speech therapy Outpatient Rehabilitation and Habilitation Services are covered up to the Benefit Limit listed in the Schedule of Benefits. Services are covered only: • If, in the opinion of your Plan Provider, there is likely to be significant improvement in your condition within the period of time benefits are covered; and • When needed to improve your ability to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports. If you are in an approved course of pulmonary rehabilitation, physical and occupational therapies are covered to the extent that they are a Medically Necessary component of the pulmonary rehabilitation. Services must be approved by the Plan. Rehabilitation and Habilitation Services are also covered under your inpatient hospital and home health benefits. When such therapies are part of an approved home care treatment plan they are available as described in section *III. Covered Benefits, Home Health Care*.

Benefit	Description
36 . 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
37 . Skilled Nursing Facility Care	
	The Plan covers care in a health care facility operated pursuant to law that provides 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.
38 . Surgery - Outpatient	
	The Plan covers outpatient surgery, including related services. Outpatient surgery is defined as any surgery or procedure in a day surgery department, ambulatory surgery department or outpatient surgery center. There are certain specialized services for which you will be directed to a Center of Excellence for care. See the section *I.D.5. Centers of Excellence* for more information.
39 . Telemedicine Virtual Visit Services	
	The Plan covers Medically Necessary telemedicine virtual visit services for the purpose of diagnosis, consultation or treatment. Telemedicine virtual visit services are limited to the use of real-time interactive audio, video or other electronic media telecommunications, telemonitoring, and telemedicine services involving stored images forwarded for future consultations, i.e. "store and forward" telecommunication as a substitute for in-person consultation with Providers. Member Cost Sharing for telemedicine virtual visit services is the same as the Member Cost Sharing for the same type of service if it had been provided through an in-person consultation. Please refer to your Schedule of Benefits for specific information on Member Cost Sharing you may be required to pay.
40 . Temporomandibular Joint Dysfunction Services	
	The Plan covers medical treatment of Temporomandibular Joint Dysfunction (TMD). Only the following services are covered: • Initial consultation with a physician • Physical therapy, (subject to the visit limit for outpatient physical therapy listed in the Schedule of Benefits) • Surgery • X-rays • Removable appliances for TMD repositioning (Please Note: This service can be provided by a dental or medical provider.) Covered Benefits for TMD do not include fixed or removable appliances that involve movement or repositioning of teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures). **Important Notice:** No other Dental Care is covered for the treatment of Temporomandibular Joint Dysfunction (TMD).

Benefit	Description
41 . Transgender Health Services	
	The Plan covers transgender health services to the extent Medically Necessary and in accordance with HPHC Clinical Guidelines. Coverage includes surgery, related physician and behavioral health visits, and outpatient prescription drugs, if you have the outpatient prescription drug coverage under this Plan. If you are planning to receive transgender health services, you should review the current HPHC Clinical Guidelines that identifies covered services under this benefit. To receive a copy of the HPHC guidelines, please call the Member Services Department at **1–877–907–4742** or go to our website at **www.harvardpilgrim.org**. Benefits for transgender health services are in addition to other benefits provided under the Plan. HPHC-NE does not consider transgender health services to be reconstructive surgery to correct a Physical Functional Impairment or Cosmetic Services. Coverage for reconstructive surgery or Cosmetic Services is limited to the services described under the Reconstructive Surgery benefit in this Benefit Handbook. **Prior Approval or Notification Required:** You must obtain prior approval for coverage under this benefit. If you use a Plan Provider, he/she will seek prior approval for you. The prior approval process is initiated by calling: **1-800-708-4414**.
42 . Urgent Care Services	
	The Plan covers services that you receive at (1) a convenience care clinic or (2) an urgent care center. Convenience care clinics provide treatment for minor illnesses and injuries. They are usually staffed by non-physician providers, such as advanced practice registered nurses, and are located in stores, supermarkets or pharmacies. To see a list of convenience care clinics covered by the Plan, please refer to your Provider Directory and search under "convenience care". Urgent care centers provide treatment for illnesses and injuries that require urgent attention but are not life threatening. Urgent care centers are independent centers or certain hospital-owned centers that provide urgent care services. Urgent care centers are staffed by doctors, advanced practice registered nurses 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". Some hospitals provide urgent care services as part of the hospital's outpatient services. Because the services provided are considered outpatient hospital services, only the hospitals are listed in the Provider Directory. These services may require higher Member Cost Sharing than urgent care services received at independent urgent care centers. Please note that these hospital services are treated differently than similar services received in a hospital emergency room. The Urgent Care benefit is a location-based benefit. Member Cost Sharing for Urgent Care will depend on the location where services are provided. For services received in a convenience care clinic, urgent care center or hospital urgent care center, please refer to the Urgent Care benefit listed in your Schedule of Benefits. For Urgent Care services received in a hospital emergency room, please refer to the emergency room benefit in your Schedule of Benefits. Coverage for Urgent Care is provided for services that are required to prevent deterioration to your health resulting from an unforeseen sickness or injury. Covered Benefits include, but are not limited to the following: • Care for minor cuts, burns, rashes or abrasions, including suturing • Treatment for minor illnesses and infections, including ear aches

Benefit	Description
Urgent Care Services (Continued)	
	• Treatment for minor sprains or strains You do not need to obtain a referral from your PCP to be covered for Urgent Care services at an urgent care center or convenience care clinic. 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 are having a Medical Emergency. These include heart attack or suspected heart attack, shock, major blood loss, or loss of consciousness. Please see the section *I.D.6. Medical Emergency Services* for more information.
43 . Vision Services	
	Routine Eye Examinations: The Plan covers routine eye examinations. **Pediatric Vision Care:** The Plan covers pediatric vision care. Please see the Pediatric VisionCare section of your Schedule of Benefits for details. **Vision Hardware for Special Conditions:** The Plan provides coverage for contact lenses or eyeglasses needed for the following conditions: • Keratonconus. One pair of contact lenses is covered per Calendar Year. The replacement of lenses, due to a change in the Member's condition, is limited to 3 per affected eye per Calendar Year. • Post cataract surgery with an intraocular lens implant (pseudophakes). Coverage is provided for 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. • Post cataract surgery without lens implant (aphakes). One pair of eyeglass lenses or contact lenses is covered per Calendar Year. Coverage is also provided for the purchase of eyeglass frames. The replacement of lenses due to a change in the Member's condition is also covered. Replacement of lenses due to wear, damage, or loss, is limited to 3 per affected eye per Calendar Year. • Post retinal detachment surgery. For a Member who wore eyeglasses or contact lenses prior to retinal detachment surgery, the Plan covers the full cost of one lens per affected eye up to one Calendar Year after the date of surgery. For Members who have not previously worn eyeglasses or contact lenses, the Plan covers either (1) a pair of eyeglass lenses and frames, or (2) a pair of contact lenses.
44 . Voluntary Sterilization	
	The Plan covers voluntary sterilization, including tubal ligation and vasectomy.
45 . Voluntary Termination of Pregnancy	
	The Plan covers voluntary termination of pregnancy when the life of the mother is endangered or when the pregnancy is a result of rape or incest.

Benefit	Description
46 . Wigs and Scalp Hair Prostheses	
	Wigs and scalp hair prostheses when needed as a result of alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment from any form of cancer or leukemia or permanent loss of scalp hair due to injury.

IV. Exclusions

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

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

Exclusion	Description
1 . Alternative Treatments	
	1. Acupuncture services that are outside the scope of standard acupuncture care. 2. Alternative or holistic services and all procedures, laboratories and nutritional supplements associated with such treatments. 3. Aromatherapy, treatment with crystals and alternative medicine. 4. Any of the following types of programs: Health resorts, spas, recreational programs, camps, outdoor skills programs, therapeutic or educational boarding schools, relaxation or lifestyle programs, and wilderness programs (therapeutic outdoor programs). 5. Massage therapy when performed by anyone other than a licensed physical therapist, physical therapy assistant, occupational therapist, or certified occupational therapy assistant. 6. Myotherapy. 7. Services by a Naturopath that are not covered by other Plan Providers under the Plan.
2 . Dental Services	
	1. Dental Care, except the specific dental services listed in this Benefit Handbook and your Schedule of Benefits. 2. For Temporomandibular Joint Dysfunction (TMD), all services of a dentist and fixed or removable appliances that involve movement or repositioning of teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures), except those services that are specifically listed under the TMD benefit or other benefits in this Benefit Handbook and your Schedule of Benefits. 3. Extraction of teeth.
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.
4 . Experimental, Unproven or Investigational Services	
	1. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.

Exclusion	Description
5 . Foot Care	
	1. Foot orthotics, except for the treatment of severe diabetic foot disease . 2. Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members with diabetes.
6 . Maternity Services	
	1. Delivery outside the Service Area after the 37th week of pregnancy, or after you have been told that you are at risk for early delivery. 2. Routine pre-natal and post-partum care when you are traveling outside the Service Area.
7 . Mental Health Care	
	1. Biofeedback. 2. Educational services or testing. No benefits are provided: (1) for educational services intended to enhance educational achievement; (2) to resolve problems of school performance; or (3) to treat learning disabilities. 3. Sensory integrative praxis tests. 4. Mental health care that is (1) provided to Members who are confined or committed to a jail, house of correction, or prison, or (2) provided by the Department of Youth Services or Department of Mental Health. 5. Services or supplies for the diagnosis or treatment of mental health and substance use disorder treatment that, in the reasonable judgment of the Behavioral Health Access Center, are any of the following: • Not consistent with prevailing national standards of clinical practice for the treatment of such conditions. • Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome. • Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
8 . Physical Appearance	
	1. Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care. 2. Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. 3. Liposuction or removal of fat deposits considered undesirable. 4. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). 5. Skin abrasion procedures performed as a treatment for acne. 6. Treatment for skin wrinkles and skin tags or any treatment to improve the appearance of the skin. 7. Treatment for spider veins. 8. Wigs, except as required by law.

Exclusion	Description
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. 2. Commercial diet plans, weight loss programs and any services in connection with such plans or programs. 3. If a service is listed as requiring that it be provided at a Center of Excellence, no coverage will be provided under this Handbook if that service is received from a Provider that has not been designated as a Center of Excellence. Please see the Handbook section *I.D.5. Centers of Excellence* for more information. 4. Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). 5. Physical examinations and testing for insurance, licensing or employment. 6. Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. 7. Testing for central auditory processing. 8. Group diabetes training, educational programs or camps.
10 . Providers	
	1. Charges for services which were provided after the date on which your membership ends. 2. Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit under this Handbook. 3. Charges for missed appointments. 4. Concierge service fees. (See the Handbook section *"Providers Fees for Special Services"* for more information.) 5. Follow-up care after an emergency room visit, unless provided or arranged by your PCP. 6. Inpatient charges after your hospital discharge. 7. Provider's charge to file a claim or to transcribe or copy your medical records. 8. Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.

Exclusion	Description
11 . Reproduction	
	1. Infertility drugs. 2. Infertility treatment including, but not limited to, therapeutic donor insemination, including related sperm procurement and banking; donor egg procedures, including related egg and inseminated egg procurement, processing and banking; assisted hatching; gamete intrafallopian transfer (GIFT); intra-cytoplasmic sperm injection (ICSI); intra-uterine insemination (IUI); in-vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT); preimplantation genetic diagnosis (PGD); microsurgical epididiymal sperm aspiration (MESA); and testicular sperm extraction (TESE). 3. Any form of Surrogacy or services for a gestational carrier. 4. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). 5. The following fees: wait list fees, non-medical costs, shipping and handling charges, etc. 6. Voluntary termination of pregnancy (except in cases of rape, incest, or when the life of the mother is endangered).
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 (unless the Member has waived Workers Compensation) or under state or federal law.
13 . Telemedicine	
	1. Telemedicine services involving fax, texting, or audio-only telephone. 2. Provider fees for technical costs for the provision of telemedicine services.
14 . Transgender Health Services	
	1. Abdominoplasty. 2. Chemical peels. 3. Collagen injections. 4. Dermabrasion. 5. Electrolysis or laser hair removal (for all indications, except when required pre-operatively for genital surgery). 6. Hair transplantation. 7. Reversal of transgender health services and all related drugs and procedures. 8. Implantations (e.g. calf, pectoral, gluteal). 9. Liposuction. 10. Lip reduction/enhancement. 11. Panniculectomy. 12. Removal of redundant skin. 13. Silicone injections (e.g. for breast enlargement). 14. Voice modification therapy/surgery. 15. Reimbursement for travel expenses.

Exclusion	Description
15 . Types of Care	
	1. Custodial Care. 2. Rest or domiciliary care. 3. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. 4. Pain management programs or clinics. 5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. 6. Private duty nursing. 7. Sports medicine clinics. 8. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
16 . Vision and Hearing	
	1. Eyeglasses, contact lenses and fittings, except as listed in this Benefit Handbook and in your Schedule of Benefits. 2. Deluxe or designer frames. 3. Hearing aid batteries, cords, and individual or group auditory training devices and any instrument or device used by a public utility in providing telephone or other communication services. 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.
17 . 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. Beauty or barber service. 4. Any drug or other product obtained at an outpatient pharmacy, except for pharmacy supplies covered under the benefit for diabetes services, unless your Plan includes outpatient pharmacy coverage. 5. Diabetes equipment replacements when solely due to manufacturer warranty expiration. 6. Donated or banked breast milk. 7. Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law. 8. Guest services. 9. Medical services that are provided to Members who are confined or committed to a jail, house of correction, or prison, or (2) provided by the Department of Youth Services. 10. Services for non-Members. 11. Services for which no charge would be made in the absence of insurance. 12. Services for which no coverage is provided in this Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure.

Exclusion	Description
All Other Exclusions (Continued)	
	13. Services that are not Medically Necessary. 14. 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"*. 15. Taxes or governmental assessments on services or supplies. 16. Transportation other than by ambulance. 17. 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 UB-04 form); and
2) Send it to HPHC-NE Claims, P.O. Box 699183, Quincy, MA 02269–9183.

B. REIMBURSEMENT FOR BILLS YOU PAY

If you pay a provider who is not a Plan Provider for a Covered Benefit, we will reimburse you less your applicable Member Cost Sharing.

Claims for Mental Health Care:

Behavioral Health Access Center
P.O. Box 30602
Salt Lake City, UT 84130–0783

Pharmacy Claims:

OptumRx
Manual Claims
P.O. Box 29044
Hot Springs, AR 71903

All Other Claims:

HPHC-NE 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 medical reimbursement claim form along with a legible claim form from the provider or facility that provided your care which includes all of the following information:

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

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

A medical reimbursement claim form can be obtained online at **www.harvardpilgrim.org** or by calling the Member Services Department at **1-877-907-4742**.

1. International Claims

If you are requesting reimbursement for services received while outside of the United States, you must submit an HPHC medical 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; and (2) the source of funds used for payment.

2. Pharmacy Claims

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

C. LIMITS ON CLAIMS

To be eligible for payment, we must receive claims (proof of loss) within one year of the date care was received or as soon as reasonably possible. In accordance with New Hampshire law, we will send you reimbursement within 30 days of receipt of all information needed to process your claims or within 15 days upon receipt of a clean, electronic claim.

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. You may have to pay the balance if the claim is for more than the Allowed Amount.

VI. Appeals and Complaints

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

A. BEFORE YOU FILE AN APPEAL

On occasion, claim denials may result from a misunderstanding with a provider or a claim processing error. Since these problems can be easy to resolve, we recommend that Members contact a Member Service Representative prior to filing an appeal. (A Member Service Representative can be reached toll-free at **1-877-907-4742** or at **711** for TTY service.) The Member Service Representative will investigate the claim and either resolve the problem or explain why the claim is being denied. If you are dissatisfied with the response of the Member Service Representative, you may file an appeal using the procedures outlined in section *VI.B. MEMBER APPEAL PROCEDURES* .

B. MEMBER APPEAL PROCEDURES

If you are dissatisfied with a decision on our coverage of services, you may appeal. Appeals may also be filed by a Member's representative or a provider acting on a Member's behalf. We have established the following steps to ensure that Members receive a timely and fair review of internal appeals:

- Our staff is available to assist you in filing an appeal. If you'd like assistance, please call **1-877-907-4742**.
- You may also obtain assistance from the New Hampshire Insurance Department. The Department may be contacted by calling **1–603–271-2261** or **1-800-852-3416**. For TDD access Members may call Relay NH at **1-800-735-2964**. Members may also write the Department at:

  New Hampshire Insurance Department
  21 South Fruit Street, Suite 14
  Concord, NH 03301

- If we do not provide you with a timely appeal or expedited appeal in accordance with the time limits stated below, we will promptly notify you of your right to proceed to external review by the New Hampshire Insurance Department without having received a decision from us. Please see below for information on external review

1. Initiating Your Appeal

To initiate your appeal, you or your representative should write or fax a letter to us about the coverage you are requesting and why you feel it should be granted (if your appeal qualifies as an expedited appeal, you may contact us by telephone). See the section *VI.B.3. Expedited Review Procedure* for the expedited appeal process.

Please be as specific as possible in your appeal request. We need all the important details in order to make a fair decision, including pertinent medical records and itemized bills. We must get this information within 180 days of the denial of coverage.

If you have a representative submit an appeal on your behalf, including a medical provider, the appeal must include a statement signed by you, authorizing the representative to act on your behalf. HPHC-NE may refuse to provide information to the representative, including a response to the appeal, until we receive a signed authorization from you.

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

For all appeals, except mental health and substance use disorder treatment appeals, please send your request to the following address:

HPHC-NE Appeals and Grievances Department
Harvard Pilgrim Health Care of New England, Inc.
1600 Crown Colony Drive
Quincy, MA 02169
Telephone: 1-877-907-4742
Fax: 1–617–509-3085

If your appeal involves a mental health or substance use disorder treatment, please send it to the following address:

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

When we receive your appeal, we will assign an Appeals and Grievances Analyst to manage your appeal throughout the appeal process, and we will send you a letter identifying your Appeals and Grievances

Analyst. That letter will include detailed information on the appeal process. Your Appeals and Grievances Analyst is available to answer any questions you may have about your appeal or the appeal process.

2. Appeal Process

Your Appeals and Grievances Analyst will investigate your appeal and determine if additional information is required. This information may include medical records, statements from your doctors, and bills and receipts for services you have received. You may also provide us with any written comments, documents, records or other information related to your claim. Should we need additional information to decide your appeal, your Appeals and Grievances Analyst will notify you. You will have 45 days to provide the requested information. After 45 days, your appeal may be closed. However, the appeal may be reopened if the requested information is submitted within 180 days of the denial of coverage.

We will review your appeal and send you a written decision within 30 days of receiving your appeal. If we request additional information from you, the 30-day time period will not run while we are awaiting the requested information. After we receive all the information needed to make a decision, your Appeals and Grievances Analyst will inform you in writing of whether we have approved or denied your appeal. Our decision of your appeal will include: (1) the titles and qualifying credentials of your Appeals and Grievances Analyst and any other person reviewing your appeal; (2) a summary of the facts and issues in the appeal; (3) a summary of the documentation relied upon; and (4) the specific reasons for the decision, including the clinical rational, if any. This decision is our final decision under the appeal process.

If our decision is not fully in your favor, the decision will also include a description of other options for further review of your appeal. These are also described below.

If your appeal involves a decision on a medical issue, your Appeals and Grievances Analyst will obtain the opinion of a qualified physician or other appropriate medical specialist. Upon request, your Appeals and Grievances Analyst will provide you with a copy, free of charge, of any written clinical criteria used to decide your appeal and the identity of the physician (or other medical specialist) consulted concerning the decision. No one involved in the initial decision to deny a claim under appeal will be a decision-maker in any stage of the appeal process. You have the right to receive, free of charge, all documents, records or other information relevant to the initial denial and your appeal.

3. Expedited Review Procedure

We will provide you with an expedited review if your appeal involves services which:

1) if delayed, could seriously jeopardize your life or health or ability to regain maximum function,
2) in the opinion of a physician with knowledge of your medical condition, would result in severe pain that cannot be adequately managed without the care or treatment, or
3) involves the continuation of inpatient services following emergency care.

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

You, your representative or a provider acting on your behalf may request an expedited appeal by telephone or fax. Please see section *VI.B.1. Initiating Your Appeal* for the telephone and fax numbers. We will investigate and respond to your request within 72 hours. We will notify you of the decision on your appeal by telephone and then send you a written decision within two business days.

If you request an expedited appeal of a decision to discharge you from a hospital, we will continue to pay for your hospitalization until we notify you of our decision.

If you are filing an expedited appeal with HPHC-NE, you may also file a request for expedited external review with the New Hampshire Insurance Department at the same time. You do not have to wait until HPHC-NE completes your expedited appeal to file for expedited external review. Please see the Section *C.2.2. Independent External Review of Appeals* for information on how to file for external review.

To enable us to conduct such a quick review of the expedited appeal, we must limit the expedited appeal process to the circumstances listed above. Your help in promptly providing all necessary information is essential for us to provide you with this quick review. If we do not have sufficient information necessary to decide your appeal, we will notify you that additional information is required within 24 hours after receipt of your appeal.

C. OPTIONS FOR FURTHER REVIEW IF YOUR APPEAL IS DENIED

If you disagree with the decision of your appeal, you may have a number of options for further review. These options are (1) Reexamination of appeals that are subject to clinical review for medical necessity by HPHC, (2) external review by an Independent Review Organization (IRO) appointed by the New Hampshire Insurance Department.

1. Reexamination

If you disagree with a decision concerning an appeal that is subject to clinical review for medical necessity, you may request reexamination of such appeal if there is additional clinical documentation that hasn't previously been reviewed by HPHC. You must request reexamination within 45 days of the date of your denial letter.

Reexamination is not available for the following types of appeals:

- Decisions involving a benefit limitation where the limit is stated in the Handbook
- Decisions involving excluded services, except Experimental, Unproven, or Investigational services
- Decisions concerning Member Cost Sharing requirements; or
- Decisions that do not involve clinical review for medical necessity.

Our reexamination process is voluntary and optional. A member may request reexamination by HPHC before seeking external review from the New Hampshire Insurance Department, as discussed below, or you may proceed directly to external review. You may also request such reexamination if the Insurance Department has determined that your appeal is not eligible for external review. However, we will not reexamine an appeal that has been accepted for external review by the Insurance Department.

2. Independent External Review of Appeals

The New Hampshire Insurance Department has prepared a publication that explains your rights to appeal certain health care service denials to an Independent Review Organization selected by the Department. The Department has also issued a form for requesting an external appeal. This form is included with clinical denial letters and can be found at the end of this Handbook. The following text is the Insurance Department's Managed Care Consumer Guide to External Appeal:

i. MANAGED CARE CONSUMER GUIDE TO EXTERNAL APPEAL

a. What is an External Appeal?

New Hampshire law gives individuals who are covered by fully-insured, health or dental insurance plans the right to have a nationally-accredited, independent, medical review organization (IRO), which is not affiliated with his/her insurance company, review and assess whether the company's denial of a specific claim or requested service or treatment is justified. This type of review is available when a recommended service or treatment is denied on the basis that it does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, and level of care or effectiveness. This review is often called Independent External Appeal, External Appeal, External Health Review or simply External Review.

b. What are the eligibility requirements for External Appeal?

To be eligible for External Appeal the following conditions must be met:

- The patient must have a fully-insured health or dental insurance plan.
- The service that is the subject of the appeal request must be either a) a covered benefit under the terms of the insurance policy or b) a treatment that may be a covered benefit.
- Unless the patient meets the requirements for Expedited External Review (see below), the patient must have completed the Internal Appeal process provided by the insurer and have received a final, written decision from the insurer relative to its review.
  - ⇒ Exception #1: The patient does not need to meet this requirement, if the insurer agrees in writing to allow the patient to skip its Internal Appeal process.
  - ⇒ Exception #2: If the patient requested an internal appeal from the insurer, but has not received a decision from the insurer within the required time frame, the patient may apply for External Appeal without having received the insurer's final, written decision.
- The patient must submit the request for External Appeal to the Department within 180 days from the date appearing on the insurance company's letter, denying the requested treatment or service at the final level of the company's Internal Appeals process.

- The patient's request for External Appeal may not be submitted for the purpose of pursuing a claim or allegation of healthcare provider malpractice, professional negligence, or other professional fault.

c. What types of health insurance are excluded from External Appeal?

In general, External Appeal is available for most health insurance coverage. Service denials relating to the following types of insurance coverage or health benefit programs are not reviewable under New Hampshire's External Appeal law:

- Medicaid (except for coverage provided under the NH Premium Assistance Program)
- The New Hampshire Children's Health Insurance Program (CHIP)
- Medicare
- All other government-sponsored health insurance or health services programs
- Health benefit plans that are self-funded by employers
  - ⇒ Note: Some self-funded plans provide external appeal rights which are administered by the employer.

d. Can someone else represent me in my External Appeal?

Yes. A patient may designate an individual, including the treating health care provider, as his/her representative. To designate a representative, the patient must complete Section II of the External Review Application Form entitled "Appointment of Authorized Representative."

e. Submitting the External Appeal:

To request an External Appeal, the patient or the designated representative must complete and submit the External Review Application Form, available on the Department's website (www.nh.gov/insurance), and all supporting documentation to the New Hampshire Insurance Department. There is no cost to the patient for an External Appeal.

Please submit the following documentation:

- The completed External Review Application Form — signed and dated on page 6.

  The Department cannot process this application without the required signature(s)
- A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the insurance company named in the appeal.
- A copy of the insurance company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.
- Any medical records, statements from the treating health care provider(s) or other information that you would like the review organization to consider in it's review.
- If requesting an Expedited External Appeal, the Provider's Certification Form.

If you have questions about the application process or the documentation listed above, please call the Insurance Department at **1–800–852–3416**.

Mailing Address:

New Hampshire Insurance Department
Attn: External Review Unit
21 South Fruit Street, Suite 14
Concord, NH 03301

Expedited External Review Applications

- May be faxed to **(603) 271–1406**, or
- Sent by overnight carrier to the Department's mailing address.

f. What is the Standard External Appeal Process and Time Frame for receiving a Decision?

It may take up to 60 days for the Independent Review Organization (IRO) to issue a decision in a Standard External Appeal.

- Within 7 business days after receiving your application form, the Insurance Department (the Department) will complete a preliminary review of your application to determine whether your request is complete and whether the case is eligible for external review.
  - ⇒ If the request is not complete, the Department will inform the applicant what information or documents are needed in order to process the application. The applicant will have 10 calendar days to supply the required information or documents.
- If the request for external appeal is accepted, the Department will select and assign an IRO to conduct the external review and will provide a written notice of the acceptance and assignment to the applicant and the insurer.
- Within 10 calendar days after assigning your case to an IRO, the insurer must provide the applicant

and the IRO a copy of all information in its possession relevant to the appeal.

- If desired, the applicant may submit additional information to the IRO by the 20th calendar day after the date the case was assigned to the selected IRO. During this period, the applicant may also present oral testimony via telephone conference to the IRO. However, oral testimony will be permitted only in cases where the Insurance Commissioner determines that it would not be feasible or appropriate to present only written information.
  - ⇒ To request a "teleconference," complete Section VII of the application form entitled "Request for Telephone Conference" or contact the Department no later than 10 days after receiving notice of the acceptance of the appeal.
- By the 40th calendar day after the date the case was assigned to the selected Independent Review Organization, the IRO shall A) review all of the information and documents received, b) render a decision upholding or reversing the determination of the insurer, and c) notify in writing the applicant and the insurer of the IRO's review decision.

g. What is an Expedited External Appeal?

Whereas a Standard External Appeal may take 60 days, Expedited External Appeal is available for those persons who would be significantly harmed by having to wait. An applicant may request expedited review by checking the appropriate box on the External Review Application Form and by providing a Provider's Certification Form, in which the treating provider attests that in his/her medical opinion adherence to the time frame for standard review would seriously jeopardize the patient's life or health or would jeopardize the patient's ability to regain maximum function. Expedited reviews must be completed in 72 hours.

If the applicant is pursuing an internal appeal with the insurer and anticipates requesting an Expedited External Appeal, please call the Department at **1–800–852–3416** to speak with a consumer services officer, so that accommodations may be made to receive and process the expedited request as quickly as possible.

Please note a patient has the right to request an Expedited External Appeal simultaneously with the insurer's Expedited Internal Appeal.

h. What happens when the Independent Review Organization makes its decision?

- If the appeal was an Expedited External Appeal, in most cases the applicant and insurer will be notified of the IRO's decision immediately by telephone or fax. Written notification will follow.
- If the appeal was a Standard External Appeal, the applicant and insurer will be notified in writing.
- The IRO's decision is binding on the insurer and is enforceable by the Insurance Department. The decision is also binding on the patient except that it does not prevent the patient from pursuing other remedies through the courts under federal or state law.

Have a question or need assistance?

Staff at the New Hampshire Insurance Department is available to help.

Call 1–800–852–3416 to speak with a consumer services officer.

D. MEMBER COMPLAINTS

If you have any Complaints about your care under the Plan or about our service, we want to know about it. We are here to help. For all complaints, except mental health and substance use disorder treatment concerns, please call or write to us at:

HPHC-NE Member Services Department
Harvard Pilgrim Health Care of New England, Inc.
Attention: Appeals and Grievances Department
1600 Crown Colony Drive.
Quincy, MA 02169
Telephone: 1-877-907-4742

For a complaint involving mental health and substance use disorder treatment, please call or write to us at:

HPHC-NE Behavioral Health Complaints
c/o Optum Behavioral Health Complaints
P.O. Box 30768
Salt Lake City, UT 84130–0768
Telephone: 1–888–777–4742
Fax: 1–248–524–7603

We will respond to you as quickly as we can. Member complaints sent to us in writing will be investigated and responded to within 30 business days of request.

VII. Eligibility

This section describes requirements concerning eligibility under the Plan.

A. MEMBER ELIGIBILITY

1. General Eligibility Requirements

To be eligible for coverage under this Plan, you must meet the following requirements:

- You must live and maintain a permanent residence in the Enrollment Area for at least 6 months of the year.
- You must meet the following requirements:
  - Agree to pay the monthly premium for coverage under the Plan;
  - Not be entitled to or enrolled under Medicare Parts, A, B or D.

If you have any questions about these requirements, you may call the Member Services Department at **1-877-907-4742**. They can give you a current list of the cities and towns in the Enrollment Area.

2. Dependent Eligibility

To be covered as a Dependent under the Plan, an individual must be one of the following:

1) The legal spouse of the Subscriber.
2) A child (including an adopted child) of the Subscriber or spouse of the Subscriber until the end of the month in which the child turns 26.
3) A child (including an adopted child) of the Subscriber or spouse of the Subscriber, who is no longer eligible under paragraph 2), above, and meets each of the following requirements: (a) is currently disabled; (b) became disabled while enrolled as a dependent under paragraph 2), above; and (c) remains chiefly financially dependent on the Subscriber. An individual will be determined to be "disabled" by HPHC-NE only if he or she: is mentally or physically incapable of earning his or her own living. In the event of a dispute concerning eligibility under this paragraph, HPHC-NE shall apply the standard for determining disability under Title II of the Social Security Act.

   HPHC-NE will require proof of such disability within 31 days following the date the individual would no longer be eligible due to age as described under Paragraph 2), above.
4) A child under 18 years of age, for whom the Subscriber or Subscriber's spouse is the court appointed legal guardian. Proof of guardianship must be submitted to HPHC-NE prior to enrollment.
5) The child of an eligible Dependent of the Subscriber until such time as the parent is no longer a Dependent.

Reasonable evidence of eligibility may be required from time to time.

B. EFFECTIVE DATE - NEW AND EXISTING DEPENDENTS

New Dependents may be added, and coverage will be effective as of the date of:

1) Marriage;
2) Birth;
3) Adoption;
4) Legal guardianship; or
5) The Subscriber becoming legally responsible for a Dependent's health care coverage.

C. EFFECTIVE DATE - ADOPTIVE DEPENDENTS

An adoptive child who has been living with you, and for whom you have been receiving foster care payments, may be covered from the date the petition to adopt is filed. An adoptive child who has not been living with you may be covered from the date of placement in your home for purposes of adoption by a licensed adoption agency.

We must receive notice of the addition within 31 days of the effective date. The addition of a new Dependent may change the Subscriber's membership for Individual Coverage to Family Coverage. If we are not notified within 30 days of the effective date, Dependents may only be added on the next effective date.

D. CHANGE IN STATUS

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

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

E. SPECIAL ENROLLMENT RIGHTS

If a Member declines enrollment for the Member's Dependent (including his or her spouse) because of other health insurance coverage, the Member may be able to enroll his or her Dependents in this Plan if the Dependent loses eligibility for that other coverage. However, enrollment must be requested within 30 days after the other coverage ends. In addition, if a Member has a new Dependent as a result of marriage, birth, adoption or placement for adoption, the Member may be able to enroll himself or herself and his or her Dependents. However, enrollment must be requested within 31 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. A Member or Dependent who loses coverage under Medicaid or CHIP as a result of the loss of Medicaid or CHIP eligibility may be able to enroll in this Plan, if enrollment is requested within 60 days after Medicaid or CHIP coverage ends. A Member or Dependent who becomes eligible for group health plan premium assistance under Medicaid or CHIP may be able to enroll in this Plan if enrollment is requested within 60 days after the Member or Dependent is determined to be eligible for such premium assistance.

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

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

G. NEWBORN COVERAGE

Coverage for a newborn child is effective from the moment of birth for up to 31 days. Coverage includes the Covered Benefits in this Handbook, including Medical Emergency services. No coverage is provided after the 31-day period, unless the Subscriber obtains coverage for the newborn within 60 days of the date of birth. Please see section *VII.E. SPECIAL ENROLLMENT RIGHTS* for additional rights upon the birth of a child.

H. MARKETPLACE MEMBERSHIP

Individuals purchasing coverage through New Hampshire's Federally Operated Health Insurance Marketplace must submit their application and enroll directly through the Marketplace. Administrative changes concerning coverage under this plan, including changes in address, effective dates of coverage or termination of coverage must be made through the Marketplace.

VIII. Premiums

A. PREMIUM AMOUNT

You are responsible for paying the premium for Covered Benefits under the Policy. Your initial premium payment for January 1st coverage under this policy is due by January 10th. If you purchase coverage through a Special Enrollment Period (SEP) through New Hampshire's Federally Operated Health Insurance Marketplace, your initial premium payment is due 30 days from the day we receive your enrollment application from the Marketplace or the effective date of coverage period, whichever is later. Premium payment for coverage thereafter is due by the date stated on your invoice which is generally the 1st day of the month.

Any misrepresentation or omission on your application may cause HPHC-NE to change your premium retroactive back to the effective date. If the age of a Member under this Policy has been misstated, all amounts payable under the Policy shall be such as the premium paid that the Member would have purchased at the current age.

The rates provided are guaranteed for the twelve (12) month period following the 1st day of your effective date or renewal date, except that the premium will change when you add or remove a Member from the Plan or when you change your coverage.

B. GRACE PERIOD

If you are a Subscriber who does not receive Advance Premium Tax Credit (APTC) assistance, this Policy has a 31 day grace period in which to pay your premium following the due date. This means that if any premium is not paid by the due date, it may be paid during the next 31 days. During the grace period, this Policy will remain in force. If the premium is not paid before the grace period ends, this Policy will lapse and will be terminated as of the paid through date..

If you are a Subscriber who receives APTC assistance and at least one month's premium has been paid, HPHC-NE will provide a grace period of at least three consecutive months (90 days). During the grace period HPHC-NE must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC from the federal government. If full premium is not received during the 90-day grace period, the policy will be terminated retroactively back to the last day of the first month of the 3 consecutive month grace period. HPHC-NE must pay claims during the first month of the grace period but may pend claims in the second and third months subject to our right to cancel the Policy as described in this Policy. You will be liable for the premium payment due including those for the grace period and for any claims payments made for services incurred after the date through with the premium is paid.

IX. Termination of Coverage

A. TERMINATION BY THE SUBSCRIBER

You may cancel your Policy at any time and for any reason. To cancel your Policy, you must contact HPHC-NE and your Policy will be cancelled on the date we receive your request or on a future date of your choosing. Any premiums that were paid beyond your termination date will be sent back to you within 30 days of receiving notice of cancellation. Cancellation will not affect payment of Covered Benefits you receive while a member of the Plan.

If you have coverage through New Hampshire's Federally Operated Health Insurance Marketplace, you must contact the Health Insurance Marketplace to cancel your policy. Termination may be processed for the same day that you notify the Health Insurance Marketplace or a later date of your choosing.

B. TERMINATION OF POLICY

Your Policy may be terminated as follows:

- HPHC-NE may cancel coverage for any Member who no longer meets eligibility requirements under the Plan (except for Medicare eligibility); or
- HPHC-NE may cancel your coverage under the Plan if you do not pay your premium. Please see Section *VIII. Premiums* for more information.

C. MEMBERSHIP TERMINATION FOR CAUSE

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

- Providing false or misleading information to the Plan on an application for membership or in an attempt to obtain benefits for which you or a Dependent are not eligible within 2 years of providing such information to HPHC-NE;
- Committing, or attempting to commit, misrepresentation or fraud against the Plan;
- Obtaining, or attempting to obtain, benefits under this Handbook for a person who is not a Member; or
- The commission of acts of physical or verbal abuse by a Member that pose a threat to providers, the Plan or other Members and that are unrelated to the Member's physical or mental condition.

Termination of membership will be effective immediately upon notice from the Plan. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Premium paid for periods after the effective date of termination will be refunded.

D. EFFECT OF TERMINATION

If your Policy is cancelled, the Subscriber cannot reapply until the next annual open enrollment period unless you qualify for enrollment under a separate special enrollment right.

E. MEMBERS WHO MOVE OUT OF THE ENROLLMENT AREA

If your coverage ends because you moved out of the Enrollment Area, you may be eligible to enroll for coverage under another health plan that has an arrangement with HPHC. You may contact the Member Services Department at **1-877-907-4742** for more information.

F. REINSTATEMENT

If you're purchasing coverage through New Hampshire's Federally Operated Health Insurance Marketplace there is no reinstatement of this policy unless the coverage was terminated due to an error on the part of HPHC–NE or New Hampshire's Federally Operated Health Insurance Marketplace.

If your premium is not paid before the applicable grace period ends (90 days for Members with APTC assistance and 31 days for all other Members), this Policy will lapse. Later acceptance of premium, along with a required reinstatement fee of up to $50, by HPHC-NE or by an agent duly authorized by HPHC-NE to accept such premium, without requiring an application for reinstatement, shall reinstate this Policy. If HPHC-NE requires an application for reinstatement, it must be submitted to HPHC-NE along with the required premium payment. Reinstatement of the Policy is subject to approval by HPHC-NE. If the application is disapproved, this Policy will not be reinstated. If the application and the applicable premium payment are received by HPHC-NE and the application is not disapproved in writing, this Policy will be reinstated upon the date of the receipt of the application. A reinstated Policy will provide coverage for services you incurred after the date of reinstatement. In all other respects your rights and the rights of HPHC-NE will remain the same, subject to any provisions noted on or attached to the reinstated Policy.

X. When You Have Other Coverage

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

Nothing in this section should be interpreted as providing coverage for any service or supply that is not expressly covered under the Handbook, Schedule of Benefits and Prescription Drug Brochure or to increase the level of coverage provided.

A. INSURANCE WITH OTHER INSURERS

If you have other valid insurance not with HPHC-NE that provides benefits for the same loss on a provision of service basis for an expense incurred basis, coverage under your HPHC-NE plan will not be prorated or reduced. When you have coverage under HPHC-NE and another plan, you are entitled to coverage from both insurers. This coverage does not apply when you have coverage under Worker's Compensation or a governmental program as described below.

B. WORKER'S COMPENSATION/GOVERNMENT PROGRAMS

If HPHC-NE has information indicating that services provided to you are covered under Worker's Compensation or by a federal, state or other government agency, HPHC-NE may suspend payment for such services until a determination is made whether payment will be made by such program. If HPHC-NE provides or pays for services for an illness or injury covered under Worker's Compensation or by a federal, state or other government agency, HPHC-NE will be entitled to recovery of its expenses from the provider of services or the party or parties legally obligated to pay for such services.

C. SUBROGATION AND REIMBURSEMENT

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

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

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

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

D. MEMBER COOPERATION

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

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

E. HPHC-NE'S RIGHTS

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

XI. Plan Provisions and Responsibilities

A. IF YOU DISAGREE WITH RECOMMENDED TREATMENT

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

B. LIMITATION ON LEGAL ACTIONS

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

C. ACCESS TO INFORMATION

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

You can obtain a copy of the Notice of Privacy Practices through the Harvard Pilgrim website, **www.harvardpilgrim.org** or by calling the Member Services Department at **1-877-907-4742**.

D. SAFEGUARDING CONFIDENTIALITY

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

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

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

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

You can obtain a copy of the Notice of Privacy Practices through the Harvard Pilgrim website, **www.harvardpilgrim.org** or by calling the Member Services Department at **1-877-907-4742**.

E. NOTICE

Any notice to a Member including plan documents, invoices, Activity Statements or letters will be sent to the Member's last address on file with HPHC-NE. It is the Member's responsibility to notify HPHC-NE of an address change to ensure mailed materials are sent to the appropriate address. HPHC-NE is not responsible for mailed materials sent to an incorrect address where a Member did not update his/her address with HPHC-NE.

Notice to HPHC-NE, other than a request for Member appeal, should be sent to:

HPHC-NE Member Services Department
1600 Crown Colony Drive
Quincy, MA 02169
1-877-907-4742
www.harvardpilgrim.org

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

F. MODIFICATION OF THIS HANDBOOK

This Benefit Handbook, Schedule of Benefits, and Prescription Drug Brochure, may be amended by us upon sixty (60) days written notice to you.

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

G. OUR RELATIONSHIP WITH PLAN PROVIDERS

Our relationship with Plan Providers is governed by separate agreements. They are independent contractors. Such Providers may not modify this Handbook or Schedule of Benefits, Prescription Drug Brochure, or create any obligation for HPHC-NE. We are not liable for statements about this Handbook by them, their employees or agents. We may change our arrangements with service Providers, including the addition or removal of Providers.

H. PROVIDER COMPENSATION ARRANGEMENTS

Under New Hampshire law HPHC-NE is required to inform you of the types of financial arrangements contained in its contracts with providers. They are described below.

HPHC-NE's compensation programs are designed to reward providers for the delivery of cost effective services, including those referral services that your physician determines to be Medically Necessary. Providers may also receive additional compensation when established goals for quality and Member satisfaction are met.

There are two main types of HPHC-NE Provider payment arrangements, as follows:

1. **Capitation.** One of the ways that HPHC-NE pays providers is through a method called "capitation." Under a capitation arrangement a provider organization receives a set dollar amount for each HPHC-NE patient for which it is responsible. Sometimes capitation is paid directly on a monthly basis. At other times the capitation payment is based on a budget. In budgeted capitation arrangements claims are paid at contracted rates minus a percentage that is withheld by HPHC-NE. At the end of the year, claims payments are reconciled against a budget. All or part of the amount that had been withheld is returned to the provider organization or retained by HPHC-NE based on that reconciliation. Providers receive a share in any surplus after reconciliation. Some capitation arrangements only apply to professional services. Others apply to professional, hospital and ancillary services.
2. **Fee-for-Service.** Under certain circumstances, HPHC-NE pays a contracted rate for the services provided. This arrangement could include additional payments or bonuses as agreed to by the parties. Fee-for-service payment is usually used for specialty care and ancillary services.

In the capitation method above, HPHC-NE provides financial protection, ("stop-loss" insurance) from excessive costs in providing medical care to HPHC-NE patients. This means that HPHC-NE Providers are responsible only up to a certain dollar amount for the care of an individual Member. As a result, the compensation of HPHC-NE Providers' is not unduly affected by an unusually large medical expense that might be necessary for care of an individual Member.

I. WELLNESS INCENTIVES

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

J. IN THE EVENT OF A MAJOR DISASTER

We will try to provide or arrange for services in the case of a major disaster. This might include war, riot, epidemic, public emergency, or natural disaster. Other causes include the partial or complete destruction of our facility(ies) or the disability of service providers. If we cannot provide or arrange services due to a major disaster, we are not responsible for the costs or outcome of this inability. However, HPHC-NE will refund premium to the extent covered benefits were not provided solely as a result of the major disaster.

K. EVALUATION OF NEW TECHNOLOGY

We have a dedicated team of staff that evaluates new diagnostics, testing, interventional treatment, therapeutics, medical/behavioral therapies, surgical procedures, medical devices and drugs as well as ones with new applications. The team manages the evidence-based evaluation process from initial inquiry to final policy recommendation in order to determine whether it is an accepted standard of care or if the status is Experimental, Investigational or Unproven. The team researches the safety and effectiveness of these new technologies by reviewing published peer reviewed medical reports and literature, consulting with expert practitioners, and benchmarking. The team presents its recommendations to internal policy committees responsible for making decisions regarding coverage of the new technology under the Plan. The evaluation process includes:

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

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

L. GOVERNING LAW

This Evidence of Coverage is governed by New Hampshire law.

M. UTILIZATION REVIEW PROCEDURES

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

- **Prospective Utilization Review (Prior Approval)**. We review selected inpatient admissions, surgical day care, outpatient/ambulatory procedures, and Medical Drugs prior to the provision of such services to determine whether proposed services meet clinical criteria for coverage. Prospective utilization review determinations will be made within two working days of obtaining all necessary information. In the case of a determination to approve an admission, procedure or service, we will give notice via the HPHC provider portal within 24 hours of the decision and will send written confirmation to you and the provider within two working days. In the case of a determination to deny or reduce benefits ("an adverse determination"), we will notify the provider rendering the service by telephone within 24 hours of the decision and will send a written or electronic confirmation of the telephone notification to you and the provider within one working day thereafter.
- **Concurrent Utilization Review**. We review selected ongoing admissions to inpatient hospitals, including acute care hospitals, rehabilitation hospitals, skilled nursing facilities and skilled home health services to assure that services being provided meet clinical criteria for coverage. Concurrent review decisions will be made within one working day of obtaining all necessary information. In the case of either a determination to approve additional services or an adverse determination, we will notify the provider rendering the service by telephone within 24 hours of the decision. We will send a written or electronic confirmation of the telephone

notification to you and the provider within one working day. In the case of ongoing services, coverage will be continued without liability to you until you have been notified of an adverse determination.

Active case management and discharge planning is incorporated as part of the concurrent review process and may also be provided upon the request of your Provider.

- **Retrospective Utilization Review**. Retrospective utilization review may be used in circumstances where services were provided before authorization was obtained. This will include the review of emergency medical admissions for appropriateness of level of care.

If you wish to determine the status or outcome of a clinical review decision you may call the Member Services Department toll free at **1-877-907-4742**. For information about decisions concerning mental health and substance use disorder treatment, you may call the Behavioral Health Access Center at **1-888-777-4742**.

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

N. QUALITY ASSURANCE PROGRAMS

The goal of our quality program is to ensure the provision of consistently excellent health care, health information and service to our Members, enabling them to maintain and improve their physical and behavioral health and well-being.

Some components of the quality program are directed to all Members and others address specific medical issues and providers.

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

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

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

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

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

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

P. PROCESS TO DEVELOP CLINICAL GUIDELINES AND UTILIZATION REVIEW CRITERIA

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

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

Criteria and guidelines used to review other services are also developed with input from physicians and other clinicians with expertise in the relevant clinical

area. The development process includes review of relevant clinical literature and local standards of practice.

Q. NON-ASSIGNMENT OF BENEFITS

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

R. NEW TO MARKET DRUGS

New prescription drugs that are introduced into the market are reviewed by the Plan prior to coverage to ensure that the drug is safe and effective. New to market drugs will be reviewed by Harvard Pilgrim's Medical Policy Department and New Technology Assessment Committee or Pharmacy Services Department along with the Pharmacy and Therapeutics Committee within the first 180 days of their introduction to the market. If the new to market drug is covered by the Plan, Prior Authorization and coverage limitations may apply.

S. PAYMENT RECOVERY

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

XII. Information on Patient Rights

The following information is provided to inform you of your rights under New Hampshire law.

As a patient you are entitled by law to the following patient rights from your health care provider:

1. The patient shall be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care and including being informed of the name, licensure status, and staff position of all those with whom the patient has contact, pursuant to RSA 151:3-b.
2. The patient shall be fully informed of a patient's rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in writing before or at admission, except for emergency admissions. Receipt of the information must be acknowledged by the patient in writing. When a patient lacks the capacity to make informed judgments, the signing must be by the person legally responsible for the patient.
3. The patient shall be fully informed in writing in language that the patient can understand, before or at the time of admission and as necessary during the patient's stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. A statement of services that are not normally covered by Medicare or Medicaid shall also be included in this disclosure.
4. The patient shall be fully informed by a health care provider of his or her medical condition, health care needs, and diagnostic test results, including the manner by which such results will be provided and the expected time interval between testing and receiving results, unless medically inadvisable and so documented in the medical record, and shall be given the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment, and to be involved in experimental research upon the patient's written consent only. For the purposes of this paragraph "health care provider" means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing health care services, including, but not limited to, a physician, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist, and any officer, employee, or agent of such provider acting in the course and scope of employment or agency related to or supportive of health care services.
5. The patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for the patient's welfare or that of other patients, if the facility ceases to operate, or for nonpayment for the patient's stay, except as prohibited by Title XVIII or XIX of the Social Security Act. No patient shall be involuntarily discharged from a facility because the patient becomes eligible for Medicaid as a source of payment.
6. The patient shall be encouraged and assisted throughout the patient's stay to exercise the patient's rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination, or reprisal.
7. The patient shall be permitted to manage the patient's personal financial affairs. If the patient authorizes the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with the patient's rights under this subdivision and in conformance with state law and rules.
8. The patient shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion.
9. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.
10. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to

be the property of the patient. The patient shall be entitled to a copy of such records, for a reasonable cost, upon request. The charge for the copying of a patient's medical records shall not exceed $15 for the first 30 pages or $.50 per page, whichever is greater; provided, that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.

11. The patient shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by the patient, such services may be included in a plan of care and treatment.
12. The patient shall be free to communicate with, associate with, and meet privately with anyone, including family and resident groups, unless to do so would infringe upon the rights of other patients. The patient may send and receive unopened personal mail. The patient has the right to have regular access to the unmonitored use of a telephone.
13. The patient shall be free to participate in activities of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients.
14. The patient shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients.
15. The patient shall be entitled to privacy for visits and, if married, to share a room with his or her spouse if both are patients in the same facility and where both patients consent, unless it is medically contraindicated and so documented by a physician. The patient has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.
16. The patient shall not be denied appropriate care on the basis of race, religion, color, national origin, sex, age, disability, marital status, or source of payment, nor shall any such care be denied on account of the patient's sexual orientation.
17. The patient shall be entitled to be treated by the patient's physician of choice, subject to reasonable rules and regulations of the facility regarding the facility's credentialing process.
18. The patient shall be entitled to have the patient's parents, if a minor, or spouse, or next of kin, or a personal representative, if an adult, visit the facility, without restriction, if the patient is considered terminally ill by the physician responsible for the patient's care.
19. The patient shall be entitled to receive representatives of approved organizations as provided in RSA 151:28.
20. The patient shall not be denied admission to the facility based on Medicaid as a source of payment when there is an available space in the facility.
21. Subject to the terms and conditions of the patient's insurance plan, the patient shall have access to any provider in his or her insurance plan network and referral to a provider or facility within such network shall not be unreasonably withheld pursuant to RSA 420-J:8, XIV.

If you believe that any of your rights have been violated by a participating provider, you have the right to file a complaint with HPHC-NE or its designee. All complaints must be submitted in writing and addressed to HPHC-NE or one of the regulatory offices listed.

HPHC-NE Member Services Department
Harvard Pilgrim Health Care of New England
Attn: Appeals and Grievances Department
1600 Crown Colony Drive
Quincy, MA 02169
1-877-907-4742
www.harvardpilgrim.org

For Massachusetts Physicians:

Board of Registration in Medicine
560 Harrison Avenue, Suite G-4
Boston, MA 02118
1–617–654-9800

Massachusetts Department of Public Health
250 Washington Street
Boston, MA 02108-4619
1–617–624-5200

For New Hampshire Physicians:

Board of Medicine
2 Industrial Park Drive, Suite #8
Concord, NH 03301-8520

State of New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301

For Maine Physicians:

Board of License in Medicine
137 State House Station
Augusta, ME 04333

Maine Bureau of Insurance
34 State House Street
Augusta, ME 04333

For Vermont Physicians:

Vermont Board of Medical Practice
109 State Street
Montpelier, VT 05609-1106

Director of Consumer Services
89 Main Street, Drawer 20
Montpelier, VT 05620-3101

XIII. MEMBER RIGHTS & RESPONSIBILITIES

- Members have a right to receive information about HPHC-NE, its services, its practitioners and providers, and Members' rights and responsibilities.
- Members have a right to be treated with respect and recognition of their dignity and right to privacy.
- Members have a right to participate with practitioners in decision-making regarding their health care.
- Members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Members have a right to voice complaints or appeals about HPHC-NE or the care provided.
- Members have a right to make recommendations regarding the organization's members' right and responsibilities policies.
- Members have a responsibility to provide, to the extent possible, information that HPHC-NE and its practitioners and providers need in order to care for them.
- Members have a responsibility to follow the plans and instructions for care that they have agreed on with their practitioners.
- Members have a responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

APPENDIX A: NEW HAMPSHIRE EXTERNAL APPEAL REVIEW FORMS

The State of New Hampshire
Insurance Department
21 South Fruit Street, Suite 14; Concord, NH 03301
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

EXTERNAL REVIEW APPLICATION FORM

Request for Independent External Appeal of a Denied Medical or Dental Claim

Section I – Applicant Information

Patient's Name:_____ Patient's Date of Birth: _____

Applicant's Name:_____ Applicant's Email: _____

Applicant's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Applicant's Phone Number(s): Daytime: (_____)_____ Evening: (_____)_____

Section II – Appointment of Authorized Representative

**** Complete this section, only if someone else is representing the patient in this appeal ****

You may represent yourself or you may ask another person, including your treating health care provider, to act as your personal representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

_____ _____

Signature of Enrollee (or legal representative – Please specify relationship or title) Date

Representative's Mailing Address: _____

City: _____State: _____ Zip Code: _____

Representative's Phone Number(s): Daytime: (_____)_____ Evening: (_____)_____

Section III - Insurance Plan Information

Member's Name: _____ Relationship to Patient: _____

Member's Insurance ID #: _____ Claim/Reference #: _____

Health Insurance Company's Name: _____

Insurance Company's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Company's Phone Number: (_____) _____

Name of Insurance Company representative handling appeal: _____

Is the member's insurance plan provided by an employer? Yes ____ No ____

- Name of employer: _____
- Employer's Phone Number: (_____) _____
- Is the employer's insurance plan self-funded? Yes* ____ No ____

*** If you are not certain, please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may provide external review, but may have different procedures.**

New Hampshire Premium Assistance Program

Is the patient's health insurance provided through the Medicaid Premium Assistance Program, which is administered by the NH Department of Health and Human Services?

Yes ____ No ____

If yes, please provide the Medicaid ID number & complete the following records release:

Medicaid ID Number: _____

I, _____, hereby authorize the New Hampshire Insurance Department to release my external review file to the New Hampshire Department of Health and Human Services (DHHS), if I request a Medicaid Fair Hearing following my independent external review. I understand that DHHS will use this information to make a Fair Hearing determination and that the information will be held confidential.

Section IV – Information about the Patient's Health Care Providers

Name of Primary Care Provider (PCP): _____

PCP's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

PCP's Phone Number: (_____) _____

Name of Treating Health Care Provider: _____

Provider's clinical specialty: _____

Treating Provider's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Treating Provider's Phone Number: (_____) _____

Section V – Health Care Decision in Dispute

Describe the health insurer company's decision in your own words. Include any information you have about the health care services, supplies or drugs being denied, including dates of service or treatment and names of health care providers. Explain why you disagree.

Please attach the following:

- Additional pages, if necessary;
- Pertinent medical records;
- If possible, a statement from the treating health care provider indicating why the disputed service, supply, or drug is medically necessary.

_____

_____

_____

_____

_____

_____

_____

_____

Continued on next page

Section VI – Expedited Review

** Complete this section, only if you would like to request expedited review **

The patient may request that the external review be handled on an expedited basis. To request expedited review, the treating health care provider must complete the attached Provider Certification Form, certifying that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

Do you request an expedited review? Yes ____ No ____

Applications for Expedited External Review may be faxed to (603) 271-1406 or sent by overnight carrier to the address on the top of this form. To email the appeal, please call the Insurance Department at 1-800-852-3416 for additional instructions.

Section VII – Request for a Telephone Conference

**** Complete this section, only if you would like to request a telephone conference ****

If the patient, the authorized representative or the treating health care provider would like to discuss this case with the Independent Review Organization and the insurer in a telephone conference, select "Yes" below and explain why you think it is important to be allowed to speak about the case. If you do not request a telephone conference, the reviewer will base its decision on the written information only. The request for a telephone conference will be granted only if there is a good reason why the written information would not be sufficient.

**** Telephone conferences often cannot be completed within the timeframe for expedited reviews ****

Do you request a telephone conference? Yes ____ No ____

My reason for requesting a phone conference is:

VIII – Authorization and Release of Medical Records

I, _____, hereby request an external review and authorize the patient's insurance company and the patient's health care providers to release all relevant medical or treatment records to the Independent Review Organization (IRO) and the New Hampshire Insurance Department. I understand that the IRO and the Department will use this information to make a determination to either reverse or uphold the insurer's denial. I also understand that the information will be kept confidential. I further understand that neither the Commissioner nor the IRO may authorize services in excess of those covered by the patient's health care plan. This release is valid for one year.

Sign Here

_____ _____

Signature of Enrollee (or legal representative – Please specify relationship or title) Date

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Before submitting this application, please verify that you have …

☐ Completed all relevant sections of the External Review Application Form
- If appointing an authorized representative, the patient must complete Section II.
- If requesting an Expedited External Review, Section VI must be completed and the Provider Certification Form must be submitted.
- If requesting a telephone conference, Section VII must be completed.

☐ Signed and dated the External Review Application Form in Section VIII.

☐ Attached the following documents:
- A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the health or dental insurance company named in the appeal.
- A copy of the Health Insurance Company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.
- Any medical records, statements from the treating health care provider(s) or other information that you would like the Independent Review Organization to consider in its review.
- If requesting an Expedited External Review, the treating Provider's Certification Form.

APPENDIX B: PEDIATRIC DENTAL BENEFIT (for children under the age of 19)

Dependents under the age of 19 are eligible for the Covered Dental Services listed in the Schedule of Benefits when such Dental Services are Necessary and are provided by or under the direction of a Dental Provider. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease does not mean that the procedure or treatment is a Covered Dental Service.

Covered Benefits are available only for the least costly clinically appropriate Dental Services. Clinical situations that can be effectively treated by a less costly, clinically appropriate alternative procedure will be covered based on the least costly procedure.

Coverage under this benefit terminates at the end of the month in which the Dependent turns 19.

Certain capitalized words in this section have special meanings. We have defined these words either above in *Section II: Glossary* of the Benefit Handbook or below in *Section II. Defined Terms For Pediatric Dental Services* of Appendix B.

I. Accessing Pediatric Dental Services

A. NETWORK BENEFITS

These Covered Benefits apply when you choose to obtain Covered Dental Services from a Plan Dental Provider. You generally are required to pay less to the provider than you would pay for services from a Non-Plan Dental Provider. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Plan Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

In order for Covered Dental Services to be paid as Network Benefits, you must obtain all Covered Dental Services directly from or through a Plan Dental Provider.

You must always verify the participation status of a Plan Dental Provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling us and/or the provider. If necessary, we can provide assistance in referring you to a Plan Dental Provider.

We will make available to you a *Directory of Network Dental Providers*. You can also call *Customer Service* at **1–800–460–0315** to determine which providers participate in the Network. The telephone number for *Customer Service* is also listed on your ID card.

B. NON-PLAN DENTAL PROVIDERS

If you are unable to find a Plan Dental Provider to render your care, you can obtain Covered Dental Services from a Non-Plan Dental Provider. on-Plan Dental Providers are reimbursed based at the Usual and Customary fee for similarly situated Plan Dental Providers for each Covered Dental Service. The actual charge made by a Non-Plan Dental Provider for a Covered Dental Service may exceed the Usual and Customary fee. As a result, you may be required to pay a Non-Plan Dental Provider an amount for a Covered Dental Service in excess of the Usual and Customary fee. In addition, when you obtain Covered Dental Services from Non-Plan Dental Providers you must file a claim with us to be reimbursed for Eligible Dental Expenses.

Covered Dental Services received from a Dental Provider outside of the United States will be reimbursed at the same level as a Non-Plan Dental Provider.

C. PRE-TREATMENT ESTIMATE

If the charge for a Dental Service is expected to exceed $300 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of Covered Benefits payable

will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

A pre-treatment estimate of Covered Benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

D. PRE-AUTHORIZATION

Pre-authorization is required for all Orthodontic Services. Speak to your Dental Provider about obtaining a pre-authorization before Dental Services are rendered. You or your Dental Provider can request Pre-authorization for these services by contacting us at **1–800–460–0315**. If you do not obtain a pre-authorization, we have a right to deny your claim for failure to comply with this requirement.

If a treatment plan is not submitted, you will be responsible for payment of any dental treatment not approved by us. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a Benefit based on the less costly procedure.

II. Defined Terms For Pediatric Dental Services

The following definitions are in addition to those listed in *Section II: Glossary* of the *Benefit Handbook*:

Covered Dental Service – a Dental Service or Dental Procedure for which Benefits are provided under this benefit.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to a Dependent under the age of 19 while the Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the Policy is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Plan Dental Providers, Eligible Dental Expenses are our contracted fee(s) for Covered Dental Services with that provider.
- For Non-Network Benefits, when Covered Dental Services are received from Non–Plan Dental Providers, Eligible Dental Expenses are the lesser of the Usual and Customary fees, as defined below or the billed charges.

Necessary - Dental Services and supplies under this benefit which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Dependent under age 19.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Dependent or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
  - Safe with promising efficacy
    - Provided in a clinically controlled research setting.
    - Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this section. The definition of Necessary used in this section relates only to Benefits under this section and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Usual, Customary and Reasonable Charge - Usual, Customary and Reasonable Charge is the maximum amount that we will pay for services from Dental Providers. The Usual, Customary and Reasonable Charge is calculated using the 80th percentile of provider reimbursement for services in the same geographic area under the FAIR Health database.

III. Pediatric Dental Exclusions

Unless specifically listed as a Covered Benefit in your Schedule of Benefits, the following services are excluded from coverage:

1. Any Dental Service or Procedure not listed as a Covered Dental Service in your Schedule of Benefits.

2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental, Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Covered Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Dependent becoming enrolled for coverage provided under this benefit.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as a Dependent or who is a member of a Dependent's family, including spouse, brother, sister, parent or child.
18. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
19. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

IV. Claims For Pediatric Dental Services

When obtaining Dental Services from a Non-Plan Dental Provider, you will be required to pay all billed charges directly to your Dental Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities listed below apply to Covered Dental Services provided under this benefit, except that when you submit your claim, you must provide us with all of the information identified below.

REIMBURSEMENT FOR DENTAL SERVICES

You are responsible for sending a request for a claim for reimbursement (proof of loss) to our office, on a form provided by or satisfactory to us.

Claim Forms. It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

- Dependent's name and address
- Dependent's identification number
- The name and address of the provider of the service(s)
- A diagnosis from the Dental Provider including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports.
- Casts, molds or study models
- Itemized bill which includes the CPT or ADA codes or description of each charge.
- The date the dental disease began
- A statement indicating that you are or you are not enrolled for coverage under any other health or dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

If you would like to use a claim form, you can request one be mailed to you by calling *Customer Service* at **1–800–460–0315**. This number is also listed on your ID Card. If you do not receive the claim form within 15 calendar days of your request, send in the proof of loss with the information stated above.

Please mail your request for reimbursement to the following address:

Claims – Harvard Pilgrim Health Care
P.O. Box 30567
Salt Lake City, UT 84130–0567

Written proof of loss should be given to the Company within 90 days after the date of the loss. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service.

V. Appeals and Grievances

APPEALS

If you are dissatisfied with a decision on our coverage of services, you may appeal. Appeals may also be filed by a Member's representative or a provider acting on a Member's behalf and must be received within 180 days of the initial denial. Our staff is available to assist you in filing an appeal. If you'd like assistance, please call *Customer Service* at **1–800–460–0315**.

To initiate your appeal, you or your representative should write a letter to us about the coverage you are requesting and why you feel it should be granted. Please be as specific as possible in your appeal request. We need all the important details in order to make a fair decision. Please send your request to the following address:

Harvard Pilgrim Health Care

Attention: Appeals
P.O. Box 30569
Salt Lake City, UT 84130–0569

You may also contact us at **1–800–460–0315** to initiate your appeal.

GRIEVANCES

If you have a complaint about your care under the Plan or about our service, we want to know about it. For all grievances, please call or write to us at:

Harvard Pilgrim Health Care

Attention: Grievances
P.O. Box 30569
Salt Lake City, UT 84130–0569
Telephone: 1–800–460–0315

For additional information on the Appeals and Grievance process, please refer to your Benefit Handbook.

Harvard Pilgrim Health Care of New England, Inc.
1600 Crown Colony Drive
Quincy, MA 02169
1–888–333–4742
www.harvardpilgrim.org