



Harvard Pilgrim
Health Care

Benefit Handbook

The Harvard Pilgrim PPO
For Self Insured Members
Massachusetts

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

INTRODUCTION

Welcome to Harvard Pilgrim Health Care (HPHC)! Your health care services are administered by Harvard Pilgrim Health Care through its affiliated provider network. This is a self-insured health benefits plan for the Plan Sponsor's employees and their eligible dependents. The Plan Sponsor has assumed financial responsibility for this Plan's health care benefits. This type of funding, known as self-funding, allows the Plan Sponsor to self-insure the health care costs associated with its employees with its own resources. HPHC will perform benefits and claims administration, and case management services on behalf of the Plan Sponsor as outlined in this Benefit Handbook and your *Schedule of Benefits*. HPHC is not, however, the issuer or insurer of your coverage.

To use the Harvard Pilgrim PPO (the Plan) effectively, you'll want to review this Benefit Handbook, including the *Schedule of Benefits*, which describes your In-Network and Out-of-Network benefits. This Plan has been designed to offer you the flexibility of obtaining Covered Benefits through the Plan's network of Participating Providers or the Non-Participating Provider of your choice. Benefits are covered both In-Network and Out-of-Network. However, your In-Network benefits provide you with a higher level of coverage.

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

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

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

- Selecting Participating Providers
- Your Benefit Handbook
- Your In-Network and Out-of-Network Benefits
- Enrollment
- Claims
- Provider Information
- Requesting a *Provider Directory*
- Requesting a Member kit
- Requesting ID cards
- Registering a concern

Deaf and hard-of-hearing Members who own, or have access to, a Teletypewriter (TTY) may communicate directly with the Member Services Department by calling our TTY machine at **1-800-637-8257**. HPHC values your input, so we would appreciate hearing from you with any comments or suggestions you may have.

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

1-888-333-4742

Internet: www.harvardpilgrim.org

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

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

[Spanish]

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

[Russian]

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

[Arabic]

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

[Portuguese]

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

[French]

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

[Greek]

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

[Haitian Creole]

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

[Italian]

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

[Traditional Chinese]

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

[Lao]

ສະມາຊິກ ທັງ ຫລາຍ ທີ່ ບໍາກ ພາສາ ອັງກິດ ບໍ່ ເປັນກໍ ສາມາດ ຕິດ ຕໍ່ ກັບ ພະນັກ ບໍລິການ ອຸກ ຄ້າ ຂອງ ໂຄງ ການ ຮັກສາ ສຸຂະພາບ Harvard Pilgrim ໄດ້ ໂດຍ ໂທ ໂປ ຫາ 1-888-333-4742 ເພື່ອ ຂໍ ຊາບ ຄໍາ ຕອບ ຂອງ ຄໍາ ຖາມ ຕ່າງໆ ຂອງ ຕົນ. ໂຄງ ການ ນີ້ ຂໍ ສະນີ ບໍລິການ ເຟຍ ພາສາ ໃນ ຫລາຍ ກວ່າ 120 ພາສາ ໂດຍ ບໍ່ ຄິດ ຄ່າ ບໍລິການ ໃດໆ ທັງ ສິ້ນ.

[Cambodian]

សមាជិកដែលមិនចេះនិយាយភាសាអង់គ្លេស ក៏អាចទូរស័ព្ទទៅការិយាល័យផ្នែកសេវាម៉ែម្លីសមាជិកនៃ ផែនការសុខភាព Harvard Pilgrim Health Care លេខ 1-888-333-4742 ដើម្បីឱ្យគេឆ្លើយសំណួររបស់អ្នកផ្សេងៗ ។ ផែនការសុខភាពនេះមានផ្តល់ជូនសេវាបកប្រែភាសាដោយ ឥតគិតថ្លៃ រហូតដល់ 120 ភាសា ។

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

TABLE OF CONTENTS

I. BENEFIT HANDBOOK	5
A. ABOUT THE PLAN.....	5
1. HOW TO USE THIS BENEFIT HANDBOOK.....	5
2. HOW YOUR IN-NETWORK COVERAGE WORKS	6
3. HOW YOUR OUT-OF-NETWORK COVERAGE WORKS.....	6
4. MEDICAL EMERGENCY SERVICES.....	7
5. PRIOR APPROVAL	7
6. SERVICES PROVIDED BY A DISENROLLED OR NON-PARTICIPATING PROVIDER.....	9
7. WHEN YOU RECEIVE IN-NETWORK AND OUT-OF-NETWORK COVERAGE FOR THE SAME CONDITION.....	9
B. COVERED BENEFITS	10
<i>(See the Schedule of Benefits for a listing of the Covered Benefits selected by your Plan Sponsor and the applicable benefit limitations and Copayments, Deductible and Coinsurance)</i>	
1. BASIC REQUIREMENTS FOR COVERAGE.....	10
2. INPATIENT CARE.....	10
3. OUTPATIENT CARE.....	11
4. FAMILY PLANNING SERVICES AND INFERTILITY TREATMENT	13
5. MATERNITY CARE	14
6. MENTAL HEALTH AND DRUG AND ALCOHOL REHABILITATION SERVICES.....	14
7. DENTAL SERVICES	16
8. OTHER SERVICES	17
9. EXCLUSIONS	22
C. REIMBURSEMENT AND CLAIMS PROCEDURES	24
1. CLAIM FILING PROCEDURES.....	24
2. BILLING BY PROVIDERS.....	24
3. REIMBURSEMENT FOR BILLS YOU PAY	24
4. LIMITS ON CLAIMS	24
D. APPEALS AND COMPLAINTS.....	25
1. BEFORE YOU FILE AN APPEAL	25
2. MEMBER APPEAL PROCEDURES	25
3. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED.....	26
4. FORMAL COMPLAINT PROCESS	27
E. ELIGIBILITY.....	28
1. MEMBER ELIGIBILITY	28
2. EFFECTIVE DATE - NEW AND EXISTING DEPENDENTS.....	28
3. EFFECTIVE DATE - ADOPTIVE DEPENDENTS.....	28
4. EFFECTIVE DATE - OFF-CYCLE ENROLLMENT.....	28
5. CHANGE IN STATUS	28
6. ADDING A DEPENDENT	28
7. SPECIAL ENROLLMENT RIGHTS.....	28
F. TERMINATION AND TRANSFER TO OTHER COVERAGE	29
1. TERMINATION BY THE SUBSCRIBER.....	29
2. TERMINATION FOR LOSS OF ELIGIBILITY.....	29
3. MEMBERSHIP TERMINATION FOR CAUSE.....	29
4. CONTINUATION OF COVERAGE REQUIRED BY LAW.....	29
5. TRANSFER TO NON-GROUP COVERAGE.....	29
6. MEMBERS ELIGIBLE FOR MEDICARE	30

TABLE OF CONTENTS
(Continued)

G. WHEN YOU HAVE OTHER COVERAGE	31
1. BENEFITS IN THE EVENT OF OTHER INSURANCE	31
2. PROVIDER PAYMENT WHEN PLAN COVERAGE IS SECONDARY	32
3. WORKER'S COMPENSATION/GOVERNMENT PROGRAMS	32
4. SUBROGATION	32
5. MEDICAL PAYMENT POLICIES	32
6. MEMBER COOPERATION.....	32
7. THE PLAN'S RIGHTS	32
8. MEMBERS ELIGIBLE FOR MEDICARE	33
H. ADMINISTRATION OF BENEFIT HANDBOOK	34
1. COVERAGE WHEN MEMBERSHIP BEGINS WHILE HOSPITALIZED	34
2. LIMITATION ON LEGAL ACTIONS.....	34
3. ACCESS TO INFORMATION.....	34
4. NOTICE.....	34
5. MODIFICATION OF THIS BENEFIT HANDBOOK.....	34
6. RELATIONSHIP OF PARTICIPATING PROVIDERS AND HPHC	34
7. MAJOR DISASTERS	35
8. MISSED APPOINTMENTS.....	35
9. EVALUATION OF NEW TECHNOLOGY	35
10. HIPAA CERTIFICATE OF CREDITABLE COVERAGE	35
11. UTILIZATION REVIEW PROCEDURES	35
12. QUALITY ASSURANCE PROGRAMS.....	35
13. PROCEDURES USED TO EVALUATE EXPERIMENTAL/INVESTIGATIONAL DRUGS, DEVICES, OR TREATMENTS	36
14. PROCESS TO DEVELOP CLINICAL GUIDELINES AND UTILIZATION REVIEW CRITERIA.....	36
I. GLOSSARY	37
II. PATIENT RIGHTS.....	41
III. MEMBER RIGHTS & RESPONSIBILITIES	42
IV. CONFIDENTIALITY	43

I. BENEFIT HANDBOOK

A. ABOUT THE PLAN

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

You receive *In-Network coverage* when you obtain Covered Benefits from Providers that have agreed to participate in the Plan. These Providers are referred to as "Participating Providers" and they have agreed to accept HPHC payment minus the Member Copayment, Coinsurance or Deductible as payment in full.

You receive *Out-of-Network coverage* when you obtain Covered Benefits from Non-Participating Providers. HPHC does not have agreements or contracts with these Providers. HPHC pays a percentage of the cost of care you receive from Non-Participating Providers which is based on the Usual, Customary and Reasonable Charges for such services. Your In-Network and *Out-of-Network coverage* is described further below. Please see your *Schedule of Benefits* to see if a Copayment, Coinsurance or Deductible applies to your coverage.

1. HOW TO USE THIS BENEFIT HANDBOOK

a. Why This Benefit Handbook Is Important

The Benefit Handbook (Handbook), the *Schedule of Benefits*, the *Prescription Drug Brochure* (if your Plan Sponsor has provided coverage for prescription drug benefits) and any applicable riders, make up the agreement setting forth the terms of the Plan. If you have eligibility questions, we recommend that you see your Plan Sponsor for information.

This Handbook describes how your coverage works. It explains what you must do to obtain coverage for services and what you can expect from the Plan. The Handbook is also your guide to the most important things you need to know about your benefits. These include:

- How to obtain benefits with the lowest out-of-pocket expense;
- What is covered, which includes most medical care you may need;
- What is not covered;
- Any limits or special rules for coverage;
- Any Copayments, Coinsurance or Deductibles you must pay which are listed in the *Schedule of Benefits*; and
- Prescription drug benefits will be listed in the *Prescription Drug Brochure*, if a Covered Benefit.

b. Words With Special Meaning

Some words in this Handbook have a special meaning. The words with special meaning are capitalized and are defined in the Glossary at the end of this Handbook.

c. How To Find What You Need To Know

The table of contents will help you find what you need to know.

We also put the most important things first. In this section we tell you how your coverage works. In the next section we tell you what is covered. Most limitations on services appear after the benefit to which they relate on the *Schedule of Benefits*. Any Copayment, Coinsurance or Deductible you have to pay is also listed in the *Schedule of Benefits*.

d. How to use Your Provider Directory

In order to be eligible for *In-Network coverage* under the Plan, services must be received from Participating Providers. These are the physicians, hospitals and other medical professionals who are either employed by HPHC or under contract to care for Plan Members. You can find Participating Providers by using the *Provider Directory*.

The *Provider Directory* identifies the Plan's specialists and other Participating Providers. It lists providers by state and town, specialty, and languages spoken. You can get a copy of the *Provider Directory* by calling the HPHC Member Services Department at **1-888-333-4742**. The HPHC Member Services Department can also answer any questions about HPHC doctors and their qualifications.

You may also view the online *Provider Directory* at the Harvard Pilgrim internet site, **www.harvardpilgrim.org**. The online Provider Directory allows you to search for providers by location. The information in the online directory may be more current than your paper directory since it is frequently updated by HPHC. The online Provider Directory also provides links to several physician profiling sites including one maintained by the Commonwealth of Massachusetts Board of Registration in Medicine at **www.massmedboard.org**.

Please note: The physicians and other medical professionals in the Plan's provider network participate through contractual arrangements that can be terminated either by a Provider or by HPHC. In addition, a provider may leave the Plan's network because of retirement, relocation or other reasons.

This means that HPHC cannot guarantee that the physician you choose will continue to participate in the Plan's network for the duration of your Plan membership.

e. Your Schedule of Benefits (or Summary of Benefits)

A summary of the benefits selected by your Plan Sponsor and covered under your Plan are listed in the *Schedule of Benefits*. A more detailed description of the benefits is in this document. In addition, the *Schedule of Benefits* contains any limitations and Copayments, Coinsurance or Deductible you must pay.

2. HOW YOUR IN-NETWORK COVERAGE WORKS

You use your *In-Network coverage* whenever you obtain Covered Benefits from HPHC Participating Providers. The Plan pays nearly all of the cost of Covered Benefits you receive from Participating Providers. You pay only Copayments for some services. Since HPHC pays Participating Providers directly, you do not have to file a claim when you use your *In-Network coverage*.

Participating Providers are under contract to provide Covered Benefits to Members of the Plan. They are listed in the *HPHC Provider Directory*. Although every effort is made to keep the *Provider Directory* up-to-date, changes may occur for a variety of reasons. Members should contact the Member Services Department at 1-888-333-4742 to verify a Provider's status.

Members are responsible for advising Providers of their membership in the Plan by showing them their identification card before receiving services.

3. HOW YOUR OUT-OF-NETWORK COVERAGE WORKS

You use your *Out-of-Network coverage* whenever you obtain Covered Benefits from Providers who are not Participating Providers. (They are also known as Non-Participating Providers.) The Plan pays only a percentage of the cost of Covered Benefits you receive from Non-Participating Providers, after you meet a yearly Deductible. You are responsible for paying the balance.

a. Paying the Out-of-Network Annual Deductible

When you use a Non-Participating Provider, you must first pay a Deductible before HPHC begins paying benefits. A Deductible is a specific dollar amount that you pay for Covered Benefits each calendar year before benefits subject to the Deductible are payable by the Plan. The *Schedule of Benefits* specifies the Deductible amounts and if your benefits include a family Deductible. Each Member

must pay the individual Deductible amount for Covered Benefits each calendar year. No family Member will pay more than the individual Deductible in a calendar year. Once the family Deductible is met in a calendar year, the Deductible is met by all Members for the remainder of the calendar year. No family Member will pay more than the individual annual Deductible. Any Deductible amount that is incurred for services rendered during the last three (3) months of a calendar year may be applied toward the Deductible requirement for the next year, provided the Member has had continuous coverage under the Plan through the same Plan Sponsor at the time the charges in the prior year were incurred. Please see your *Schedule of Benefits* to see if a Deductible carryover applies to your coverage. Deductible amounts for all services are considered incurred as of the date of service.

b. Paying Copayments and the Out-of-Network Coinsurance

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. You must first pay any applicable Copayments. Then, after the appropriate Deductible amount is met, you will be responsible for paying the Coinsurance amount. Coinsurance is a percentage of the costs that you must pay for certain Covered Benefits. Copayment, Deductible, and Coinsurance amounts are listed in the *Schedule of Benefits*.

c. Out-of-Pocket Maximum

A limit on the amount of Cost Sharing that you must pay for all Covered Benefits. This excludes any amounts that you pay for prescription drugs. Out-of-Pocket Maximum amounts, if applicable to your Plan, are specified in your *Schedule of Benefits*.

d. Lifetime Benefit Maximum

The Lifetime Benefit Maximum is the total amount the Plan will pay in Covered Benefits for one Member under this Benefit Handbook. If applicable, you will find specific information and limitations on the Lifetime Benefit Maximum listed in the *Schedule of Benefits*.

e. Charges in Excess of the Usual, Customary and Reasonable Charges

A Non-Participating Provider may charge amounts in excess of the Usual, Customary and Reasonable Charges. In those instances, you will be financially responsible for the difference between what the Non-Participating Provider charges and the Usual, Customary and Reasonable Charge.

4. MEDICAL EMERGENCY SERVICES

You are always covered for care in a Medical Emergency. In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. Your emergency room Copayment is listed on the *Schedule of Benefits*.

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

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

Please note that if you are hospitalized you must call the Plan within 48 hours or as soon as you can.

5. PRIOR APPROVAL

The Plan maintains a Prior Approval Program designed to make sure that the use of certain Covered Benefits is appropriate. You or your designee are responsible for obtaining Prior Approval before receiving these services, whenever you use a Non-Participating Provider. If you use a Participating Provider, he/she will obtain Prior Approval for you. The Prior Approval Program benefits both the Plan and its Members by ensuring the appropriate use of health care services and reducing health care costs and the premiums that must be charged for providing health insurance. Prior Approval is an ongoing process that continues throughout the time Covered Benefits are rendered.

The Prior Approval Program evaluates whether a service is Medically Necessary, including whether it is, and continues to be, provided in an appropriate setting. When Prior Approval is obtained, the Plan will pay up to the full benefit limit stated in this Benefit Handbook and the *Schedule of Benefits* for the period or service approved. If Prior Approval is not obtained in advance, whenever you use Non-Participating Providers, you will be responsible for paying the penalty amount stated in

the *Schedule of Benefits* in addition to any Copayments, Coinsurance and Deductibles. If the Plan determines at any point that a service is not Medically Necessary, no payments will be made for such services, you will be notified of the Plan's decision and you will be responsible for the entire cost of those services.

Prior Approval does not entitle you to benefits not otherwise payable under this Benefit Handbook.

To seek Prior Approval, you should call: **1-800-708-4414**.

a. When To Seek Prior Approval

Prior Approval is required for any inpatient admission, and the services listed below to assure full payment of benefits under this Benefit Handbook and *Schedule of Benefits*. Please remember that a penalty amount will be deducted from your benefit when receiving care from a Non-Participating Provider for these services, if Prior Approval is not obtained.

- An admission to an inpatient facility, including admissions for maternity care, psychiatric care and substance abuse rehabilitation
- A transfer from one inpatient facility to another
- Partial hospitalization for psychiatric or substance abuse treatment
- Day Surgery
- Human organ transplants
- Advanced reproductive technologies
- Physical, speech and occupational therapy
- Any services provided in the Member's home

For planned admissions Out-of-Network, you must seek Prior Approval in advance. To assure that Prior Approval will be completed in a timely manner, you should contact the Prior Approval Program at least five (5) business days in advance of the admission. In the event of a Medical Emergency admission, you or your designee must notify the Prior Approval Program within 48 hours or as soon as possible.

If either the hospital or physician are Non-Participating you are responsible for obtaining Prior Approval.

Please refer to the chart below to determine who is responsible for requesting approval for hospital admissions.

Admitted by:	Admitted to:	Approval Responsibility
Participating Physician	Participating Hospital	Participating Physician
Participating Physician	Non-Participating Hospital	Member
Non-Participating Physician	Participating Hospital	Member
Non-Participating Physician	Non-Participating Hospital	Member

b. How To Seek Prior Approval

To seek Prior Approval for Out-of-Network care, you should call: 1-800-708-4414. The following information must be given:

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

For Out-of-Network inpatient admissions the following additional information must be given:

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

c. What the Prior Approval Program Does

Once the Prior Approval process has been initiated, the Prior Approval Program will evaluate the need for care. You and your attending physician will be notified of the Prior Approval Program's decision to approve or not to approve the Covered Benefits. During the course of treatment, the Prior Approval Program will review your care with your Providers to make sure the services continue to be Medically Necessary. All decisions not to approve your services will be reviewed by a qualified physician.

d. Effect of Prior Approval on Coverage

For services that are approved, Covered Charges will be paid at the applicable percentage stated in the *Schedule of Benefits*. If Prior Approval is not obtained in advance, you will be responsible for paying the penalty amount stated in the *Schedule of Benefits* in addition to any Copayments, Coinsurance, and Deductibles. The penalty amount will not be applied to the Deductible or Annual Out-of-Pocket Maximum. If HPHC determines at any point that a service is not Medically Necessary, no payments will be made for such services, you will be notified of HPHC's decision and you will be responsible for the entire cost of those services. Prior Approval does not entitle you to benefits not otherwise payable under this Benefit Handbook.

When the Prior Approval Program denies a coverage request, it will notify you and your physician as soon as possible. Prior Approval will be denied if it is determined that the treatment is not Medically Necessary. This might include, for example, (a) when treatment could be provided on an outpatient basis, (b) when the proposed level of inpatient care is not appropriate to your medical condition, or (c) when inpatient care is no longer necessary.

e. Differences of Opinion

If there is a difference of opinion about the need for services requiring Prior Approval, the Prior Approval Program will notify both you and your attending physician as soon as possible. The Prior Approval Program will try to reach an agreement with your physician. If an agreement cannot be reached, the Prior Approval Program will not approve the services. If you are denied prior approval, you may appeal this decision. Please see section D. Appeals and Complaints.

6. SERVICES PROVIDED BY A DISENROLLED OR NON-PARTICIPATING PROVIDER

a) Pregnancy

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

b) Terminal Illness

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

c) New Membership

If you are a new Member, the Plan will provide In-Network coverage for services delivered by a physician who is not an HPHC Provider, under the terms of this Handbook and your *Schedule of Benefits*, for up to 30 days from your effective date of coverage if;

- Your employer only offers employees a choice of plans in which the physician is not
- A participating provider, and
- The physician is providing you with an ongoing course of treatment.

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

Services received from a disenrolled or nonparticipating provider as described in paragraphs a, b, and c, above, are only covered when the physician agrees to:

- Accept reimbursement from HPHC at the rates applicable prior to notice of disenrollment as payment in full and not to impose Cost Sharing with respect to the Member in an amount that would exceed the Cost Sharing that could have been imposed if the provider had not been disenrolled;

- Adhere to the quality assurance standards of HPHC and to provide the Plan with necessary medical information related to the care provided; and
- Adhere to the Plan's policies and procedures, obtaining prior authorization and providing Covered Benefits pursuant to a treatment plan, if any, approved by the Plan.

7. WHEN YOU RECEIVE IN-NETWORK AND OUT-OF-NETWORK COVERAGE FOR THE SAME CONDITION

Under some circumstances, you may receive services from both a Participating Provider and a Non-Participating Provider for the same medical condition. When this occurs, your entitlement to In-Network or *Out-of-Network coverage* always depends upon the participation status of the individual service provider. For example, you may receive treatment from a physician who is a Participating Provider but choose to obtain tests from a laboratory that is not a Participating Provider. Since your benefits depend upon the participation status of the provider, the physician's service would be covered at the *In-Network coverage* level and the laboratory would be covered at the *Out-of-Network coverage* level.

The benefit payment level that is applied to a hospital admission depends on the participation status of both the admitting physician and the hospital. If you are admitted to a participating hospital by an Participating Provider both the hospital and physician are paid at the *In-Network coverage* level. If you are admitted to a participating hospital by a Non-Participating Provider, the hospital's charges are paid at the *In-Network coverage* level but the physician's charges are paid at the *Out-of-Network coverage* level. Likewise if you are admitted to an Out-of-Network hospital by a Participating Provider, the hospital's charges are paid at the *Out-of-Network coverage* level but the physician's charges are paid at the *In-Network coverage* level.

B. COVERED BENEFITS

It is important for you to note that some of the benefits listed in this section may not be available to you under the plan design chosen by your Plan Sponsor. Benefit limitations or variations and any Copayment, Coinsurance and Deductible amounts applicable to your plan design will be listed on the *Schedule of Benefits*. This section describes Plan benefits and whether a service requires Prior Approval from HPHC.

You have one set of benefits per calendar year. If a Covered Benefit has a benefit limit, the limit applies whether you choose to receive care In-Network or Out-of-Network or both. For example, if a Covered Benefit is limited to ten visits per calendar year and you receive nine visits In-Network and one visit Out-of-Network, then you will have reached your benefit limit and will no longer have coverage for that benefit for the remainder of the calendar year.

1. BASIC REQUIREMENTS FOR COVERAGE

To be covered, all services and supplies must be:

- Medically Necessary;
- Received while an active Member of the Plan; and
- Listed in Section B. 1-8.(Covered Benefits) and not listed in Section B.9. (Exclusions)

Please see your *Schedule of Benefits* for any special limits or exclusions from coverage.

In-Network services must be provided by a Participating Provider. The only exception is care needed in a Medical Emergency.

2. INPATIENT CARE

The Plan covers the following inpatient services:

- Semi-private room and board
- Doctor visits, including consultation with specialists
- Medications
- Lab and x-ray services
- Intensive care
- Surgery, including related services
- Anesthesia, including the services of a nurse-anesthetist
- Radiation therapy
- Physical therapy, occupational therapy and speech therapy
- Private duty nursing (if a Covered Benefit – Please see your *Schedule of Benefits*)

Coverage of a hospital admission depends on both the participation of the admitting physician and the hospital. If the hospital or physician is a Non-Participating Provider, coverage for the Non-Participating Provider is at the Out-of-Network benefit payment level. If you are admitted to a participating hospital by a participating physician, payment to both is made at the In-Network benefit payment level.

Please refer to the chart below as a guideline of the benefit payment levels when using various Provider combinations.

	Admitted by: Participating Physician	Admitted by: Non-Participating Physician
Admitted to: Participating Hospital	Hospital - In-Network benefit payment level Physician - In-Network benefit payment level	Hospital - In-Network benefit payment level Physician - Out-of-Network benefit payment level
Admitted to: Non-Participating Hospital	Hospital - Out-of-Network benefit payment level Physician - In-Network benefit payment level	Hospital - Out-of-Network benefit payment level Physician - Out-of-Network benefit payment level

All inpatient admissions including partial hospitalization for psychiatric and substance abuse treatment, and day surgery require Prior Approval. An admission includes the transfer from one inpatient facility to another.

If you are using a Participating Provider, he or she will obtain this for you. If you are using a Non-Participating Provider, you are responsible for obtaining Prior Approval. The Prior Approval process is initiated by calling: **1-800-708-4414**. Further information about Prior Approval may be found in Section A.5.

Please see the *Schedule of Benefits* for detailed information on the payment amounts and your financial obligations.

Specific inpatient care benefits are described below.

a. Acute Hospital Care

The Plan covers acute hospital care, including emergency admissions, to the extent Medically Necessary. There is no limit on the number of days covered.

You must obtain Prior Approval when using a Non-Participating Provider. The Prior Approval process is initiated by calling: 1-800-708-4414. Further information about Prior Approval may be found in Section A.5.

b. Skilled Nursing Facility Care

The Plan covers care in a health care facility, or part of one, licensed to provide skilled nursing care on an inpatient basis. Such coverage is provided up to the benefit limit described in the *Schedule of Benefits* only when you need daily skilled nursing care or rehabilitative services that must be provided in an inpatient setting.

You must obtain Prior Approval when using a Non-Participating Provider. The Prior Approval process is initiated by calling: 1-800-708-4414. Further information about Prior Approval may be found in Section A.5.

c. Rehabilitation Hospital Care

The Plan covers care in a health care facility, or part of one, licensed to provide rehabilitative care on an inpatient basis up to the limit described in the *Schedule of Benefits*. Rehabilitative care includes physical, speech and occupational therapies.

You must obtain Prior Approval when using a Non-Participating Provider. The Prior Approval process is initiated by calling: 1-800-708-4414. Further information about Prior Approval may be found in Section A.5.

RELATED EXCLUSIONS

The following are not covered for all types of inpatient care:

- Personal items, including telephone and television charges
- All charges over the semi-private room rate, except when a private room is Medically Necessary
- Rest or Custodial Care
- Blood or blood products
- Charges after discharge
- Charges after the date in which membership ends
- Private duty nursing (unless a Covered Benefit – please see your *Schedule of Benefits*)

3. OUTPATIENT CARE

The Plan covers outpatient care that you receive from a Provider at a doctor's office, clinic or hospital.

See the *Schedule of Benefits* for detailed information on payment amounts and your financial obligations.

Prior Approval is required to receive the following specialized services: outpatient physical, speech or occupational therapy; organ transplants; advanced reproductive technology; and any services provided in your home.

a. Preventive Care in the Doctor's Office

The Plan covers preventive care according to your individual medical needs. Covered preventive care includes: physical examinations; annual gynecological examinations; immunizations; vision and hearing screening; diagnostic screening and tests including, but not limited to; health education; and nutritional counseling.

The following diagnostic screenings and tests are covered: hereditary and metabolic screening at birth; newborn hearing screening test; tuberculin tests; lead screenings; hematocrit, hemoglobin or other appropriate blood tests, human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish bone marrow transplant donor suitability, and urinalysis; annual cytological screenings; and mammograms including a baseline mammogram for women between the ages of thirty-five and forty and an annual mammogram for women forty years of age and older.

Covered pediatric care includes: physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and developmental screening, and assessment at the following intervals: at least six visits per year are covered for a child from birth to age one. At least three visits per year are covered for a child from age one to age two. At least one visit per year is covered for a child from age two to age six.

1) Routine Physical Examinations

The Plan covers routine physical examinations. School, sports, camp, and premarital examinations are also covered.

RELATED EXCLUSIONS:

- Exams, other than those stated above, including insurance, licensing, and employment exams

2) Eye Examinations

Eye examinations with an ophthalmologist or optometrist are covered up to the limit described in the *Schedule of Benefits*.

Please note this benefit is not covered by all Plan Sponsors. Please see your *Schedule of Benefits*.

b. Sick or Injured Care

The Plan covers care when you are sick or injured. Services include, but are not limited to necessary care and treatment of medically diagnosed congenital defects and birth abnormalities or premature birth, injections, diagnostic tests and x-rays, dressings, sutures, casting, and radiation therapy.

c. Emergency Care

In the event of a Medical Emergency, you are covered at the In-Network benefit payment level in a hospital emergency room.

Please remember, if you need follow-up care after you are treated in an emergency room, you must get your care from Participating Providers for coverage to be at the In-Network benefit payment level.

d. Diagnostic Lab and X-Rays

The Plan covers outpatient diagnostic laboratory and x-ray services to diagnose illness, injury, or pregnancy.

HPHC also covers human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish bone marrow transplant donor suitability (including testing for A, B, or DR antigens, or any combination, consistent with rules, regulations and criteria established by the Department of Public Health).

e. Physical and Occupational Therapies

Outpatient physical and occupational therapies are each covered up to the benefit limit described in the *Schedule of Benefits*. Services are covered only when needed to improve your ability to perform Activities of Daily Living and when, in the opinion of your physician, there is likely to be significant improvement in your condition within that time period.

Physical and occupational therapies are covered as part of a pulmonary rehabilitation course of treatment to the extent Medically Necessary. These services must be approved by HPHC.

Please note that the outpatient physical and occupational therapies for children under the age of 3 is covered to the extent Medically Necessary. The benefit limit stated in *Schedule of Benefits* does not apply.

Physical and occupational therapies are also covered under your inpatient hospital, home health and hospice benefits. When such therapies are part of an approved home care treatment plan they are available on a short-term intermittent basis. (Please see the home health and hospice care benefits described later in this section for information on in-home coverage.)

Physical and occupational therapies require Prior Approval. You must obtain Prior Approval when using a Non-Participating Provider. The Prior Approval process is initiated by calling: 1-800-708-4414. Further information about Prior Approval may be found in Section A.5.

f. Speech-Language and Hearing Services

The Plan covers diagnosis and treatment of speech, hearing and language disorders when Medically Necessary and provided by HPHC speech-language pathologists and HPHC audiologists. If you require speech therapy, your physician will order therapy for you based on your condition or needs.

Speech therapy requires Prior Approval. You must obtain Prior Approval when using a Non-Participating Provider. The Prior Approval process is initiated by calling: 1-800-708-4414. Further information about Prior Approval may be found in Section A.5.

RELATED EXCLUSIONS:

- Educational services or testing, except services covered under the benefit for Early Intervention Services, below

- Services for problems of school performance
- Sensory integrative praxis tests
- Vocational rehabilitation, or vocational evaluations focused on job adaptability, job placement, or therapy to restore function for a specific occupation

g. Early Intervention Services

The Plan covers early intervention services when Medically Necessary. Coverage is provided for Members from birth through the Member’s third birthday. The Plan provides coverage up to the limits described in your *Schedule of Benefits*. Covered Benefits include:

- Screening and assessment of the need for services
- Physical, speech, and occupational therapy
- Psychological counseling
- Nursing care

g. Surgical Day Care

Surgical Day Care is a surgery or procedure performed in a Surgical Day Care department, ambulatory surgery department or outpatient surgery center that requires operating room, anesthesia and recovery room services. The Plan covers outpatient Surgical Day Care, including related services.

Surgical Day Care requires Prior Approval. You must obtain Prior Approval when using a Non-Participating Provider. The Prior Approval process is initiated by calling: 1-800-708-4414. Further information about Prior Approval may be found in Section A.5.

h. Second Opinions

There may be times when you want a second opinion. The Plan covers a second opinion from a licensed physician regarding proposed treatment or diagnosis.

i. Allergy Treatment

The Plan covers allergy testing, antigens and allergy treatments.

4. FAMILY PLANNING SERVICES AND INFERTILITY TREATMENT

a. Family Planning Services

The Plan covers family planning services including pregnancy testing and genetic counseling. (Some of the services listed below are covered if your Plan

Sponsor selected such coverage. The *Schedule of Benefits* will list these benefits if covered.)

- Annual gynecological examination
- Family planning consultation
- Pregnancy testing
- Voluntary sterilization, including tubal ligation and vasectomy (if a Covered Benefit, please see your *Schedule of Benefits*)
- Voluntary termination of pregnancy (if a Covered Benefit, please see your *Schedule of Benefits*)
- Contraceptive monitoring
- Genetic counseling
- Injection of birth control medication and the insertion and removal of birth control implants and devices is covered. However, such medications, implants and devices themselves are only covered if your Plan Sponsor has selected a Prescription Drug Rider with birth control coverage.

RELATED EXCLUSIONS:

- Reversal of voluntary sterilization
- Birth control medications, implants and devices, unless your Plan Sponsor has selected a Prescription Drug Rider with birth control coverage

Please note that some Plan Sponsors do not cover voluntary sterilization including tubal ligation and vasectomy, and voluntary termination of pregnancy, except as Medically Necessary to prevent the death of the mother. Please see your *Schedule of Benefits* to see if these are listed exclusions.

b. Infertility Treatment

Infertility is defined as the inability of a presumably healthy individual to conceive or produce conception during a period of one year. Some of the services listed below are covered if your Plan Sponsor selected such coverage. The *Schedule of Benefits* will list these benefits if covered.

The Plan covers the following infertility treatments:

- Consultation and evaluation
- Laboratory tests
- Artificial insemination, including related sperm procurement and banking (if a Covered Benefit, please see your *Schedule of Benefits*.)

- Advanced reproductive technologies, including, but not limited to, in-vitro fertilization (IVF), including embryo placement, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intra-cytoplasmic sperm injection (ICSI), and donor egg procedures, including related egg and inseminated egg procurement, processing and banking, (if a Covered Benefit, please see your *Schedule of Benefits*.)

Important Notice: HPHC uses clinical guidelines to evaluate whether infertility services are Medically Necessary. If you are receiving care for infertility, HPHC recommends that you review the current guidelines. To obtain a copy, please call **1-888-888-4742** ext. **38723**.

Advanced reproductive technologies require Prior Approval.

You must obtain Prior Approval when using a Non-Participating Provider. The Prior Approval process is initiated by calling: 1-800-708-4414. Further information about Prior Approval may be found in Section A.5.

Please note this benefit is not covered by all Plan Sponsors. Please see your *Schedule of Benefits*.

RELATED EXCLUSIONS:

- Reversal of voluntary sterilization
- Any infertility treatment related to voluntary sterilization or its reversal
- Infertility treatment for Members who are not medically infertile
- Any form of surrogacy

5. MATERNITY CARE

The Plan covers the following maternity care services:

- Prenatal exams
- Diagnostic tests
- Diet regulation
- Pre-natal genetic testing
- Post-partum care
- 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 cesarean section. Any decision to shorten the inpatient stay for the mother and her newborn will be

made by the attending health care Provider in consultation with the mother.

- One home visit by a registered nurse or certified nurse midwife if the mother elects to participate in an early discharge.
- Routine nursery charges (This includes common services given to a healthy newborn.)

You must obtain Prior Approval for inpatient services when using a Non-Participating Provider. The Prior Approval process is initiated by calling: 1-800-708-4414. Further information about Prior Approval may be found in Section A.5.

RELATED EXCLUSIONS:

- Services for a newborn who has not been enrolled as a Member, other than nursery charges for routine services provided to a healthy newborn
- Planned home births

6. MENTAL HEALTH AND DRUG AND ALCOHOL REHABILITATION SERVICES

The Plan covers both inpatient and outpatient mental health care as well as drug and alcohol rehabilitation services.

For *In-Network coverage* of mental health care or drug or alcohol rehabilitation services, you must call the Behavioral Health Access Center at 1-888-777-4742. The phone line is staffed by licensed mental health clinicians. A clinician will assist you in determining the type of care you need, finding appropriate Participating Providers, and arranging the services you require.

HPHC requires consent to the disclosure of information regarding services for mental disorders to the same extent it requires consent for disclosure of information for other medical conditions. Any determination of Medical Necessity of mental health services will be made in consultation with a licensed mental health professional.

Mental health services are subject to limits described in your *Schedule of Benefits*, except in one of the three circumstances described below. The limits in the *Schedule of Benefits* do not apply under those circumstances, and mental health services are covered to the extent that they are Medically Necessary. The three circumstances are:

1) Biologically-Based Mental Disorders:

When services are required for a biologically-based mental disorders. Biologically-based mental disorders are: (1) schizophrenia; (2) schizoaffective

disorders; (3) major depressive disorder; (4) bipolar disorder; (5) paranoia and other psychotic disorders; (6) obsessive-compulsive disorder; (7) panic disorder (8) delirium and dementia; (9) affective disorders; and (10) any mental disorder designated a biologically-based mental disorder by the Commissioner of the Massachusetts Department of Mental Health.

Please note this benefit is not covered by all Plan Sponsors. Please see your *Schedule of Benefits*.

2) Services Required As A Result Of Rape:

When services are required to diagnose and treat rape-related mental or emotional disorders for victims of rape or victims of assault with the attempt to commit rape.

Please note this benefit is not covered by all Plan Sponsors. Please see your *Schedule of Benefits*.

3) Services For Children With Non-biologically-based Mental, Behavioral Or Emotional Disorders:

When services are required to diagnose and treat non-biological-based mental, behavioral or emotional disorders that substantially interfere with or limit functioning and social interactions for children through the age of 18. Substantial interference with, or limitation of, function must be documented by the physician, or when evidenced by conduct including, but not limited to:

- the inability to attend school
- the need for hospitalization as a result of the disorder
- a pattern of conduct or behavior caused by the disorder that poses a serious danger to self or others

Coverage under this subsection shall continue after the child's 19th birthday until either the course of treatment specified in the child's treatment plan is completed or coverage under the Plan is terminated, whichever comes first. If treatment of a 19 year old, as specified in his or her treatment plan, has not been completed at the time coverage under this Plan is terminated, additional rights to coverage for mental health treatment apply. Please call Member Services for further information.

Please note this benefit is not covered by all Plan Sponsors. Please see your *Schedule of Benefits*.

PLEASE NOTE: For *In-Network coverage*, all mental health and drug and alcohol rehabilitation services must be obtained through a Participating Provider. The Behavioral Health Access Center can help direct you to the appropriate Participating Provider. The only exception is care required in a

Medical Emergency. This exception is described in Section A.4. of this Handbook.

Listed below is a detailed description of your mental health and drug and alcohol coverage:

a. Inpatient Services - Mental Health

- Inpatient care is covered up to the limit described in your *Schedule of Benefits*. That limit does not apply for the treatment of a biologically-based mental disorder, rape-related mental or emotional disorder, or a non-biologically-based mental, behavioral or emotional disorder for children, as described above. Under those circumstances, inpatient hospitalization is covered to the extent Medically Necessary.
- Care in a partial hospitalization program is covered up to the limit described in your *Schedule of Benefits*. Partial hospitalization is an intensive outpatient program that provides coordinated services in a therapeutic setting. Each partial hospitalization day counts as one-half of a psychiatric hospital day and is deducted from the limit described in your *Schedule of Benefits* available for inpatient services. Partial hospitalization will only be covered if you and your Provider agree that this treatment is best for you. That limit does not apply for the treatment of a biologically-based mental disorder, rape-related mental or emotional disorder, or a non-biologically-based mental, behavioral or emotional disorder for children, as described above. Under those circumstances, partial hospitalization is covered to the extent Medically Necessary.

Please note this benefit is not covered by all Plan Sponsors. Please see your *Schedule of Benefits*.

You must obtain Prior Approval when using a Non-Participating Provider. The Prior Approval process is initiated by calling: 1-888-777-4742. Further information about Prior Approval may be found in Section A.5.

b. Inpatient Services - Drug and Alcohol Rehabilitation

- Inpatient rehabilitative care for drug and alcohol abuse is covered up to the limit described in your *Schedule of Benefits*. That limit does not apply to services provided in conjunction with treatment of mental disorders. Under those circumstances, inpatient rehabilitative care is covered to the extent Medically Necessary.
- Care in a partial hospitalization program is covered up to the limit described in your *Schedule of Benefits*. Partial hospitalization is an intensive outpatient

program that provides coordinated services in a therapeutic setting. Each partial hospitalization day counts as one-half of an inpatient hospital day and is deducted from the limit described in your *Schedule of Benefits* available for inpatient services. Partial hospitalization will only be covered if you and your Provider agree that this treatment is best for you. That limit does not apply to services provided in conjunction with treatment of mental disorders. Under those circumstances, partial hospitalization is covered to the extent Medically Necessary.

- Inpatient detoxification is covered as long as it is Medically Necessary.

Please note this benefit is not covered by all Plan Sponsors. Please see your *Schedule of Benefits*.

You must obtain Prior Approval when using a Non-Participating Provider. The Prior Approval process is initiated by calling: 1-888-777-4742. Further information about Prior Approval may be found in Section A.5.

RELATED EXCLUSION:

- Methadone Maintenance

c. Outpatient Services - Mental Health Care

The Plan covers outpatient mental health care for evaluation, diagnosis, treatment and crisis intervention up to the limit described in your *Schedule of Benefits*. That limit does not apply for the treatment of a biologically-based mental disorder, rape-related mental or emotional disorder, or a non-biologically-based mental, behavioral or emotional disorder for children, as described above. Under those circumstances, outpatient, mental health services is covered to the extent Medically Necessary.

Please note this benefit is not covered by all Plan Sponsors. Please see your *Schedule of Benefits*.

RELATED EXCLUSIONS:

- Educational services or testing, except services covered under the benefit for Early Intervention Services; and
- Services for problems of school performance
- The Plan does not cover mental health services that are (1) provided to Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health.

d. Outpatient Services - Drug and Alcohol Rehabilitation Services

The Plan covers outpatient drug and alcohol rehabilitation services for evaluation, diagnosis, treatment and crisis intervention up to the limit described in your *Schedule of Benefits*. That limit does not apply for the treatment provided in conjunction with treatment of mental disorders. Under those circumstances, outpatient drug and alcohol rehabilitation is covered to the extent Medically Necessary.

Please note this benefit is not covered by all Plan Sponsors. Please see your *Schedule of Benefits*.

RELATED EXCLUSION:

- Methadone Maintenance

e. Outpatient Detoxification and Psychopharmacological Services

The Plan covers outpatient detoxification and psychopharmacological services to the extent they are Medically Necessary.

Please note this benefit is not covered by all Plan Sponsors. Please see your *Schedule of Benefits*.

For *In-Network coverage*, the Behavioral Health Access Center can direct or arrange your care, as described previously in this section.

RELATED EXCLUSION:

- Methadone Maintenance

f. Psychological Testing and Neuropsychological Assessment

The Plan covers psychological testing and neuropsychological assessment when Medically Necessary.

Please note this benefit is not covered by all Plan Sponsors. Please see your *Schedule of Benefits*.

RELATED EXCLUSIONS:

- Educational services or testing, except services covered under the benefit for Early Intervention Services;
- Sensory integrative praxis tests; and
- Services for problems of school performance

7. DENTAL SERVICES

The Plan covers only the limited dental services described below.

a. Extraction of Impacted Teeth

If your Plan Sponsor has selected coverage for extraction of impacted teeth as part of your benefit package, the Plan covers extraction of bony impacted teeth. Pre-operative and post-operative care, x-rays and anesthesia are covered.

Please note this benefit is not covered by all Plan Sponsors. Please see your *Schedule of Benefits*.

RELATED EXCLUSIONS:

- Removal of impacted teeth to prepare for or support orthodontic, prosthodontic, or periodontal procedures

b. Preventive Dental Care

If your Plan Sponsor has selected coverage for preventive dental care as part of your benefit package, the following services are covered up to the age limit described in your *Schedule of Benefits*. The Plan covers two preventive dental exams per calendar year. Only the following services are covered:

- Cleaning
- Fluoride treatment
- Teaching plaque control
- X-rays

Please note this benefit is not covered by all Plan Sponsors. Please see your *Schedule of Benefits*.

RELATED EXCLUSIONS:

- All dental services except those listed above

c. Emergency Dental Care

The Plan covers emergency dental care needed due to an injury to sound, natural teeth. All services, except for suture removal, must be received within 72 hours of injury. Only the following services are covered:

- Extraction of teeth needed to avoid infection of teeth damaged in the injury
- Suturing and suture removal
- Re-implanting and stabilization of dislodged teeth
- Re-positioning and stabilization of partly dislodged teeth
- Medication received from the Provider

RELATED EXCLUSIONS:

- Fillings
- Crowns

- Gum care, including gum surgery
- Braces
- Root canals
- Bridges
- Dentures
- Bonding

8. OTHER SERVICES

a. Home Health Care

When you are homebound for medical reasons, the Plan covers the home health care services and hospice care stated below on a short-term intermittent basis. To be eligible for home health care, your Provider must find that skilled nursing care or physical therapy are an essential part of active treatment. There must also be a defined medical goal that your Provider expects you will meet in a reasonable period of time.

Care provided on a short-term intermittent basis means care that is provided fewer than eight hours per day, on a less than daily basis, up to 35 hours per week, for up to 21 consecutive days. If you receive more than one type of skilled service in the home, these time limits apply to all services combined.

When you qualify for home health care services as stated above, the Plan also covers the following on a short-term intermittent basis when Medically Necessary:

- Skilled nursing care
- Physical therapy
- Occupational therapy
- Speech therapy
- Medical social services
- Nutritional counseling
- Services of a home health aide

Durable medical equipment and supplies are also covered to the extent that they are a Medically Necessary component of the home health care services being provided.

Home health care requires Prior Approval. You must obtain Prior Approval when using a Non-Participating Provider. The Prior Approval process is initiated by calling: 1-800-708-4414. Further information about Prior Approval may be found in Section A.5.

Please note that physical, speech and occupational therapies covered under the home health care benefit are not subject to any visit limit.

No Copayment applies to durable medical equipment received as part of authorized home health care.

RELATED EXCLUSIONS:

- Continuous or long-term home health care services
- Private duty nursing

b. Hospice Services

The Plan covers hospice services for terminally ill Members with a limited life-expectancy. Care may be provided at home or on an inpatient basis. (Inpatient care is only covered when Medically Necessary to control pain and manage acute and severe clinical problems which cannot be managed in a home setting.)

Covered Benefits include: physician services; nursing care; social services; counseling services; care to relieve pain; home health aide services; occupational, physical, speech, and respiratory therapy; medical supplies; appliances; drugs which cannot be self-administered; and respite care.

All admissions and care provided in the home require Prior Approval.

You must obtain Prior Approval when using a Non-Participating Provider. The Prior Approval process is initiated by calling: 1-800-708-4414. Further information about Prior Approval may be found in Section A.5.

c. House Calls

The Plan covers house calls from a licensed physician to the extent they are Medically Necessary.

d. Durable Medical and Prosthetic Equipment

The Plan covers durable medical equipment including prosthetic devices when Medically Necessary and ordered by your Provider up to the benefit limit described in your *Schedule of Benefits*. The cost of the repair and maintenance of covered equipment is also covered.

HPHC will determine whether to rent or buy all equipment. For equipment that is covered In-Network, HPHC may recover the equipment, excluding prosthetic devices, if your Provider

decides you no longer need it or your membership ends.

Coverage is only available for:

- The least costly equipment or prosthesis, including prosthetic arms and legs which is the most appropriate model that adequately meets the Member's needs in the performance of Activities of Daily Living; and
- One item of each type of equipment that meets the Member's need. 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.

Durable medical equipment is covered only if it meets all the following criteria:

- It is primarily and customarily used in the treatment of an illness or injury or for the rehabilitation of a malformed body part;
- It is able to withstand repeated use;
- It is not generally useful in the absence of disease or injury;
- It is appropriate for home use (not physician or hospital equipment);
- It provides direct aid or relief of the Member's medical condition;
- It is not for sports-related or special occupational purposes; and
- It is recommended by the Member's physician.

Covered equipment includes:

- Respiratory equipment
- Certain types of braces
- Oxygen and oxygen equipment
- Hospital beds
- Wheelchairs
- Walkers
- Crutches
- Canes
- Blood glucose monitors, including voice-synthesizers and visual magnifying aids when Medically Necessary for their use

Covered prostheses include:

- Prosthetic arms and legs, other than electronic and myoelectric devices (unless specifically covered in your *Schedule of Benefits*)
- Artificial eyes
- Breast prostheses, including replacements and mastectomy bras
- Ostomy supplies
- Wigs, up to the benefit limit described in your *Schedule of Benefits*
- Therapeutic or molded shoes, and foot orthotics needed to prevent or treat complications of diabetes, up to the benefit limit described in your *Schedule of Benefits*

Please note this benefit is not covered by all Plan Sponsors. Please see your *Schedule of Benefits*.

Durable Medical Equipment (DME) and Prosthetic Equipment is covered up to the DME benefit limit described in your *Schedule of Benefits*. The DME benefit limit does not apply to breast prostheses (including replacements and mastectomy bras), respiratory equipment (including oxygen), glucometers, or durable medical equipment ordered as part of an authorized home health care program. The DME benefit limit may not apply to prosthetic arms and legs, please see your *Schedule of Benefits* to determine if the limit applies. The benefit limit and Copayment, Coinsurance and Deductible amounts are based on the cost of equipment to HPHC.

RELATED EXCLUSIONS:

The following items are not covered:

- Exercise equipment
- Therapeutic or molded shoes, and foot orthotics, (unless specifically covered in your *Schedule of Benefits*)
- Hearing aids (unless specifically covered in your *Schedule of Benefits*)
- Dentures
- Wigs (unless specifically covered in your *Schedule of Benefits*)
- Electronic and myoelectric artificial limbs (unless specifically covered in your *Schedule of Benefits*)
- Repair or replacement of equipment or devices as a result of loss, negligence, willful damage, or theft

- Any devices or special equipment needed for sports or occupational purposes
- Any home adaptations, including, but not limited to, home improvement and home adaptation equipment

e. Ambulance Transport

In the event of an emergency, the Plan covers ambulance transport to the nearest hospital that can provide the care you need. The Plan also covers Medically Necessary transfers from one health care facility to another.

f. Cosmetic Surgery

For purposes of this Benefit Handbook, cosmetic surgery is any procedure to change or restore appearance.

The Plan covers cosmetic surgery only to repair severe disfigurement due to injury or disease or birth defect, including post-mastectomy coverage for 1) reconstruction of the breast on which the mastectomy was performed; 2) surgery and reconstruction of the other breast to produce symmetrical appearance; and 3) prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Prior Approval is required for any inpatient admission or Day Surgery.

You must obtain Prior Approval when using a Non-Participating Provider. The Prior Approval process is initiated by calling 1-800-708-4414. Further information about Prior Approval may be found in Section A.5.

RELATED EXCLUSIONS:

- Liposuction
- Otoplasty
- Breast enlargement or reduction
- Cosmetic rhinoplasty unless it is needed to repair appearance damaged by an illness or injury that occurs during your membership

g. Kidney Dialysis

The Plan covers kidney dialysis on an inpatient, outpatient, or at home basis. When Medicare is primary, the Plan will cover services only to the extent payments would exceed what would be payable by Medicare. Coverage for dialysis in the home includes non-durable medical supplies, drugs and equipment necessary for dialysis. The Plan

covers installation of home dialysis equipment up to \$300 in a member's lifetime.

Prior Approval is required for any inpatient admission and any services provided in the home. You must obtain Prior Approval when using a Non-Participating Provider. The Prior Approval process is initiated by calling 1-800-708-4414. Further information about Prior Approval may be found in Section A.5.

h. Human Organ Transplants

The Plan covers Medically Necessary human organ transplants, including bone marrow transplants for a Member with metastasized breast cancer.

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.

Human organ transplants require Prior Approval. You must obtain Prior Approval when using a Non-Participating Provider. The Prior Approval process is initiated by calling 1-800-708-4414. Further information about Prior Approval may be found in Section A.5.

RELATED EXCLUSIONS:

- Human organ transplants that are Experimental or Unproven

i. Special Infant Formulas and Low Protein Foods

The Plan covers the following:

- 1) Special infant formulas, including those formulas approved by the Department of Public Health
- 2) Formulas for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, or chronic intestinal pseudo-obstruction
- 3) Low protein foods, for inherited diseases of amino and organic acids. This coverage is limited to the amount described in your *Schedule of Benefits*.

j. Diabetes Treatment

The Plan covers the following services for persons with diabetes to the extent Medically Necessary:

- Insulin
- Oral agents for controlling blood sugar
- Blood test strips
- Glucose, ketone and urine test strips
- Diabetic laboratory tests
- Needles, insulin syringes, and insulin pens
- Lancets
- Blood glucose monitors and monitoring strips for home use; including voice-synthesizers and visual magnifying aids when Medically Necessary for their use
- Insulin pumps and supplies
- Therapeutic and molded shoes and inserts for severe diabetic foot disease when referred by the Member's physician and prescribed by a podiatrist or other qualified doctor and furnished by a podiatrist, orthotist, prosthetist or pedorthist
- Outpatient diabetes self-management training and education programs, including medical nutrition therapy provided by a diabetes health care provider

You must get a prescription from your Provider and present it at any pharmacy for insulin, oral agents, test strips, needles, standard insulin syringes, insulin pens and lancets. For *In-Network coverage* you must use an HPHC participating pharmacy. A list of HPHC participating pharmacies is available from the Member Services Department.

Please note this benefit is not covered by all Plan Sponsors. Please see your *Schedule of Benefits*.

k. Cardiac Rehabilitation

The Plan covers cardiac rehabilitation. Coverage includes only Medically Necessary services for Members with established coronary artery disease or unusual and serious risk factors for such disease.

l. Temporomandibular Joint Dysfunction (TMD) Services

Your coverage for TMD services is limited to medical services only. The Plan covers only the following services:

- Initial consultation
- X-rays

- Physical therapy, subject to the visit limit for outpatient physical therapy
- Surgery

RELATED EXCLUSIONS:

- All services of a dentist, except oral surgery

m. Clinical Trials for the Treatment of Cancer

The Plan covers services for Members enrolled in a qualified clinical trial of a treatment for any form of cancer under the terms and conditions provided for under applicable state or federal law. All of the requirements for coverage under the Plan apply to coverage under this benefit. The following services are covered under this benefit: (1) all services that are Medically Necessary for treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the Plan; and (2) the reasonable cost of an investigational drug or device that has been approved for use in the clinical trial to the extent it is not paid for by its manufacturer, distributor or provider.

If you are participating in a qualified clinical trial, please notify our Care Management Team. You can do this by calling the Member Services Department at **1-888-333-4742**. The Care Management Team can provide you with assistance concerning your clinical trial participation.

n. Non Self-Administered Drugs

The Plan covers non self-administered drugs, including, hormone replacement therapy (HRT) when Medically Necessary. Coverage includes non self-administered drugs that have been approved by the United States Food and Drug Administration, except drugs that the Plan excludes or limits.

o. Prescription Drug Coverage

If your Plan Sponsor has selected coverage for prescription drugs as part of your benefit package, please see the *Prescription Drug Brochure* included in your Member Kit. When you have prescription drug coverage, your prescription drug Copayments are listed on your ID Card.

Please note this benefit is not covered by all Plan Sponsors. Please see your *Prescription Drug Brochure*.

p. Chiropractic Care

If your Plan Sponsor has selected coverage for chiropractic care as part of your benefit package, the

Plan covers care by a chiropractor up to the amount described in your *Schedule of Benefits* for the treatment of orthopedic and neuromuscular conditions. The following services are covered:

- Initial diagnostic X-ray
- Care within the scope of standard chiropractic practice

Please note this benefit is not covered by all Plan Sponsors. Please see your *Schedule of Benefits*.

RELATED EXCLUSIONS:

- Care outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, treatment of infectious disease, or treatment with crystals
- Diagnostic testing other than an initial X-ray

q. Vision Hardware for Special Conditions

If your Plan Sponsor has selected coverage for vision hardware as part of your benefit package, the Plan provides limited coverage for contact lenses or eyeglasses needed for certain eye conditions. The coverage provided for these conditions is as follows:

- 1) Post cataract surgery with an intraocular lens implant (pseudophakes). Coverage is limited to \$140 per surgery toward the purchase and fitting 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 covered in full.
- 2) Post cataract surgery without lens implant (aphakes). One pair of eyeglass or contact lenses is covered in full per calendar year. Coverage of up to \$50 per year is also provided for the purchase of eyeglass frames. The replacement of eyeglasses or contact lenses, due to a change in the Member's prescription of .50 diopters or more is also covered. Replacement of eyeglasses due to wear, damage, or loss, is limited to 3 pairs per member per calendar year. Replacement of contact lenses due to wear, damage, or loss, is limited to 3 lenses per eye per calendar year.
- 3) Keratonconus. One pair of contact lenses is covered in full 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.
- 4) Post retinal detachment surgery that occurred while a Plan Member. 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 year after the date of surgery. For Members who have not previously worn eyeglasses or contact lenses, the Plan covers the full cost of a pair of eyeglass lenses and up to \$50 toward the purchase of the frame, or the full cost of a pair of contact lenses.

Please note this benefit is not covered by all Plan Sponsors. Please see your *Schedule of Benefits*.

r. Hypodermic Syringes and Needles

If your Plan Sponsor has selected coverage for hypodermic syringes and needles as part of your benefit package, the Plan covers hypodermic syringes and needles to the extent Medically Necessary.

You must get a prescription from your Provider and present it at any pharmacy for coverage. For *In-Network coverage* you must use an HPHC participating pharmacy. A list of HPHC participating pharmacies is available from the Member Services Department or at www.harvardpilgrim.org.

Please note this benefit is not covered by all Plan Sponsors. Please see your *Schedule of Benefits*.

The following are optional benefit Riders which your Plan Sponsor may select as part of your plan design. If any of these optional benefits are part of your plan design, the benefit will be described in separate brochures included in your *Schedule of Benefits*.

s. Vision Care Rider

t. Preventive Dental Rider for Adults

u. Prescription Drug Rider

9. EXCLUSIONS

The Plan does not cover any of the following:

- Services for cosmetic purposes, except as described in this Benefit Handbook.
- Commercial diet plans, weight loss programs, and any services in connection with such plans or programs.
- Transsexual surgery and all related drugs and procedures.
- Drugs, devices, treatments or procedures that are Experimental or Unproven
- Eyeglasses, contact lenses and fittings, except as listed in this Handbook and the *Schedule of Benefits*.

- Refractive eye surgery, including laser surgery and orthokeratology, for correction of myopia, hyperopia and astigmatism.
- Transportation other than by ambulance.
- Services that are not Medically Necessary.
- Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy.
- Any treatment with crystals.
- Services for a newborn who has not been enrolled as a Member, other than nursery charges for routine services provided to a healthy newborn.
- All charges over the semi-private room rate, except when a private room is Medically Necessary.
- Hospital charges after the date of discharge
- Birth control injections, implants and devices, unless your Plan Sponsor has provided birth control coverage under a Prescription Drug Rider.
- Pre-implantation genetic diagnosis.
- A provider's charge to file a claim or to transcribe or copy your medical records.
- Taxes or assessments on services or supplies.
- Services for which no coverage is provided in the Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure (if your Plan Sponsor has selected this coverage).
- Services for which you are legally entitled to treatment at government expense. This includes disabilities related to military service.
- Services for which payment is required to be made by a Workers' Compensation plan or an employer under state or federal law.
- Osteopathic manipulation, electrolysis, routine foot care services, biofeedback, pain management programs, massage therapy, and sports medicine clinics.
- Blood and blood products.
- Educational services (including problems of school performance) or testing for developmental, educational, or behavioral problems except such services covered under the benefit for Early Intervention.
- Sensory integrative praxis tests.
- Any home adaptations, including, but not limited to, home improvements and home adaptation equipment.

- Physical examinations for insurance, licensing or employment purposes.
 - Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
 - Rest or Custodial Care.
 - Personal comfort or convenience items; non-durable medical supplies, unless used in the course of diagnosis or treatment in a medical facility or in the course of authorized home health care; exercise equipment; dentures; and derotation knee braces; and repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage or theft.
 - Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal) and any form of surrogacy.
 - Infertility treatment for Members who are not medically infertile.
 - Devices or special equipment needed for sports or occupational purposes.
 - Care 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 infectious disease. Diagnostic testing for chiropractic care other than an initial x-ray.
 - Services for which no charge would be made in the absence of insurance.
 - 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 Benefit Handbook.
 - Services for non-Members and services after membership termination
 - Services or supplies given to you by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
 - Charges for missed appointments.
 - Any services not specified in this Benefit Handbook and *Schedule of Benefits*.
 - Planned home births.
 - The Plan does not cover mental health benefits that are (1) provided to Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Dept. of Youth Services; or (2) provided by the Dept. of Mental Health.
 - Methadone maintenance
- The Plan does not cover the following services unless specifically provided in your *Schedule of Benefits*:**
- Dental services, except the specific dental services listed in your *Schedule of Benefits*. Restorative, periodontal, orthodontic, endodontic, prosthodontic, and dental services for temporomandibular joint dysfunction (TMD) are not covered. Removal of impacted teeth to prepare for or support orthodontic, prosthodontic, or periodontal procedures and dental fillings, crowns, gum care, including gum surgery, braces, root canals, bridges and bonding are not covered.
 - Preventive dental care or extraction of teeth.
 - Routine annual eye exams.
 - Eyeglasses, contact lenses and fittings, except as listed in your *Schedule of Benefits*.
 - Chiropractic services, including osteopathic manipulation, unless a benefit for such services is listed in your *Schedule of Benefits*.
 - Acupuncture, aromatherapy, and alternative medicine, unless a benefit for such services is listed in your *Schedule of Benefits*.
 - Hearing aids, dentures, and wigs unless a benefit for such is listed in your *Schedule of Benefits*.
 - Therapeutic or molded shoes, and foot orthotics, unless a benefit for such services is listed on the *Schedule of Benefits*.
 - Private Duty Nursing, unless a benefit for such services is listed in your *Schedule of Benefits*.
 - Electric and myoelectric artificial arms and legs, unless a benefit for such services is listed in your *Schedule of Benefits*.

C. REIMBURSEMENT AND CLAIMS PROCEDURES

The information in this section applies when you receive services from a Non-Participating Provider. In most cases, you should not receive bills from a Participating Provider.

1. CLAIM FILING PROCEDURES

In order to be paid by HPHC, all claims must be filed in writing or electronically. (Providers should contact HPHC for instructions concerning electronic filing.) Claims must be submitted to the following addresses:

Claims for Pharmacy Services

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

Claims for Mental Health and Drug and Alcohol Rehabilitation Services:

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

All Other Claims:

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

2. BILLING BY PROVIDERS

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

- 1) Bill HPHC on a standard health care claim form (such as the CMS 1500 or the UB-82/92 form); and
- 2) Send it to HPHC at the address listed on the back of your Plan ID card.

3. REIMBURSEMENT FOR BILLS YOU PAY

If you pay a Provider for a Covered Benefit, send your receipts from the Provider to HPHC showing proof of payment.

Here is the information we need to process your claim:

- 1) The Member's full name and address;
- 2) The Member's date of birth;
- 3) The Member's Plan ID number (on the front of the patient's Plan ID card);

- 4) The name and address of the person or institution providing the services for which the claim is made and their tax identification number
- 5) The date the service was rendered;
- 6) The CPT code or (a brief description of the illness or injury) for which payment is sought;
- 7) The Member's diagnosis
- 8) the amount of the Provider's charge
- 9) For pharmacy items, a drug receipt stating: the Member's name and Plan ID number, the name of the drug or medical supply, the drug National Drug Code (NDC) number, the quantity, the number of day's supply, the date the prescription was filled, the prescribing physician's name, the pharmacy name and address, and the amount paid.

Reimbursement for prescription drugs will only be made if prescription drug coverage is selected by your Plan Sponsor. Information on prescription drug coverage may be found in your *Prescription Drug Brochure*.

Members may contact the MedImpact help desk at 1-800-788-2949 for assistance with pharmacy claims.

Please note that we may need more information for some claims. If you have any questions about claims, please call the HPHC Member Services Department at 1-888-333-4742.

4. LIMITS ON CLAIMS

To be eligible for payment, HPHC must receive your claims within one year of the date care was received. The Plan limits the amount paid for services that are not rendered by Participating Providers. The most we will pay for such services is the Usual, Customary and Reasonable Charge. You may have to pay the balance if the claim is for more than the Usual, Customary and Reasonable Charge.

D. APPEALS AND COMPLAINTS

This section explains HPHC's procedures for processing appeals and complaints and the options available to you if an appeal is denied.

1. BEFORE YOU FILE AN APPEAL

Claim denials may result from a misunderstanding with a provider or a claim processing error. Since these problems can be easy to resolve, we recommend that Members contact an HPHC Member Service Representative prior to filing an appeal. (A Member Service Representative can be reached toll free at **(888) 333-4742** or at **(800) 637-8257** for TTY service.) The Member Service Representative will investigate the claim and either resolve the problem or explain why the claim is being denied. If you are dissatisfied with the response of the Member Service Representative, you may file an appeal using the procedures outlined below.

2. MEMBER APPEAL PROCEDURES

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

HPHC staff is available to assist you with the filing of an appeal. If you wish such assistance, please call **(888) 333-4742**.

a. **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 Section D.2.c. for the expedited review procedure.) 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 one hundred and eighty (180) days of the denial of coverage.

If you have a representative, including a medical provider, submit an appeal on your behalf, the appeal must include a statement, signed by you, authorizing the representative to act on your behalf. In the case of an expedited appeal, such authorization must be provided within 48 hours after submission of the appeal.

For all appeals, except mental health and drug and alcohol rehabilitation services appeals, please send your request to the following address:

**HPHC Member Appeals
Member Services Department
Harvard Pilgrim Health Care, Inc.
1600 Crown Colony Drive
Quincy, MA 02169.**

**Telephone: (888) 333-4742
FAX: (617) 509-3085**

If your appeal involves a mental health and drug and alcohol rehabilitation service, please send it to the following address:

**HPHC Member Appeals
P.O. Box 850346
Braintree, MA 02185**

**Telephone: (888) 777-4742
FAX: (800) 383-2194**

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

When we receive your appeal, we will assign an Appeal Coordinator to manage your appeal throughout the appeal process. We will send you a letter identifying your Appeal Coordinator. That letter will include detailed information on the appeal process. Your Appeal Coordinator is available to answer any questions you may have about your appeal. Please feel free to contact your Appeal Coordinator if you have any questions or concerns about the appeal process.

b. **Appeal Process**

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

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

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

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

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

If your appeal involves a decision on a medical issue, the Appeal Coordinator will obtain the opinion of a qualified physician or other appropriate medical specialist. The health care professional conducting the review must not have either participated in any prior decision concerning the appeal or be the subordinate of such person. Upon request, your Appeal Coordinator 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.

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

c. Expedited Review Procedure:

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

If delayed, could seriously jeopardize your life or health or ability to regain maximum function,

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

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 you with an expedited review.

You, your representative or a provider acting on your behalf may request an expedited appeal by telephone or fax. (Please see "Initiating Your Appeal," above, for the telephone and fax numbers.) HPHC will investigate and respond to your request within 72 hours. We will notify you of the decision on your appeal by telephone and send you a written decision within two business days thereafter.

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

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, HPHC will notify you that additional information is required within 24 hours after receipt of your appeal.

**3. WHAT YOU MAY DO
IF YOUR APPEAL IS DENIED**

If you disagree with the decision of your appeal, you may (1) have your appeal decision reconsidered, (2) seek alternative dispute resolution through the U.S. Department of Labor or (3) seek legal action under Section 502(a) of the Employee Retirement Income Security Act (ERISA). You may take any one of these actions in any order. For example, you are not required to request reconsideration before seeking alternative dispute resolution or legal action. Below is a summary of these options.

a. Reconsideration of an Appeal Decision

Many Plan Sponsors offer reconsideration following an appeal decision. Please see your Plan Document Face Sheet, enclosed with this Benefit Handbook, to determine what rights, if any, you have to reconsideration of your appeal.

b. Alternative Dispute Resolution

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

c. Legal Action

You may also be able to bring legal action under Section 502(a) of the Employee Retirement Income Security Act (ERISA).

4. FORMAL COMPLAINT PROCESS

If you have any concerns about your care under the Plan or about HPHC's service, HPHC wants to know about it. HPHC is here to help. Please call or write to:

**HPHC Member Services Department
Harvard Pilgrim Health Care
1600 Crown Colony Drive
Quincy, MA 02169**

**Attn: Member Concerns
1-888-333-4742**

We will respond to you as quickly as we can. Most concerns can be investigated and responded to within thirty (30) days.

E. ELIGIBILITY

This section describes requirements concerning eligibility under the Plan. It is important to understand that eligibility of Dependents and effective dates of coverage are determined by the Plan Sponsor. Please see your Plan Sponsor or the Plan Administrator listed on your Face Sheet included with this Handbook for descriptions of eligibility for Dependents and effective dates of coverage.

1. MEMBER ELIGIBILITY

a. Subscriber Eligibility

To be a Subscriber under this Handbook, you must:

- 1) Be an employee of the Plan Sponsor, in accordance with employee eligibility guidelines agreed to by the Plan Sponsor and HPHC;
- 2) Be enrolled through a Plan Sponsor that is up-to-date in the payment of the applicable payment for coverage

b. Dependent Eligibility

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

2. EFFECTIVE DATE - NEW AND EXISTING DEPENDENTS

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

3. 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 for purposes of adoption by a licensed adoption agency.

4. EFFECTIVE DATE - OFF-CYCLE ENROLLMENT

Under the Health Insurance Portability and Accountability Act of 1996, individuals may enroll in the Plan at any time if: 1) the employee's spouse or eligible dependent has lost other insurance; 2) the employer contributions toward the Dependent's coverage are terminated; 3) the employee marries; or 4) the employee has a newborn or adopts a child. For items # 1, 2, or 3, the effective date must be no later than the first day of the first month after HPHC receives the enrollment request. For item # 4, the new child's

effective date must be the date of birth, or in the case of adoption, the date of adoption or placement for adoption.

5. CHANGE IN STATUS

It is your responsibility to inform your Plan Sponsor and HPHC of all changes that affect Member eligibility. These changes include: address changes; marriage of a Dependent; death of a Member; and when a Dependent is no longer enrolled in an accredited educational institution on a full-time basis. Please note HPHC must have your current address on file in order to correctly process claims for Out-of-Network care.

6. ADDING A DEPENDENT

It is important to understand that eligibility of Dependents and effective dates of coverage are determined by the Plan Sponsor. Dependents of eligible employees who meet eligibility guidelines will be enrolled in the Plan using HPHC enrollment forms or in a manner otherwise agreed to in writing by HPHC and the Plan Sponsor. HPHC must receive proper notice from the Plan Sponsor of any Member enrollment in, or termination from, the Plan no more than 60 days after such change is to be effective unless otherwise required by law. Please see your Plan Sponsor or the Plan Administrator listed on the Face Sheet included with this Handbook for information on Dependent eligibility and effective dates of coverage.

7. SPECIAL ENROLLMENT RIGHTS

If an employee declines enrollment for the employee and his or her Dependents (including his or her spouse) because of other health insurance coverage, the employee may be able to enroll in this Plan in the future along with his or her Dependents, provided that enrollment is requested within 30 days after other coverage ends. In addition, if the employee has a new Dependent as a result of marriage, birth, adoption or placement for adoption, the employee may be able to enroll along with his or her Dependents, provided that enrollment is requested within 30 days after the marriage, birth, adoption or placement for adoption.

F. TERMINATION AND TRANSFER TO OTHER COVERAGE

1. TERMINATION BY THE SUBSCRIBER

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

2. TERMINATION FOR LOSS OF ELIGIBILITY

A Member's coverage will end under this Plan if the Plan Sponsor contract through which the Member receives coverage is terminated. The Member's coverage may also end under this Plan for failing to meet any of the specified eligibility requirements. HPHC or the Plan Sponsor will inform you in writing if coverage ends for loss of eligibility.

You may be eligible for continued enrollment under federal law, if your membership is terminated. See "Continuation of Coverage Required by Law" in this Section for more information.

PLEASE NOTE THAT HPHC MAY NOT HAVE CURRENT INFORMATION CONCERNING MEMBERSHIP STATUS. PLAN SPONSORS HAVE UP TO 60 DAYS TO NOTIFY HPHC OF ENROLLMENT CHANGES. AS A RESULT, THE INFORMATION WE HAVE MAY NOT BE CURRENT. ONLY YOUR PLAN SPONSORS CAN CONFIRM MEMBERSHIP STATUS.

3. MEMBERSHIP TERMINATION FOR CAUSE

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

- Providing false or misleading information on an application for membership;
- The failure to pay Copayments or Coinsurance;
- Committing or attempting to commit fraud to obtain benefits for which the Member is not eligible under this Handbook;
- Obtaining or attempting to obtain benefits under this Handbook for a person who is not a Member; or
- The commission of acts of physical or verbal abuse by a Member which pose a threat to Providers or other Members and which are unrelated to the Member's physical or mental condition.

Notice of termination of membership for providing false information shall be effective immediately upon notice to a Member. Notice of termination of membership for the other causes will be effective 15 days after notice. Premium paid for periods after the effective date of termination will be refunded.

4. CONTINUATION OF COVERAGE REQUIRED BY LAW

a. Federal Law

If you lose Plan Sponsor eligibility and the Plan Sponsor has 20 or more employees, you may be eligible for continuation of group coverage under the Federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA). You should contact your Plan Sponsor for more information if health coverage ends due to: 1) separation from employment; 2) reduction of work hours; or 3) loss of dependency status. Continuation of coverage may not be extended beyond the applicable time allowed under federal law.

The size of your Plan Sponsor will determine whether you select your continuation of coverage rights under federal law.

5. TRANSFER TO NON-GROUP COVERAGE

HPHC has non-group plans for people who are no longer eligible for coverage through their Plan Sponsor. To be eligible for non-group coverage you must:

1. Send us notice that you are applying to convert within 63 days of the last day of Plan Sponsor coverage;
2. Maintain residence within the HPHC Enrollment Area;
3. Be eligible for non-group enrollment under the state and federal laws that apply where you live;
4. Not have been terminated from membership in the Plan for cause, as listed in this Benefit Handbook; and
5. Pay the non-group premium for the period starting with the date Plan Sponsor coverage ends.

The non-group premium must be received by HPHC within 60 days of the due date.

Non-Group coverage is only available to residents of states in which HPHC, or one of its affiliated health plans, offer non-group health maintenance organization coverage at the time coverage is sought. (At the time of this writing, HPHC and its affiliates offer non-group plans to cover members in New Hampshire, Massachusetts, and Maine).

The applicant may enroll only in a plan offered in his or her state of residence. Benefits vary by state and are different than those offered under this Benefit Handbook.

Please call HPHC Member Services for current information on the availability and benefits of non-group plans offered by HPHC, or an HPHC affiliate, in the state where you live.

6. MEMBERS ELIGIBLE FOR MEDICARE

If your membership ends because you are eligible for Medicare under circumstances in which federal law permits Medicare to be the primary payer for Medicare-covered services, you may apply for coverage under an HPHC plan for Medicare enrollees. You may contact HPHC's Member Services Department for more information.

G. WHEN YOU HAVE OTHER COVERAGE

This section explains how benefits under this *Benefit Handbook* will be coordinated with other insurance benefits available to pay for health services that a Member has received. Benefits are coordinated among insurance carriers to prevent duplicate recovery for the same service. Nothing in this section should be interpreted to provide coverage for any service or supply that is not expressly covered under this Handbook or to increase the level of coverage provided.

1. BENEFITS IN THE EVENT OF OTHER INSURANCE

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

Coordination of benefits will be based upon the Usual, Customary and Reasonable Charge for any service that is covered at least in part by any of the plans involved. If benefits are provided in the form of services, or if a provider of services is paid under a capitation arrangement, the reasonable value of such services will be used as the basis for coordination. No duplication in coverage of services shall occur among plans.

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

In the case of Health Benefit Plans that contain provisions for the coordination of benefits, the following rules shall decide which Health Benefit Plans are primary or secondary:

a. Dependent/Non-Dependent

The benefits of the plan that covers the person as an employee, member or subscriber are determined before those of the plan that covers the person as a dependent.

b. A Dependent Child Whose Parents Are Not Separated or Divorced

The order of benefits is determined as follows:

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

c. Dependent Child/Separated or Divorced Parents

Unless a court order, of which HPHC has knowledge, specifies one of the parents as responsible for the health care benefits of the child, the order of benefits is determined as follows:

- 1) First the plan of the parent with custody of the child;
- 2) Then, the plan of the spouse of the parent with custody of the child;
- 3) Finally, the plan of the spouse of the non-custodial parent.

d. Active/Inactive Employee

The benefits of the plan that covers the person as an active employee are determined before those of the plan that covers the person as a laid-off or retired employee.

e. Longer/Shorter Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the plan that covered the employee, member or subscriber longer are determined before those of the plan that covered that person for the shorter time.

If a Member is covered by a Health Benefit Plan that does not have provisions governing the coordination of benefits between plans, that plan will be the primary plan.

2. PROVIDER PAYMENT WHEN PLAN COVERAGE IS SECONDARY

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

3. WORKER'S COMPENSATION/ GOVERNMENT PROGRAMS

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

4. SUBROGATION

Subrogation is a means by which health plans recover expenses for benefits provided where a third party is legally responsible for a Member's injury or illness.

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

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

illness or injury is designated or described as being for damages other than health care expenses. The subrogation and recovery provisions in this section apply whether or not the Member recovering money is a minor.

To enforce its subrogation rights under this Handbook, the Plan 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 the Plan for which such party is, or may be, liable.

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

5. MEDICAL PAYMENT POLICIES

For Members who are entitled to benefits under the medical payment benefit of a motor vehicle, motorcycle, boat, homeowners, hotel, restaurant or other insurance policy, such coverage shall become primary to the coverage under this Handbook for services rendered in connection with a covered loss under that policy. The benefits under this Handbook shall not duplicate any benefits to which the Member is entitled under any medical payment policy or benefit. All sums payable for services provided under this Handbook to Members that are covered under any medical payment policy or benefit are payable to the Plan.

6. MEMBER COOPERATION

The Member agrees to cooperate with the Plan 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 the Plan, b) the execution of any instruments deemed necessary by the Plan to protect its rights and c) the prompt assignment to the Plan of any moneys received for services provided or paid for by the Plan and d) the prompt notification to the Plan of any instances that may give rise to the Plan's rights. The Member further agrees to do nothing to prejudice or interfere with the Plan's rights to subrogation or coordination of benefits.

Failure of the Member to perform the obligations stated in this Subsection shall render the Member liable to the Plan for any expenses the Plan may incur, including reasonable attorney's fees, in enforcing its rights under this Handbook.

7. THE PLAN'S RIGHTS

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

8. MEMBERS ELIGIBLE FOR MEDICARE

A Member, who is eligible for Medicare, and for whom Medicare is permitted by federal law to be the primary payer, must be covered by both Parts A & B of Medicare and must assign benefits under both Parts to the Plan.

For a Member who is eligible for Medicare by reason of End Stage Renal Disease, the Plan will be the primary payer for Covered Benefits during the "coordination period" specified by federal regulations at 42 CFR Section 411.62. Thereafter, Medicare will be the primary payer. When Medicare is primary (or would be primary if the Member were timely enrolled) the Plan will pay for services only to the extent payments would exceed what would be payable by Medicare.

When the Plan provides benefits to a Member for which the Member is eligible under Medicare, the Plan shall be entitled to reimbursement from Medicare for such services. The Member shall take such action as is required to assure this reimbursement.

H. ADMINISTRATION OF BENEFIT HANDBOOK

This Section has information about how we administer this Benefit Handbook. It describes what happens if: your membership starts while you are in a hospital; you disagree with a Participating Provider's recommended treatment; or you miss your appointment. This Section also explains: our use of your medical records; where we send notices to you; the limits on legal actions; changes to this Benefit Handbook; the relationship of the HPHC and Participating Providers; and our responsibility in case of a major disaster.

1. COVERAGE WHEN MEMBERSHIP BEGINS WHILE HOSPITALIZED

a. General Coverage Rules

Coverage under the Plan begins at 12:01 AM on the date coverage is effective. Coverage ends at midnight on the date a Member's coverage is terminated. There is no coverage for any service received after midnight on the date a Member's coverage terminates. All authorizations for services issued by HPHC or Participating Providers assume continuation of membership and are invalid after termination of membership.

There are times when Plan membership begins when the Member is already hospitalized. This can happen when:

- Your Plan Sponsor changes your coverage;
- The Subscriber selects Plan coverage; or
- Your child is born.

The Plan covers such hospitalization from the time membership is effective. However, to obtain *In-Network coverage*, you must be receiving services from a Participating Provider.

2. LIMITATION ON LEGAL ACTIONS

Any legal action against HPHC for failing to provide Covered Benefits must be brought within 2 years of the denial of any benefit. This does not apply to actions for medical malpractice.

3. ACCESS TO INFORMATION

The Member agrees that, except where restricted by law, HPHC may have access to (1) all health records and medical data from health care Providers providing services covered under this Benefit 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. Information from a Member's

medical record and information about a Member's physician patient and hospital patient relationships will be kept confidential and will not be disclosed without the Member's consent, except for:

- a. Use in connection with the delivery of care under this Benefit Handbook or in the administration of this Benefit Handbook, including utilization review and quality assurance activities;
- b. Use in bona fide medical research in accordance with regulations of the U.S. Department of Health and Human Services and the Food and Drug Administration for the protection of human subjects;
- c. Use in education within Participating facilities; and
- d. Where required by law.

You can request a copy of the Notice of Privacy Practices by call the HPHC Member Services Department at **1-888-333-472** or through the Harvard Pilgrim internet site: **www.harvardpilgrim.org**.

4. NOTICE

Any notice to a Member may be sent to the last address of the Subscriber on file with HPHC. Notice to HPHC should be sent to HPHC Member Services Department, 1600 Crown Colony Drive, Quincy, MA 02169.

5. MODIFICATION OF THIS BENEFIT HANDBOOK

This Benefit Handbook and *Schedule of Benefits* brochure may be amended by HPHC upon written notice to your Plan Sponsor at least sixty (60) days prior to any material change in your Covered Benefits. Subscribers will be given written notice of any material changes in Covered Benefits. Amendments do not require the consent of Members.

This Benefit Handbook including the *Schedule of Benefits, Prescription Drug Brochure* and applicable riders, is the entire contract between you and HPHC. It can only be modified in writing by an authorized officer of the HPHC. No other action by HPHC, including the deliberate non-enforcement of any benefit limit shall be deemed to waive or alter any part of this Benefit Handbook or applicable brochures.

6. RELATIONSHIP OF PARTICIPATING PROVIDERS AND HPHC

The relationship of the HPHC to Participating Providers, other than HPHC employees, is governed by separate agreements. They are independent contractors. Such Providers may not modify this Benefit Handbook or *Schedule of Benefits* brochure, *Prescription Drug*

Brochure, and any applicable riders or create any obligation for the. HPHC is not liable for statements about this Benefit Handbook by them, their employees or agents. HPHC may change its arrangements with service Providers, including the addition or removal of Participating Providers, without notice to Members.

For any questions regarding this Benefit Handbook, Members may contact HPHC at **1-888-333-4742**.

7. MAJOR DISASTERS

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

8. MISSED APPOINTMENTS

Providers may charge you for appointments you miss if you do not cancel before the scheduled appointment. You can call the Provider to find out how much advance notice is needed to cancel an appointment. HPHC will not count missed appointments toward any benefit limits.

9. EVALUATION OF NEW TECHNOLOGY

The Plan covers medical devices; diagnostic, medical and surgical procedures and drugs as described in your *Benefit Handbook*, *Schedule of Benefits*, and if applicable, your *Prescription Drug Brochure*. This includes new devices, procedures and drugs, as well as those with new applications, as long as they are not Experimental or Unproven.

HPHC has a dedicated team of staff that evaluates diagnostics, medical therapies, surgical procedures, medical devices and drugs. The team manages the evidence-based evaluation process from initial inquiry to final policy recommendation. The team researches the safety and effectiveness of these new technologies by reviewing published medical reports, literature, expert consultation with 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.

10. HIPAA CERTIFICATE OF CREDITABLE COVERAGE

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

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

If requested by your Plan Sponsor, HPHC will send this certificate to Members upon termination of membership. However, Members may call the Member Services Department at **1-888-333-4742** at any time within two (2) years from the date coverage ended to request a free copy of their certificate from HPHC.

11. UTILIZATION REVIEW PROCEDURES

HPHC uses the following utilization review procedures to evaluate the Medical Necessity of selected health care services, and facilitate clinically appropriate, cost-effective management of Members' care:

- Prospective utilization review (pre-certification) of elective inpatient admissions, surgical day care, and outpatient/ambulatory procedures; and
- Concurrent utilization review of authorized admissions to hospitals and extended care facilities, and skilled home health services.

Active case management and discharge planning is incorporated as part of the concurrent review process. Retrospective utilization review may be utilized in situations where services were provided before Plan authorization was obtained.

Members who wish to determine the status or outcome of utilization review decisions should call Member Services toll-free at **1-888-333-4742**.

12. QUALITY ASSURANCE PROGRAMS

The goal of HPHC's Quality Program is to ensure the provision of consistently excellent health care, health information and service to Plan 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 Participating Providers and contracted facilities, as well as the development and dissemination of clinical standards and guidelines in areas such as preventive care, medical records, appointment access,

confidentiality, and the appropriate use of drug therapies and new medical technologies.

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

(Please note that some Plan Sponsors do not cover all these disease management programs. Please check with your Plan Sponsor or benefit administrator for a description of programs available under your Plan.)

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

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

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

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

14. PROCESS TO DEVELOP CLINICAL GUIDELINES AND UTILIZATION REVIEW CRITERIA

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

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

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

HPHC's Clinician Advisory Committees, comprised of actively practicing physicians from throughout the network, serve as the forum for the discussion of specialty-specific clinical programs and initiatives, and provide guidance on strategies and initiatives to evaluate or improve care and service. Clinician Advisory Committees work in collaboration with Medical Management leadership to develop and approve utilization review criteria.

I. GLOSSARY

This Section lists the words with special meaning in the Benefit Handbook.

Activities of Daily Living

The normal functions of daily life, including walking, speaking, eating, transferring, bathing, dressing, continence and using the toilet. Activities of Daily Living do not include special functions needed for occupational purposes or sports.

Anniversary Date

The date agreed to by HPHC and your Plan Sponsor upon which yearly Plan Sponsor administrative fees are adjusted and benefit changes become effective.

Behavioral Health Access Center

The organization, designated by HPHC, responsible for coordinating services for Members in need of mental health, or drug or alcohol rehabilitation care. If you need mental health or drug or alcohol rehabilitation care call the Behavioral Health Access Center at 1-888-777-4742.

Behavioral Health Provider

A provider who is a licensed physician specializing in a the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker (LICSW), a licensed mental health counselor, psychiatric social workers, or a licensed nurse mental health clinical specialist.

Benefit Handbook (or Handbook)

This legal document, including the *Schedule of Benefits*, and the *Prescription Drug Brochure*, and any applicable Riders which sets forth the services covered by the Plan, the exclusions from coverage and the conditions of coverage for Members.

Coinsurance

A percentage of the costs that you must pay for certain Covered Benefits. Coinsurance amounts applicable to your Plan are stated in your *Schedule of Benefits*.

Copayment

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

Please note: In very limited cases the Copayment may exceed the contract rate payable by HPHC for a service. If the Copayment is greater than the contract rate, you are responsible for the full Copayment, and the provider keeps the entire Copayment.

Copayment Level 1

The Copayment that applies to certain covered outpatient services. Please refer to your *Schedule of Benefits* for additional information on the covered outpatient services subject to Copayment Level 1.

Copayment Level 2

The Copayment that applies to most outpatient specialty services. Please refer to your *Schedule of Benefits* for additional information on Covered Benefits subject to Copayment Level 2.

Cost Sharing

The financial responsibility of Members for certain Covered Benefits. Cost Sharing may include Deductible, Copayments and Coinsurance. Please refer to your *Schedule of Benefits* for the specific Cost Sharing amounts that apply to your Plan.

Covered Benefits

The health care services and supplies for which a Member is covered at the benefit level provided in the *Schedule of Benefits*. Covered Benefits under this Plan are described in Section I.B.

Covered Charges

Expenses incurred by an Insured for Covered Benefits. Covered Charges do not include any amount in excess of a benefit limit stated in this Benefit Handbook and the *Schedule of Benefits* or in the excess of Usual, Customary and Reasonable charges.

Custodial Care

Services that are furnished mainly to assist a person in Activities of Daily Living. Examples of such services include: room and board, routine nursing care, help in personal hygiene, and supervision in daily activities.

Deductible

A specific dollar amount that you pay for Covered Benefits each calendar year before any benefits subject to the Deductible are payable by the Plan. Deductible amounts are incurred on the date of service. Deductible amounts specific to your Plan are stated in the *Schedule of Benefits*.

Each Member must pay the individual Deductible amount for Covered Benefits each calendar year. No Family Member will pay more than individual Deductible in a calendar year.

In some instances, a family Deductible applies. The family Deductible is met when any combination of Members in a family reach the family Deductible

Amount. Once the family Deductible has been met in a calendar year, the Deductible is met by all Members for the remainder of the calendar year.

Any Deductible amount that is incurred for services rendered during the last three (3) months of a calendar year may be applied toward the Deductible requirement for the next year, provided the Member has had continuous coverage under the Plan through the same Plan Sponsor at the time the charges in the prior year were incurred. Please see your *Schedule of Benefits* to see if a Deductible carryover applies to your coverage. (Deductible amounts for all services are considered incurred as of the date of service.)

Dependent

A Member of the Subscriber's family who meets the eligibility requirements for coverage through a Subscriber as agreed upon by the Plan Sponsor and HPHC. This eligibility is documented as part of the contract between the Plan Sponsor and HPHC. Please see your Plan Sponsor's benefits administrator for details on the agreement between HPHC and your Plan Sponsor.

Experimental or Unproven

A service, procedure, device, or drug will be deemed Experimental or Unproven by HPHC under this Benefit Handbook for use in the diagnosis or treatment of a particular medical condition if any of the following is true:

- a. The service, procedure, device, or drug is not recognized in accordance with generally accepted medical standards as being safe and effective for the use in the evaluation or treatment of the condition in question. In determining whether a service has been recognized as safe or effective in accordance with generally accepted medical standards, primary reliance will be placed upon data from published reports in authoritative medical or scientific publications that are subject to peer review by qualified medical or scientific experts prior to publication. In the absence of any such reports, it will generally be determined that a service, procedure, device or drug is not safe and effective for the use in question.

Please note, autologous bone marrow transplants for the treatment of breast cancer, as required by law, are not considered Experimental or Unproven when they satisfy the criteria identified by the Massachusetts Department of Public Health.

- b. In the case of a drug, the drug has not been approved by the United States Food and Drug Administration (FDA). However, non-experimental off-label uses of FDA approved drugs are covered.

- c. For purposes of the treatment of infertility only, the service, procedure, drug or device has not been recognized as a "non-experimental infertility procedure" under the Massachusetts Infertility Benefit Regulations at 211 CMR Section 37.00 et.seq.

Family Coverage

Coverage for a Subscriber and one or more Dependents.

Harvard Pilgrim Health Care, Inc. (HPHC)

Harvard Pilgrim Health Care, Inc. is a Massachusetts corporation that is licensed as a Health Maintenance Organization (HMO). HPHC provides or arranges for health care benefits to its Members through Preferred Provider Arrangements with a network of physicians, specialists and other Providers.

Harvard Vanguard Medical Associates (Harvard Vanguard)

Harvard Vanguard Medical Associates is a medical group practice affiliated with HPHC. Members who are enrolled in Harvard Vanguard, must obtain routine eye examinations and extraction of impacted teeth, if a covered benefit, at a Harvard Vanguard office for In-Network coverage.

Individual Coverage

Coverage for a Subscriber only (No coverage for Dependents is provided)

In-Network

The level of benefits or coverage a Member receives when Covered Benefits are obtained through a Participating Provider.

Lifetime Benefit Maximum

The Lifetime Benefit Maximum is the total amount the Plan will pay in Covered Benefits for one Member under this Benefit Handbook. If applicable, you will find specific information and limitations on the Lifetime Benefit Maximum listed in the *Schedule of Benefits*.

Medical Emergency

A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the Member or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part. With respect to a pregnant woman who is having contractions, Medical

Emergency also means that there is inadequate time to effect a safe transfer to another hospital before delivery or that transfer may pose a threat to the health or safety of the woman or the unborn child.

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

Medically Necessary or Medical Necessity

Those health care services that are consistent with generally accepted principles of professional medical practice as determined by whether: (a) the service is the most appropriate supply or level of service for the Member's condition, considering the potential benefit and harm to the individual; (b) the service is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; and, (c) for services and interventions that are not widely used, the use of the service for the Member's condition is based on scientific evidence.

Member

Any Subscriber or Dependent covered by this Handbook.

Non-Participating Provider

HPHC does not have special agreements or contracts with Non-Participating Providers. Therefore, a payment schedule for services received from Non-Participating Providers based on Usual, Customary, and Reasonable Charges has been adopted. When care is received from a Non-Participating Provider, Members are responsible for an annual Deductible, Coinsurance and any amounts in excess of the payment schedule. These financial responsibilities are described in the *Schedule of Benefits*.

Out-of-Network

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

Out-of-Pocket Maximum

A limit on the amount of Cost Sharing that you must pay for all Covered Benefits. This excludes any amounts that you pay for prescription drugs. Out-of-Pocket Maximum amounts, if applicable to your Plan, are specified in your Schedule of Benefits.

Participating Provider

Providers who are under contract to provide care to Plan Members. Participating Providers are listed in the *Provider Directory*.

Plan

A package of health care benefits known as The Harvard Pilgrim Health Care PPO that is administered by HPHC on behalf of your Plan Sponsor. HPHC or your Plan Sponsor may take any action on behalf of the Plan. This Plan offers coverage under a preferred Provider arrangement whereby Members are provided financial incentives to obtain covered health care services from a Participating Provider.

Plan Sponsor

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

Prior Approval

The 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 each inpatient admission, transfer from one inpatient facility to another, partial hospitalization for psychiatric and substance abuse treatment, Day Surgery, human organ transplants, advanced reproductive technologies, physical, speech and occupational therapy, and any services provided in your home. The Prior Approval program is described in Section A.5.

Provider

A Provider is defined as: a hospital or facility that is licensed to provide inpatient medical, surgical, or rehabilitative services; a Skilled Nursing Facility; and medical professionals including: physicians, psychiatrists, podiatrists, nurse practitioners, physician's assistants, psychiatric social workers, licensed nurse mental health clinical specialist, psychotherapists, psychologists, licensed independent clinical social workers, licensed mental health counselors, physicians with recognized expertise in specialty pediatrics (including mental health care), nurse midwives, and nurse anesthetists, and early intervention specialists who are credentialed and certified by the Massachusetts Department of Public Health.

Provider Directory

A directory that identifies HPHC Providers. HPHC revises the *Provider Directory* from time to time.

Qualified Medical Support Order (QMSO)

A court order providing for coverage of a child under a group health plan that meets the requirements of the Employee Retirement Income Security Act (ERISA). A child enrolled under QMSO is subject to the same terms

and limitations stated in this Handbook, Schedule of Benefits, Prescription Drug Brochure, and any applicable riders.

Rehabilitative Services

Health care services designed to restore a person's ability to perform Activities of Daily Living after a disabling injury or illness. Only the following Rehabilitative Services are covered: physical therapy; speech therapy; occupational therapy; cardiac rehabilitation; or an organized program of these services.

Schedule of Benefits (or Summary of Benefits)

A document which outlines your Cost Sharing and any benefit limits that apply to your benefit plan.

Skilled Nursing facility

An inpatient extended care facility, or part of one, licensed to provide skilled nursing services.

Subscriber

The person who meets the eligibility requirements described in this Benefit Handbook or as agreed to by the Plan Sponsor and HPHC.

Surgical Day Care

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.

Terminal Illness

A Terminal Illness is an illness that is likely to cause death within six months.

Usual, Customary and Reasonable Charge

An amount that is consistent, in the judgment of HPHC, with the normal range of charges by health care Providers for the same, or similar, products or services in the geographical area where the product or service was provided to a Member. HPHC utilizes the Health Insurance Association of America (HIAA) fee schedule to determine the appropriate reimbursement for each geographic area. The Member may request information regarding reimbursement for a specific service by contacting the HPHC Member Services Department at **1-888-333-4742**. If HPHC cannot reasonably determine the normal range of charges where the product or services were provided, HPHC will utilize the normal range of charges in Boston, MA. The Usual, Customary, and Reasonable charge is the maximum amount upon which HPHC will base payments for Covered Benefits.

II. PATIENT RIGHTS

This section describes your rights as a patient.

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

- To request and obtain the name and specialty, if any, of the physician or other person responsible for your care or the coordination of your care;
- To have all your medical records and communications kept confidential to the extent provided by law;
- To have all reasonable requests answered promptly and adequately within the capacity of the treating Provider;
- To obtain a copy of any rules or regulations which apply to your conduct as a patient;
- To request and receive any information a Provider has available regarding financial assistance and free health care;
- To inspect your medical records and to receive a copy of your records for a reasonable fee;
- To refuse to be examined, observed, or treated by students or any other staff without jeopardizing access to medical care and attention;
- To refuse to serve as a research subject and to refuse any care or examination the primary purpose of which is educational rather than therapeutic;
- To have privacy during medical treatment within the capacity of the Provider's office;
- To prompt life-saving treatment in an emergency without discrimination based on economic status or source of payment; and without delaying treatment to discuss source of payment, unless delay will not cause risk to your health;
- To informed consent to the extent provided by law;
- To request and receive an itemized copy of your bill or statement of charges, if any, including third party payments towards the bill, regardless of the sources of payment;
- To request and receive an explanation of the relationship, if any, of the physician to any health care facility or educational institutions if this relationship relates to your care or treatment; and
- In the case of a patient suffering from breast cancer, to be provided with complete information on alternative treatments that are medically appropriate.

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 or its designee. All complaints must be submitted in writing and addressed to HPHC or one of the regulatory offices listed below:

**Appeals Coordinator
Member Services Department
Harvard Pilgrim Health Care
1600 Crown Colony Drive
Quincy, MA 02169**

For Massachusetts Physicians:

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

For Rhode Island Physicians:

Rhode Island Department of Public Health
Licensure and Discipline
3 Capitol Hill
Providence, RI 02908
(401) 222-2231

For New Hampshire Physicians:

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

For Maine Physicians:

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

For Vermont Physicians:

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

III. MEMBER RIGHTS & RESPONSIBILITIES

This section describes your rights and responsibilities as a Member.

- Members have a right to receive information about Harvard Pilgrim, 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 Harvard Pilgrim 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 Harvard Pilgrim 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.

IV. CONFIDENTIALITY

Harvard Pilgrim is committed to ensuring and safeguarding the confidentiality of its Members' information, in all settings, including personal and medical information. Harvard Pilgrim staff access, use and disclose Member information only in connection with providing services and benefits and in accordance with Harvard Pilgrim's confidentiality policies. Harvard Pilgrim permits only designated employees, who are trained in the proper handling of Member information, to have access to and use of our information. Harvard Pilgrim sometimes contracts with other organizations or entities to assist with the delivery of care or administration of benefits. Any such entity is informed of Harvard Pilgrim's confidentiality and privacy standards.

When you enrolled with HPHC, you consented to certain uses and disclosures of information which are necessary for the provision and administration of services and benefits, such as: coordination of care, including 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 Harvard Pilgrim discloses Member information, it does so using the minimum amount of information necessary to accomplish the specific activity.

Harvard Pilgrim discloses its Members' personal information only: (1) in connection with the delivery of care or administration of benefits, such as utilization review, quality assurance activities and third-party reimbursement by other payers, including self-insured employer groups; (2) when you specifically authorize the disclosure; (3) in connection with certain activities allowed under law, such research and fraud detection; (4) when required by law; or (5) as otherwise allowed under the terms of your Benefit Handbook. Whenever possible, HPHC discloses Member information without Member identifiers and in all cases only discloses the amount of information necessary to achieve the purpose for which it was disclosed. HPHC will not disclose to other third parties, such as employers, member-specific information (i.e. information for 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, HPHC and all of its contracted health care providers agree to provide Members access to, and a copy of, their medical records upon a Member's request. In addition, your medical records cannot be released to a third party without your consent or unless permitted by law.

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



1600 Crown Colony Drive
Quincy, MA 02169

1-888-333-4742
www.harvardpilgrim.org