HPHC Insurance Company

Benefit Handbook

THE BEST BUY HSA PPO PLAN

MAINE

This benefit plan is provided to you by your employer on a self-insured basis. HPHC Insurance Company 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, HPHC Insurance Company is not the issuer, insurer or provider of your coverage.

EFFECTIVE DATE: 01/01/2026
ASO_02

INTRODUCTION

Welcome to The Best Buy HSA PPO Plan (the Plan). Thank you for choosing us to help meet your health care needs. Your benefits are provided by your Plan Sponsor, generally an employer or union. HPHC Insurance Company, Inc. (HPHC) administers the plan's benefits on behalf of your Plan Sponsor.

This is a self-insured health benefits plan for the Plan Sponsor's employees and their dependents. The Plan Sponsor has assumed the 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 insurer of your coverage.

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

To use the Plan effectively, you will want to review this Handbook and the Schedule of Benefits, which describe 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 Plan Providers or the Non-Plan Provider of your choice. Benefits are covered both In-Network and Out-of-Network. However, in most cases, your In-Network benefits provide you with a higher level of coverage with lower out of pocket costs.

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

If you choose to receive Covered Benefits from a provider or at a facility that is not a Plan Provider, your benefits will be covered at the Out-of-Network level.

Some benefits have limits on the amount of coverage provided in a Plan Year or Calendar Year. If a Covered Benefit has a benefit limit, your In-Network and Out-of-Network services are usually combined and count against each other to reach your benefit limit. Please see your Schedule of Benefits for detailed information regarding benefit limits on your coverage.

When you enroll, you receive the covered health care services described in this Handbook, the Schedule of Benefits, the Prescription Drug Brochure (if applicable) and any riders or amendments to those documents.

As a Member, you can take advantage of a wide range of helpful online tools and resources. For instance, your secure online account offers you a secure place to help manage your health care. You are able to check your Schedule of Benefits and Benefit Handbook, review prescription drug and medical claim histories, compare Hospitals and much more! Through **your secure online account**, you are also able to estimate health care costs for services from Plan Providers before receiving the services and compare cost estimates between Plan Providers allowing you to better manage your

out-of-pocket costs. For details on how to register for a secure online account, log on to **www.harvardpilgrim.org** .

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

- Selecting Plan Providers
- Your Benefit Handbook
- Your In-Network and Out-of-Network benefits
- Your enrollment
- Your claims
- Pharmacy management procedures
- Provider information
- Requesting a Provider Directory
- Requesting a Member Kit
- Requesting ID cards
- Registering a complaint

We can usually accommodate questions from non-English speaking Members, as we offer language interpretation services in more than 180 languages free of charge.

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

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

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

Medical Necessity Guidelines

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

Harvard Pilgrim Health Care

a Point32Health company

Language Assistance Services

Arabic (العربية) انتباه: إذا كنت تتحدث لغة أخرى غير الإنجليزية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا. يرجى الاتصال بالرقم الموجود على بطاقة هوية العضو الخاصة بك.

French (Français) ATTENTION : Si vous parlez une langue autre que l'anglais, des services d'assistance linguistique gratuits sont à votre disposition. Veuillez appeler le numéro indiqué sur votre carte d'adhérent.

Greek (Ελληνικά) ΠΡΟΣΟΧΗ: Εάν μιλάτε κάποια άλλη γλώσσα πέρα από τα αγγλικά, γλωσσικές υπηρεσίες χωρίς χρέωση είναι στη διάθεσή σας. Καλέστε τον αριθμό στην κάρτα μέλους σας.

Gujarati (ગુજરાતી) ધ્યાન આપો: જો તમે અંગ્રેજી સિવાય બીજી ભાષા બોલો છો, તો ભાષા હિાય વિાઓ, તમારા માટે મફત ઉપલબ્ધ છે. કૃપા કરીને તમારા ભિય આઈડી કાડડ પરના નંબર પર કૉલ કરો.

Haitian Creole (Kreyòl Ayisyen) ATANSYON: Si w pale yon lang ki pa Anglè, gen sèvis èd pou lang ki disponib gratis pou ou. Tanpri rele nimewo ki sou kat ID manm ou a.

Hindi (हिंदी) ध्यान दें: अगर आप अंग्रेजी के अलावा कोई दूसरी भाषा बोलते हैं, तो भाषा सहायता सेवाएं आपके लिए निःशुल्क उपलब्ध हैं। कृपया अपने सदस्य आईडी कार्ड पर दिए गए नंबर पर कॉल करें।

Italian (Italiano) ATTENZIONE: se parli una lingua diversa dall'inglese, sono disponibili gratuitamente servizi di assistenza linguistica. Chiama il numero indicato sulla tua tessera membro identificativa.

Khmer (ភាសាខ្មែរ) ប្រសិនបើអ្នក កនិយាយភាសាបរសេើបេបេ្រើពីភាសាអង់បលេ សេ បសេវាកមេ្មងជំនួ យភាសា ដលែឥតលិតថ្លេ លិអាចរកហានសេ្រាអ្នក ក។ សូ មេ្រើេ្រើកាន់បលខេ្រើបលើ ID ភាតសាជិករេស់អ្នក ក។

Korean (한국어) 알림: 영어 이외의 언어를 사용하신다면 언어 지원 서비스를 무료로 제공해 드립니다. 가입자 ID 카드에 명시된 번호로 전화하시기 바랍니다.

Lao (ພາສາລາວ) ກະລຸນາ ຮັບຊາບ: ຖ້າ ທ່ານເວົ້າພາສາອື່ນນອກ ເໜືອຈາກ ພາສາ ອັງກິດ, ທ່ານສາມາດໃຊ້ບໍລິການຊ່ວຍເຫຼືອ ດ້ານພາສາ ໄ ດ ໂດຍບໍ່ເສຍ ຄ່າ. ກະລຸນາໂທຫາເບີ ທ່ ຢ ໃນ ບັດປະຈໍາ ຕົວສະມາຊິກຂອງ ທ່ານ.

Polish (polski) UWAGA: Jeśli posługujesz się językiem innym niż angielski, możesz bezpłatnie korzystać z usług pomocy językowej. Zadzwoń pod numer podany na Twojej karcie członkowskiej.

Portuguese (Português) ATENÇÃO: caso fale outro idioma que não o inglês, são lhe disponibilizados gratuitamente serviços de assistência linguística. Ligue para o número no seu cartão de identificação de membro.

Russian (Русский) ВНИМАНИЕ! Если вы не говорите на английском языке, то можете бесплатно воспользоваться услугами языковой поддержки. Позвоните по номеру, указанному на вашей идентификационной карте участника.

Spanish (Español) ATENCIÓN: Si usted habla un idioma que no sea inglés, están disponibles para usted, sin costo, servicios de asistencia en otros idiomas. Llame al número que figura en su tarjeta de identificación de miembro.

Traditional Chinese (繁體中文) 注意事項：如果您講非英語的其他語言，我們可以為您提供免費的語言協助服務。請撥打您會員 ID 卡上的電話號碼。

Vietnamese (Tiếng Việt) LƯU Ý: Nếu quý vị nói ngôn ngữ khác không phải tiếng Anh, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Vui lòng gọi đến số điện thoại trên thẻ ID hội viên của quý vị.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Please call the number on your member ID card.

Continued on next page

General Notice About Nondiscrimination and Accessibility Requirements

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

HPHC:

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

If you need these services, contact our Civil Rights Compliance Officer (see below for contact information).

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity) you can file a grievance with:

Point32Health Civil Rights Legal Coordinator
1 Wellness Way
Canton, MA 02021-1166

866-750-2074, TTY service: 711
Fax: 617-668-2754
Email: **OCRCoordinator@point32health.org**

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

800-368-1019, 800-537-7697 (TDD)

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

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

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I. How the Plan Works

This section describes how to use your Benefit Handbook and how your coverage works under 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 participating in the Plan. These Providers are referred to as "Plan Providers" and they have agreed to accept our payment minus the Member Cost Sharing as payment in full.

In Massachusetts, Maine, Rhode Island and New Hampshire, there are certain specialized services that must be received from designated Plan Providers, referred to as "Centers of Excellence" to receive In-Network coverage. Please see section *I.D.4. Centers of Excellence* for further information.

You receive Out-of-Network coverage when you obtain Covered Benefits from Non-Plan Providers. The Plan does not have agreements or contracts with these Providers. The Plan pays a percentage of the cost of care you receive from Non-Plan Providers, up to the Allowed Amount for the service, unless it is a Surprise Bill. See section *V. Reimbursement and Claims Procedures* for additional information. Your In-Network and Out-of-Network coverage is described further below.

A. HOW TO USE THIS BENEFIT HANDBOOK

1. Why This Benefit Handbook Is Important

This Benefit Handbook, the Schedule of Benefits, the Prescription Drug Brochure (if your Plan includes our outpatient pharmacy coverage) and any applicable riders make up the agreement stating the terms of the Plan.

The Benefit Handbook describes how your membership works. It explains what you must do to obtain coverage for services and what you can expect from HPHC and the Plan. It's also your guide to the most important things you need to know, including:

- How to obtain benefits with the lowest out-of-pocket expense
- Covered Benefits
- Exclusions
- The requirements for In-Network and Out-of-Network coverage

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

2. Words With Special Meaning

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

3. How To Find What You Need To Know

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

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

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

B. HOW TO USE YOUR PROVIDER DIRECTORY

The Provider Directory lists the Plan Providers you may use to obtain In-Network Benefits. You may view the Provider Directory online at our website, **www.harvardpilgrim.org**. You can also get a paper copy of the Provider Directory, free of charge, by calling the Member Services Department at **1–888–333–4742.**

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

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 network because of retirement, relocation or other reasons. This means that we cannot guarantee that the Physician you choose will continue to participate in the network for the duration of your membership. You may be eligible for transition

of services if your provider leaves the network (please see section for details.

C. MEMBER OBLIGATIONS

1. Show Your Identification Card

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

2. Share Costs

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

- Copayments
- Coinsurance
- Deductibles

Your Plan also has an Out-of-Pocket Maximum that limits the amount of Member Cost Sharing you will be required to pay. Your specific Member Cost Sharing responsibilities are listed in your Schedule of Benefits. See section *I.E. MEMBER COST SHARING* for more information on Copayments, Coinsurance, Deductibles and Out-of-Pocket Maximums.

3. Obtain Prior Approval

You are required to obtain Prior Approval before receiving certain Covered Benefits. Please see section *I.F. PRIOR APPROVAL* for more information on these requirements.

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

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

D. HOW TO OBTAIN CARE

IMPORTANT POINTS TO REMEMBER

1) The Plan provides you with two levels of benefits known as In-Network benefits and Out-of-Network benefits.
2) In-Network benefits are available for Covered Benefits received from Plan Providers.
3) Plan Providers are providers that are under contract with HPHC to provide services to Members.
4) Out-of-Network benefits are available for Covered Benefits received from Non-Plan Providers.
5) Some services require Prior Approval by the Plan.
6) In the event of a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number.

The Plan offers two different levels of coverage, referred to in this Handbook as "In-Network" and "Out-of-Network" benefits.

1. How Your In-Network Benefits Work

In-Network benefits are available when you receive Covered Benefits from a Plan Provider. Your Member Cost Sharing is generally lower for In-Network benefits. In-Network coverage applies to Plan Providers in Massachusetts, Maine, New Hampshire , Rhode Island, Vermont, and a large number of providers in HPHC's affiliated national network around the country. Since HPHC, as funded by the Plan, pays Plan Providers directly, you do not have to file a claim when you use your In-Network benefits.

Plan Providers are under contract to provide Covered Benefits to Members of the Plan. They are listed in the Plan 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.

When obtaining In-Network benefits, some services require Prior Approval by the Plan. Please see section *I.F. PRIOR APPROVAL* for more information on the Prior Approval Program.

Please Note: In Massachusetts, Maine, Rhode Island and New Hampshire, there are certain specialized services that must be received from designated Plan Providers, referred to as "Centers of Excellence" to receive In-Network coverage. Please see section*I.D.4. Centers of Excellence* for further information.

2. How Your Out-of-Network Benefits Work

Out-of-Network Benefits are available when you receive Covered Benefits from Non-Plan Providers. The Plan pays only a percentage of the cost of Covered Benefits you receive from Non-Plan Providers. You are responsible for paying the balance. Your Member Cost Sharing is generally higher for Out-of-Network benefits. However, you have more flexibility in obtaining care and may go to the licensed health care professional of your choice.

When obtaining Out-of-Network benefits, some services require Prior Approval by the Plan. Please see section *I.F. PRIOR APPROVAL* for information on the Prior Approval Program.

Payments to Plan Providers are usually based on a contracted rate between us and the Plan Provider. Since we have no contract with Non-Plan Providers, there is no limit on what such providers can charge. You are responsible for any amount charged by a Non-Plan Provider in excess of the Allowed Amount for the service, unless it is a Surprise Bill. See section *V. Reimbursement and Claims Procedures* for additional information.

3. Selecting a Plan Provider

To obtain In-Network benefits you must receive services from a Plan Provider. Your out-of-pocket costs will almost always be lower if you use your In-Network benefits by using a Plan Provider. Plan Providers include a large number of specialists and health care institutions in Maine and surrounding states. In addition, HPHC offers a large national network of Plan Providers across the United States. You may use the HPHC Provider Directory to find Plan Providers. The Provider Directory identifies the Plan's participating specialists, Hospitals and other providers. It lists providers by state and town, specialty, and languages spoken. You may view the Provider Directory online at our website, **www.harvardpilgrim.org**. You can also get a copy of the Provider Directory, free of charge, by calling the Member Services Department at **1–888–333–4742**.

If you have difficulty finding a Plan Provider who can provide the services you need, we will assist you. For help finding a provider, please call **1-888-333-4742**.

If no Plan Provider has the professional expertise needed to provide a Medically Necessary Covered Benefit, we will assist you in finding an appropriate Non-Plan Provider.

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 network because of retirement, relocation or other reasons. This means that we cannot guarantee that the Physician you choose will continue to participate in the network for the duration of your membership.

4. Centers of Excellence

Plan Providers with special training, experience, facilities or protocols for certain specialized services are designated as "Centers of Excellence."

Centers of Excellence are selected by us based on the findings of recognized specialty organizations or government agencies such as Medicare. Centers of Excellence are located in Massachusetts, Maine, Rhode Island and New Hampshire. To receive In-Network coverage in these states, you must obtain care at a Center of Excellence for the following service(s):

- Weight loss surgery (bariatric surgery)

Important Notice: If you choose to receive care in MA, ME, RI or NH for the above service at a facility other than a contracted Center of Excellence, coverage will be at the Out-of-Network benefit level.

To receive In-Network benefits for the service listed above outside of MA, ME, RI or NH, you must obtain care at a Hospital that is listed as a Plan Provider. See your Provider Directory for a list of participating Hospitals.

If you choose to receive care for the above service at a facility other than a Plan Provider, coverage will be at the Out-of-Network benefit level.

A list of Centers of Excellence may be found in the Provider Directory. The Provider Directory is available online at **www.harvardpilgrim.org** or by calling our Member Services Department at **1–888–333–4742**.

We may revise the list of services that must be received from a Center of Excellence upon 30 days' notice to Members. Services or procedures may be added to the list when we identify services in which significant improvements in the quality of care may be obtained through the use of selected providers. Services or procedures may be removed from the list if we

determine that significant advantages in quality of care will no longer be obtained through the use of a specialized panel of providers.

5. Covered Benefits from Our Affiliated National Network of Providers

HPHC offers a comprehensive network of Plan Providers located in Massachusetts, New Hampshire, Rhode Island, Vermont, and Maine. In addition, HPHC's national provider network allows Members to obtain In-Network benefits outside of those states. To locate one of these Providers, log onto our website at **www.harvardpilgrim.org** or call Member Services at **1–888-333-4742**.

6. How to get Care After Hours

Either your doctor or a covering provider is available to direct your care 24-hours a day. Talk to your doctor to find out what arrangements are available for care after normal business hours. Some doctors may have covering Physicians after hours and others may have extended office/clinic hours. In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number.

7. Medical Emergency Services

In a Medical Emergency, including a mental health condition, you should go to the nearest emergency facility or call 911 or other local emergency number. Your emergency room Member Cost Sharing is listed in your Schedule of Benefits. Please remember that if you are hospitalized, you must call the Plan at **1-888-333-4742** within 48 hours or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to the Plan by an attending emergency Physician no further notice is required. See the *Glossary* for additional information on Medical Emergency Services.

E. MEMBER COST SHARING

Below are descriptions of Member Cost Sharing that may apply when using Plan or Non-Plan Providers. Member Cost Sharing under your Plan may apply to services received In-Network, Out-of-Network or both. There may be two types of office visit cost sharing that apply to your Plan: a lower cost sharing known as "Level 1" and a higher cost sharing known as "Level 2." Member Cost Sharing may include Copayments, Coinsurance, or Deductible amounts, as described throughout this section. See your Schedule of Benefits for Cost Sharing details that are specific to your Plan.

When using Plan Providers, you are only responsible for your Member Cost Sharing. Plan Providers are prohibited from balance billing you. When using Non-Plan Providers, you are responsible for your Member Cost Sharing and any amount charged by a Non-Plan Provider in excess of the Allowed Amount, unless it is a Surprise Bill.

1. Copayment

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

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

2. Deductible

A Deductible is a specific dollar amount that is payable by a Member for Covered Benefits received each Plan Year or Calendar Year before any benefits subject to the Deductible are payable by the Plan. If a family Deductible applies, it is met when any combination of Members in a covered family incur expenses for services to which the Deductible applies. Deductible amounts are incurred on the date of service. You may have different Deductibles that apply to different Covered Benefits under your Plan. If a Deductible applies to your Plan, it will be listed in your Schedule of Benefits.

If your Plan has a Deductible, it will have both an individual Deductible and a family Deductible. However, please note that a family Deductible only applies if you have Family Coverage. Unless a family Deductible applies, you are responsible for the individual Deductible for Covered Benefits each Plan Year or Calendar Year. If you are a Member with Family Coverage, the Deductible can be satisfied in one of two ways:

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

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

Once a Deductible is met, coverage by the Plan is subject to any other Member Cost Sharing that may apply.

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

Some Plans include a Deductible Rollover. A Deductible Rollover allows you to apply any Deductible amount incurred for Covered Benefits during the last three (3) months of a year toward the Deductible for the next year. In order for a Deductible Rollover to apply, the Member (or Family) must have had continuous coverage under the Plan through the same Plan Sponsor at the time the charges for the prior year were incurred. If a Deductible Rollover applies, it will be stated in your Schedule of Benefits.

3. Coinsurance

After the appropriate Deductible amount is met, you may be responsible for paying a Coinsurance amount, which is a percentage of the Allowed Amount or the Recognized Amount, if applicable. When using Plan Providers, the Allowed Amount is based on the contracted rate between HPHC and the Provider. When using Non-Plan Providers, the Allowed Amount is based on the Provider's charge for the service up to the Allowed Amount for the service. In general, higher Coinsurance amounts will apply to Out-of-Network services. Coinsurance amounts are listed in your Schedule of Benefits.

4. Out-of-Pocket Maximum

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

Certain expenses do not apply to the Out-of-Pocket Maximum. Penalty amounts and charges above the Allowed Amount never apply to the Out-of-Pocket Maximum.

In most cases where an Out-of-Pocket Maximum is included in the Plan, you have both an individual Out-of-Pocket Maximum and a family Out-of-Pocket Maximum. If you are a Member with Family Coverage, your Out-of-Pocket Maximum can be reached in one of two ways:

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

b. If any number of Members in a covered family collectively meet the family Out-of-Pocket Maximum, then all Members of the covered family have no additional Member Cost Sharing for the remainder of the Plan Year or Calendar Year.

If a Member changes to Family Coverage from Individual Coverage or to Individual Coverage from Family Coverage within a Plan Year or Calendar Year, expenses that Member incurred for Covered Benefits toward the Out-of-Pocket Maximum under the prior coverage will apply toward the Out-of-Pocket Maximum limit under his/her new coverage. If the incurred Out-of-Pocket Maximum amount is greater than the new Out-of-Pocket Maximum limit, the Member will have no additional cost sharing for that Plan Year or Calendar Year.

5. Out-of-Network Charges in Excess of the Allowed Amount

On occasion, a Non-Plan Provider may charge amounts in excess of the Allowed Amount. In those instances, you will be financially responsible for the difference between what the Provider charges and the amount of the Allowed Amount payable by the Plan. This means that you will be responsible for paying the full amount above the Allowed Amount, unless it is a Surprise Bill. Amounts charged by a Non-Plan Provider in excess of the Allowed Amount do not count toward the Out-of-Pocket Maximum. You may contact the Member Services Department at **1–888–333–4742** or call **711** for TTY service if you have questions about the maximum Allowed Amount

that may be permitted by HPHC for a service. See section *V. Reimbursement and Claims Procedures* for additional information.

6. Penalty

The amount that a Member is responsible to pay for certain Out-of-Network medical services or Medical Drugs when Prior Approval has not been received before obtaining the services. The Penalty charge is in addition to any Member Cost Sharing amounts. The Penalty charge will be no more than $500. Penalty charges do not count towards any Out-of-Pocket Maximum. Please see your Schedule of Benefits for your Out–of–Network Penalty Payment amount. Please see section *I.F. PRIOR APPROVAL* for a detailed explanation of the Prior Approval Program.

7. Combined Payment Levels

Under some circumstances you may receive services from both a Plan Provider and a Non-Plan Provider when obtaining care. When this occurs, our entitlement to In-Network or Out-of-Network coverage always dependents upon the participation status of the individual service Provider and whether you chose to receive services from a Non-Plan Provider. For example, you may receive treatment in a Plan Provider's office but choose to receive associated blood work from a non-plan laboratory. In this example, the Plan Provider would be paid at the In-Network coverage level and the laboratory would be paid at the Out-of-Network coverage level because the laboratory is a Non-Plan Provider and you chose to receive those services from a Non-Plan Provider. However, if a Plan Provider directs you to a Non-Plan Provider and you did not choose that Non-Plan Provider to provide such services, you would be entitled to In-Network coverage for those services from the Non-Plan Provider

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 a Plan Provider admits you to a participating Hospital, both the Hospital and Physician are paid at the In-Network coverage level. If an Out-of-Network Physician admits you to a participating Hospital, 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 a Plan Provider admits you to a non-plan Hospital, 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. All Out-of-Network payments by the Plan are limited to the Allowed Amount.

F. PRIOR APPROVAL

Prior Approval must be obtained before receiving certain medical services, Medical Drugs or mental health and substance use disorder treatment from a Non-Plan Provider or Plan Provider outside the Service Area. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. This section explains when Prior Approval is required and the procedures to follow to meet those requirements.

Please Note: Your doctor or Hospital can seek Prior Approval on your behalf. Also, you do not need to obtain Prior Approval if services are needed in a Medical Emergency.

For a detailed list of services that require Prior Approval or for updates and revisions to the Prior Approval list, please visit our website at **www.harvardpilgrim.org**. If you have questions regarding services that require Prior Approval, please contact Member Services at **1–888–333–4742**.

1. When Prior Approval is Required

Prior Approval must be obtained for any of the services listed below.

1) **The following Mental Health and Substance Use Disorder Treatments:**
   - **Psychological testing and Neuropsychological testing**
   - **Applied Behavior Analysis (ABA) services for the treatment of Autism**
   - **Repetitive Transcranial Magnetic Stimulation (rTMS)**
2) **The following Medical Services:**
   - **Inpatient services**
   - **Outpatient services and treatments** including, but not limited to: infertility treatment; genetic testing; home health care; advanced radiology; and pain management.
   - **Outpatient surgery**
   - **Low protein foods**
   - **Medical formulas**
   - **Diabetic equipment**
   - **Positive airway pressure devices, including CPAP and BIPAP devices**

- **Power wheelchairs**
- **Non-emergency medical transportation**

  Please note, Prior Approval is not required for transportation provided by wheelchair van.
- **Prosthetic arms and legs**
- **Dental services**

  Please note, the Plan provides very limited coverage for Dental Care. (Please see "Dental Services" in section III. Covered Benefits and your Schedule of Benefits for details.)

3) **Medical Drugs prescribed to treat a medical, mental health or substance use disorder condition.**

   Please Note: Not all plans cover every service listed on the Prior Approval List. Please see your Schedule of Benefits to determine if your Plan provides coverage for a specific benefit or call the Member Services Department at **1–888–333–4742**.

2. How to Obtain Prior Approval

To seek Prior Approval for medical services, Medical Drugs or mental health and substance use disorder treatment received from a Non-Plan Provider or a Plan Provider outside the Service Area, you should call:

- **1-800-708-4414** for medical services
- **1–877–907–4742** for Medical Drugs
- **1-800-708-4414** for mental health and substance use disorder treatment

The following information must be given when seeking Prior Approval for medical services or Medical Drugs:

- 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 inpatient admission to a Non-Plan Provider or a Plan Provider outside the Service Area, 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

3. The Effect of Prior Approval on Coverage

If you obtain Prior Approval when required, the Plan will pay up to the full benefit limit stated in this Benefit Handbook and your Schedule of Benefits.

If you do not obtain Prior Approval when required, you will receive coverage only for services later determined to be Medically Necessary and will be responsible for any applicable Member Cost Sharing. For medical services or Medical Drugs received from a Non-Plan Provider, you will also be responsible for paying the penalty amount stated in the Schedule of Benefits.

If HPHC determines at any point that a service is not Medically Necessary, no coverage will be provided for the services at issue, and you will be responsible for the entire cost of those services.

Prior Approval does not entitle you to any benefits not otherwise payable under this Benefit Handbook or the Schedule of Benefits.

Please see section *X.J. UTILIZATION REVIEW PROCEDURES* for information on the time limits for Prior Approval decisions and reconsideration procedures for Providers if coverage is denied. Please see section *VI. Appeals and Complaints* for a description of your appeal rights if coverage for a service is denied by HPHC.

4. What Prior Approval Does

The Prior Approval program may do different things depending upon the service in question. These may include:

- Assuring that the proposed service will be covered by the Plan and that benefits are being administered correctly.
- Consulting with Providers to provide information and promote the appropriate delivery of care.
- Evaluating whether a service is Medically Necessary, including the level of care, place of service and whether it is, and continues to be, provided in an appropriate setting.

If the Prior Approval Program conducts a medical review of a service, you and your attending Physician will be notified of the Plan's decision to approve or not to approve the care proposed. If part of the review is related to level of care, place of service or setting, then providing services in a higher level of care will not be considered Medically Necessary when those same

services can be safely provided to you in a lower level of care, place of service or setting. All decisions to deny a medical service will be reviewed by a Physician (or, in the case of Medical Drugs or mental health and substance use disorder treatment, a qualified clinician) in accordance with written clinical criteria. Medical review criteria will be based on many sources including medical policy and clinical guidelines. The relevant criteria will be made available to Providers and Members upon request.

If the Prior Approval Program denies a coverage request, it will send you a written notice that explains the decision, your Provider's right to obtain reconsideration of the decision, and your appeal rights.

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

1. Disenrollment of a Plan Provider

If your Provider is disenrolled as a Plan Provider for reasons unrelated to fraud or quality of care, we will use our best efforts to provide you with written notice at least 60 days prior to the date of your Plan Provider's disenrollment. That notice will also explain the process for selecting a new Plan Provider. You may be eligible to continue to receive In-Network coverage for services provided by the disenrolled Plan Provider, under the terms of this Handbook and your Schedule of Benefits, for at least 60 days after the disenrollment date.

You may also be eligible to continue to receive coverage for the following services from the disenrollment date or the date of the disenrollment member notice (whichever is later):

i. Active Course of Treatment

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

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

ii. Pregnancy

If you are a female Member and are pregnant, you may continue to receive In-Network coverage for services from your disenrolled provider through delivery and up to 6 weeks of postpartum visits immediately following childbirth.

iii. Terminal Illness

A Member with a terminal illness may continue to receive In-Network coverage for services delivered by the disenrolled provider until the Member's death.

2. New Membership

If you are a new Member, we will provide coverage for services delivered by a physician who is not a Plan Provider, under the terms of this Handbook and your Schedule of Benefits, for up to 60 days from your effective date of coverage if the physician is providing you with an ongoing course of treatment. We will provide you with written notice explaining the process for obtaining an alternate Plan Provider.

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.

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

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

- Accept reimbursement from us at the rates applicable prior to the start of the transitional period as payment in full and not to impose Member Cost Sharing with respect to the Member in an amount that would exceed the Member Cost Sharing that could have been imposed if the provider had not been terminated;
- Adhere to our policies and procedures, including procedures regarding Referrals, obtaining Prior Approval and providing Covered Benefits pursuant to a treatment plan, if any, approved by us.

H. MEDICAL NECESSITY GUIDELINES

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our Medical Necessity Guidelines applicable to a service or procedure for which coverage is requested. Medical Necessity Guidelines may be obtained by calling **1-888-333-4742**.

I. PROVIDER FEES FOR SPECIAL SERVICES (CONCIERGE SERVICES)

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

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

J. BUNDLED PAYMENT ARRANGEMENTS

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

K. CARE MANAGEMENT PROGRAMS

The Plan provides care management programs for Members with certain illnesses and injuries, subject to Member residency and provider licensure. These programs are designed to encourage the use of the most appropriate and cost-effective treatment and to provide support for the Member's care. Care management may include programs for medical and behavioral health care including, but not limited to:

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

The Plan may work with certain providers to establish care management programs. The Plan or providers affiliated with the care management program may identify and contact Members that may find benefit from participating in one of these programs. These members are identified through internal claims data indicating a recent diagnosis or service. Members can also self-refer by contacting their PCP or calling Member Services. The Plan or providers may also contact Members to:

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

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

II. Glossary

This section lists words with special meaning within the Handbook.

Accident or Accidental Injury Accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided and that occurs while the insurance is in force.

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

Adverse Benefit Determination Any of the following, including but not limited to (1) an Adverse Health Care Treatment Decision or (2) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Covered Benefit, including an action based on a determination of a Member's ineligibility to participate in the Plan.

Adverse Health Care Treatment Decision A health care treatment decision made by or on behalf of HPHC denying in whole or in part payment for a provision of otherwise Covered Benefits requested by or on behalf of a Member. Adverse Health Care Treatment Decision includes a rescission determination and an initial coverage eligibility determination.

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

The Allowed Amount for In-Network benefits is the contracted rate the Plan has agreed to pay Plan Providers.

If services provided by a Non-Plan Provider are Covered Benefits under this Benefit Handbook, the Allowed Amount for such services depends upon where you receive the service, as explained below:

a. If you receive Out-of-Network services in the states of Massachusetts, New Hampshire, Vermont, Rhode Island, or Maine, the Allowed Amount is defined as follows:

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

An amount that is consistent, in the judgment of the Plan, with the normal range of charges by health care Providers for the same, or similar, products or services provided to a Member. If the Plan has appropriate data for the area, the Plan will determine the normal range of charges in the geographic area where the product or services were provided to the Member. If the Plan does not have data to reasonably determine the normal range of charges where the products or services were provided, the Plan will utilize the normal range of charges in Boston, Massachusetts. Where services are provided by non-Physicians but the data on provider charges available to the Plan is based on charges for services by Physicians, the Plan will, in its discretion, make reasonable reductions in its determination of the allowable charge for such non-Physician Providers.
b. If you receive Out-of-Network services outside of the states of Massachusetts, New Hampshire, Vermont, Rhode Island, or Maine, the Allowed Amount is defined as follows:

The Allowed Amount is the lower of the Provider's charge or a rate determined as described below:
The Allowed Amount is determined based on 150% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.

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

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

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

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

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

Anniversary Date The date agreed to by HPHC and your Plan Sponsor upon which the yearly benefit changes normally become effective. This Benefit Handbook, Schedule of Benefits, Prescription Drug Brochure (if your Plan includes outpatient pharmacy coverage) and any applicable

riders will terminate unless renewed on the Anniversary Date.

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

Authorized Representative A person to whom you have given express written consent to represent you in an external review; a person authorized by law to provide consent to request and external review on your behalf; a family member or treating health care provider if you are unable to provide consent to request an external review; or a provider from which you are receiving active treatment.

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

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

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

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

Centers of Excellence Plan Providers with special training, experience, facilities or protocols for certain services, selected by us based on the findings of recognized specialty organizations or government agencies such as Medicare. Certain specialized services are only covered as In-Network services in Massachusetts, Maine, Rhode Island or New Hampshire when received from designated Centers of Excellence.

Clinical Peer A Physician or other licensed health care practitioner who holds a non-restricted license in a state in the U.S., is board certified in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review, and whose compensation does not depend, directly or indirectly, upon the quantity, type, or cost of the medical condition, procedure, or treatment that the practitioner approves or denies on behalf of the Plan.

Coinsurance A percentage of the Allowed Amount, or Recognized Amount, if applicable, for certain Covered Benefits that must be paid by the Member. Coinsurance amounts are in addition to any Deductible and any applicable Copayment. Coinsurance amounts applicable to your Plan are stated in your Schedule of Benefits.

✔ FOR EXAMPLE: If the Coinsurance for a service is 20%, you pay 20% of the Allowed Amount while the Plan pays the remaining 80%. (In the case of Out-of-Network services, the Plan only pays up to the Allowed Amount, unless it is a Surprise Bill.)

Copayment A fixed dollar amount you must pay for certain Covered Benefits. The Copayment is usually due at the time services are rendered or when you are billed by the provider.

Your specific Copayment amounts, and the services to which they apply, are listed in your Schedule of Benefits.

Occasionally the Copayment may exceed the contract rate payable by the Plan 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.

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

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

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

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

Deductible A specific dollar amount that is payable by a Member for Covered Benefits received each Plan Year or Calendar Year before any benefits subject to the Deductible are payable by the Plan. There may be an individual Deductible and a family Deductible, and you may have different Deductibles that apply to different Covered Benefits under your Plan. When a Deductible applies to your Plan, it will be stated in your Schedule of Benefits. The Deductible does not apply to non-Covered Benefits.

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

Deductible Rollover A Deductible Rollover allows you to apply any Deductible amount that you have paid for Covered Benefits during the last three months of a Plan Year or Calendar Year toward the Deductible for the next Plan Year or Calendar Year. To be eligible for a Deductible Rollover, a Member must have had continuous coverage with us through the same Plan Sponsor at the time the prior Plan

Year or Calendar Year charges were incurred. Deductible Rollover amounts may also apply to the Out-of-Pocket Maximum for the next Plan Year or Calendar Year. If your Plan has a Deductible Rollover it will be listed in your Schedule of Benefits.

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

Dependent A Member of the Subscriber's family who (1) meets the eligibility requirements for coverage through a Subscriber as agreed upon by the Plan Sponsor and HPHC and (2) is enrolled in the Plan.

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

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

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

Hospital An inpatient facility that is licensed to operate pursuant to law and that is primarily and continuously engaged in providing or operating (either on its premises or in facilities available to the Hospital on a prearranged basis and under the supervision of a staff of licensed Physicians) medical, diagnostic, and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made.

HPHC Insurance Company, Inc. (HPHC) HPHC Insurance Company, Inc. is an insurance company and Third-Party Administrator (TPA) that offers Administrative Services Only (ASO) for self-insured group health plans. It provides, arranges, or administers health care benefits for Members through a network of Plan Providers. Under self-insured plans such as this one, HPHC does not insure the benefits but administers them on behalf of the Plan Sponsor, including adjudicating claims and managing benefits.

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 Plan Provider.

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

Medical Emergency The sudden and, at the time, unexpected onset of a physical or mental health condition, including severe pain, manifesting itself by symptoms of sufficient severity, regardless of the final diagnosis that is given, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the absence of immediate medical attention for the Member could reasonably be expected to result in: (a) placing the Member's physical and/or mental health in serious jeopardy (or with respect to pregnant woman, the health of the woman or her unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. 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. A Medical Emergency includes a situation involving a pregnant woman who is having contractions where there is either inadequate time to safely transfer her to another Hospital before delivery or any transfer may pose a threat to the safety of the woman or unborn child.

Please remember that if you are hospitalized, you must call the Plan within 48 hours or as soon as you can. If the notice of hospitalization is given to the Plan by an attending

emergency Physician, no further notice is required.

Medical Emergency Services Services provided during a Medical Emergency, including:

- A medical screening examination (as required under section 1867 of the Social Security Act or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital, or an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Medical Emergency, and
- Further medical examination and treatment, within the capabilities of the staff and facilities available at the hospital or independent freestanding emergency department, as applicable, as are required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further exam or treatment is provided).
- Items and services, otherwise covered under the Plan, that are provided by a Non-Plan Provider or facility (regardless of the department of the hospital in which the items and services are provided) after the Member is stabilized and as part of an inpatient stay or outpatient services that are connected to the original Medical Emergency, unless each of the following conditions are met:
  a. The Provider or facility, as described above, determines the Member is able to travel using non-medical transportation or non-emergency medical transportation.
  b. The Provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
  c. The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
  d. Any other conditions as specified by the Secretary.

Medically Necessary or Medical Necessity Health care services or products provided to a Member for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:

- Consistent with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Demonstrated through scientific evidence to be effective in improving health outcomes;
- Representative of best practices in the medical profession; and
- Not primarily for the convenience of the enrollee or Physician or the other health care practitioner.

Please Note: To determine coverage of Medically Necessary services, we use Medical Necessity Guidelines (MNG) created using clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of the Medical Necessity Guideline(s) applicable to a service or procedure for which coverage is requested by going online to **www.harvardpilgrim.org** or by calling the Member Services department at **1-888-333-4742**.

Medicare The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Member Any Subscriber or Dependent covered under the Plan.

Member Cost Sharing The responsibility of Members to assume a share of the cost of the benefits provided under the Plan. Member Cost Sharing may include Copayments, Coinsurance and Deductibles. Please refer to your Schedule of Benefits for the specific Member Cost Sharing that applies to your Plan. There may be two types of office visit cost sharing that apply to your Plan: a lower cost sharing known as "Level 1" and a higher cost sharing known as "Level 2."

Non-Plan Provider A Provider who does not have a special agreement or contract with HPHC or its affiliates. The payment schedule for services received from Non-Plan Providers is based on the Allowed Amount or Out-of-Network Rate, if applicable. When care is received from a Non-Plan Provider, Members are responsible for the applicable Deductible and Coinsurance plus any amounts in excess of the Allowed Amount, unless it is a Surprise BIll. These financial responsibilities are described in your Schedule of Benefits.

Nurse A person duly licensed as a Nurse, including a registered Nurse, licensed practical Nurse, and a licensed Nurse who is certified by the American Nurses' Association as a clinical specialist in adult psychiatric and mental health nursing or as a clinical specialist in child and adolescent psychiatric and mental health nursing that provides services within the scope of an applicable statute or administrative rules of the licensing or registry board of the applicable state.

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

Out-of-Network Rate With respect to a Surprise Bill, the total amount paid by the Plan to a Non-Plan Provider for Covered Benefits under section 2799A-1 and 2799A-2 of the Public Service Act and their implementing regulations for: (1) Emergency Medical Services, (2) non-emergency

ancillary services, (3) non-emergency, non-ancillary services, and (4) air ambulance services. The amount is based on: (1) Applicable state law, (2) an All Payer Model Agreement if adopted, (3) the initial payment made by us or the amount subsequently agreed to by the Non-Plan Provider and us, or (4) the amount determined by Independent Dispute Resolution between us and the Non-Plan Provider.

Out-of-Pocket Maximum An Out-of-Pocket Maximum is a limit on the amount of Deductibles, Copayments, and Coinsurance that a member must pay for certain Covered Benefits in a Plan Year or Calendar Year. The Out-of-Pocket Maximum is stated in your Schedule of Benefits.

Please Note: Penalty payments and charges above the Allowed Amount never apply to the Out-of-Pocket Maximum.

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

Penalty The amount that a Member is responsible to pay for certain Out-of-Network medical services or Medical Drugs when Prior Approval has not been received before receiving the services. The Penalty charge is in addition to any Member Cost Sharing amounts. Please see section *I.F. PRIOR APPROVAL* for a detailed explanation of the Prior Approval Program. A Penalty amount does not apply to an Out-of-Pocket Maximum, if any.

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

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

Physician A person duly licensed as a Doctor of Medicine or Doctor of Osteopathy that provides services within the scope of an applicable license and training and in accordance with applicable laws.

Plan This package of health care benefits 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.

Plan Provider Providers who are under contract to provide In-Network services to Plan Members, and have agreed to charge Members only the applicable Copayments, Coinsurance and Deductible amounts for Covered Benefits. Plan Providers are listed in the Provider Directory.

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. The Plan Sponsor pays for the health care coverage provided under the Plan. The Plan Sponsor is generally the Subscriber's Employer or Union.

Plan Year The one-year period for which benefits are purchased and administered. Benefits for which limited yearly coverage is provided renew at the beginning of the Plan Year. Benefits for which limited coverage is provided every two years renew at the beginning of every second Plan Year. Generally, the Plan Year begins on the Plan's Anniversary Date. Benefits under your Plan are administered on either a Plan Year or Calendar Year basis. Please see your Schedule of Benefits to determine which type of year your Plan utilizes.

✔ FOR EXAMPLE: A Plan Year could begin on April 1st and end on March 31st or begin on January 1st and end on December 31st.

Prior Approval or Prior Approval Program (also known as Prior Authorization) A program to (1) verify that certain Covered Benefits are and continue to be, Medically Necessary and provided in an appropriate and cost-effective manner or (2) arrange for the payment of benefits.

Please see section *I.F. PRIOR APPROVAL* for a detailed explanation of the Prior Approval Program.

Provider Providers include, but are not limited to Hospitals; Skilled Nursing Facilities; and medical professionals including: Physicians, psychiatrists, Nurse practitioners, advanced practice registered Nurses, Physician assistants, certified midwives, certified Nurse midwives, certified registered Nurse anesthetists, registered first Nurse assistants, dentists, independent practice dental hygienists, dental hygiene therapists, naturopaths, acupuncturists, chiropractors, essential health care providers (rural health clinics), and licensed mental health professionals, including psychologists, clinical social workers, marriage and family therapists, psychiatric/mental health advanced registered Nurse practitioners, alcohol and drug counselors, clinical mental health counselors, optometrists, and pastoral psychotherapists/counselors. Services must be within the lawful scope of the licensing required for such Provider in Maine. Plan Providers are listed in the Provider Directory.

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

Recognized Amount With respect to a Surprise Bill, the amount on which a Copayment, Coinsurance or Deductible is based for Medical Emergency Services and certain non-emergency Covered Benefits when

provided by Non-Plan Providers. The amount under sections 2799A-1 and 2799A-2 of the Public Service Act and their implementing regulations is based on: (1) Applicable state law, (2) an All Payer Model Agreement if adopted, or (3) the lesser of the amount billed by the Provider or the qualifying payment amount as determined under applicable law.

Please Note: Member Cost Sharing based on the Recognized Amount may be higher or lower than Member Cost Sharing based on the Allowed Amount.

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

Schedule 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 Benefit Handbook. In addition, the Schedule of Benefits states the Copayments, Coinsurance or Deductible you must pay and any limitations on coverage.

Service Area The Service Area includes the states of Massachusetts, Maine, New Hampshire, Rhode Island, and Vermont.

Sickness An illness or disease of an insured person.

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

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

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

Surprise Bill An unexpected bill you may receive if: (1) You obtain services from a Non-Plan Provider in an emergency, (2) you obtain services from a Non-Plan Provider while you were receiving a service from a Plan Provider or facility, and you did not knowingly select the Non-Plan Provider, (3) you obtain air ambulance services from a Non-Plan Provider, or (4) you obtain services from a Non-Plan Provider during a service previously approved or authorized by HPHC where you did not knowingly select a Non-Plan Provider.

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

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

III. Covered Benefits

This section describes all of the benefits available under the Plan. Please see your Schedule of Benefits for your specific Covered Benefits. If your Plan includes our outpatient pharmacy coverage, that coverage is described in your Prescription Drug Brochure.

Some benefits have limits on the amount of coverage provided in a Plan Year or Calendar Year. If a Covered Benefit has a benefit limit, your In-Network or Out-of-Network benefits are combined and count toward your benefit limit. For example, if the 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 have reached your benefit limit. That benefit will not be covered again until the next Plan Year or Calendar Year.

Member Cost Sharing information and any applicable benefit limitations that apply to your Plan are listed in your Schedule of Benefits. Benefits are administered on a Plan Year or Calendar Year basis. Please see your Schedule of Benefits to determine which type of year your Plan utilizes.

The Plan does not impose any restrictions, limitations or exclusions related to preexisting conditions on your Covered Benefits. Products and services to treat a mental health condition will be classified as a mental health benefit where consistent with generally recognized independent standards of current medical practice.

Basic Requirements for Coverage

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

- Listed as a Covered Benefit in this section.
- Medically Necessary.
- Not excluded in section *IV. Exclusions*.
- Received while an active Member of the Plan.
- In-Network services must be provided by a Plan Provider. The only exception is care needed in a Medical Emergency.
- Some services require Prior Approval by the Plan. Please see section *I.F. PRIOR APPROVAL* for information on the Prior Approval Program.
- In Massachusetts, Maine, Rhode Island and New Hampshire, there are certain specialized services that must be received from designated Plan Providers, referred to as "Centers of Excellence," to receive In-Network coverage. Please see section *I.D.4. Centers of Excellence* for a list of these services.

Benefit	Description
1 . Acupuncture Treatment	
	The Plan may cover acupuncture treatment, including, electro-acupuncture, that is provided for the treatment of neuromusculoskeletal pain. **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.

Benefit	Description
2 . Ambulance and Medical Transport	
	Emergency Ambulance Transport If you have a Medical Emergency, your Plan covers ambulance transport to the nearest Hospital that can provide you with Medically Necessary care. **Non-Emergency Medical Transport** You're also covered for non-emergency medical transport, including but not limited to ambulance and wheelchair vans, between Hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary. Services must be arranged by a Provider. **Prior Approval Required:** You must obtain Prior Approval for non-emergency medical transportation. Please note Prior Approval is not required for transportation provided by a wheelchair van. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
3 . Autism Spectrum Disorders Treatment	
	The Plan covers the following services for the treatment of autism spectrum disorders up to the limit stated in your Schedule of Benefits: • Any assessments, evaluations or tests by a licensed Physician or psychologist to diagnose whether a Member has an autism spectrum disorder. • Rehabilitation and Habilitation Services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain and restore the functioning of an individual to the extent possible. To be covered by the Plan, applied behavior analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts. • Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker. See the "Mental Health and Substance Use Disorder Treatment" benefit for details. • Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist. See the "Rehabilitation and Habilitation Services" benefit for details. • Prescription drugs in the same manner as provided for the treatment of any other illness or condition, if your Plan includes our outpatient prescription drug coverage. See your Prescription Drug Brochure for more information. For purposes of this section the following terms have defined as follows: "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior. "Autism spectrum disorders" means any of the pervasive developmental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

Benefit	Description
Autism Spectrum Disorders Treatment (Continued)	
	Prior Approval Required: You must obtain Prior Approval for Applied Behavior Analysis (ABA) services. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
4 . Bariatric Surgery	
	The Plan covers the surgical treatment of obesity and morbid obesity (bariatric surgery). Services are covered in accordance with the patient qualification and treatment standards set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons. Coverage may be limited or excluded under your Plan unless services are performed at a designated Center of Excellence. Please see section *I.D.4. Centers of Excellence* for important information concerning your coverage for this service. **Important Notice:** We use Medical Necessity Guidelines to evaluate whether bariatric surgery is Medically Necessary. If you are planning to receive bariatric surgery services, we recommend that you review the current Medical Necessity Guidelines. To obtain a copy, please call the Member Services Department at **1-888-333-4742**.
5 . Breast Cancer Treatment	
	The Plan covers breast cancer treatment, including prostheses and the following services: • Inpatient care for a mastectomy, a lumpectomy or a lymph node dissection is covered for a period of time determined to be medically appropriate by the attending Physician, in consultation with the Member. • If the Member elects breast reconstruction following mastectomy surgery, the Plan covers reconstruction in the manner chosen by the Member and the Physician. Coverage includes reconstruction of the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. • Physical complications for all stages of mastectomy, including lymphademas are covered in a manner determined in consultation with the attending Physician and the Member.
6 . Chemotherapy and Radiation Therapy	
	The Plan covers outpatient chemotherapy administration and radiation therapy at a Hospital or other outpatient medical facility. Covered Benefits include the facility charge, the charge for related supplies and equipment, and Physician services for anesthesiologists, pathologists and radiologists. **Prior Approval Required:** You must obtain Prior Approval for radiation oncology. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.

Benefit	Description
7 . Chiropractic Care/Treatment by Adjustment or Manipulation	
	The Plan may cover Medically Necessary chiropractic services for musculoskeletal conditions up to the benefit limit stated in your Schedule of Benefits. Therapeutic adjustive and manipulative services are covered when performed by an allopathic, osteopathic or chiropractic doctor. The following services are covered: • Diagnostic x-ray • Care within the scope of standard chiropractic practice **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.
8 . Clinical Trials	
	The Plan covers services for Members enrolled in a qualified clinical trial for the treatment, prevention or detection of any form of cancer or other life-threatening disease under the terms and conditions provided for under Maine and federal law. All of the requirements for coverage under the Plan apply to coverage under this benefit. Coverage is provided under this benefit for services that are Medically Necessary for the treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the Plan.
9 . COVID-19 Services	
	The Plan covers the following COVID-19 services: • COVID-19 screening and testing for COVID-19, except when such screening and testing is part of a surveillance testing program. This coverage is provided at no cost to the Member after the Deductible has been met. • COVID-19 immunization is covered for any COVID-19 vaccine licensed or authorized under an emergency use authorization by the United States Food and Drug Administration that is recommended by the United States Centers for Disease Control and Prevention Advisory Committee on Immunization Practices, or successor organization, for administration to a Member. This coverage is provided at no cost to the Member.
10 . Dental Services	
	Important Notice: The Plan does not provide dental insurance. It covers only the limited Dental Care described below. No other Dental Care is covered. **Emergency Dental Care:** The Plan covers emergency Dental Care needed due to an injury to sound, natural teeth. All services, except for suture removal, must be received within three days of injury. Only the following services are covered: • Extraction of the teeth damaged in the injury when needed to avoid infection • Reimplantation and stabilization of dislodged teeth • Repositioning and stabilization of partly dislodged teeth • Suturing and suture removal • Medication received from the provider

Benefit	Description
Dental Services (Continued)	
	Extraction of Teeth Impacted in Bone: The Plan may cover extraction of teeth impacted in bone. If covered under your Plan, only the following services are covered: • Extraction of teeth impacted in bone Pre-operative and post-operative care, immediately following the procedure • Anesthesia • Bitewing x-rays **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. **Dental Services for Cancer Patients** The plan covers Medically Necessary dental procedures for Members who have been diagnosed with cancer. Covered services include the following: • Fluoride treatment • Laboratory assessments, medications and treatments • Medically Necessary dental procedures to reduce the risk of infection, eliminate infection, or to treat tooth loss or decay prior to beginning cancer treatment • Medically Necessary dental procedures to reduce the risk of infection, eliminate infection, or to treat tooth loss or decay that are a direct or indirect result of cancer treatment **Prior Approval Required:** You must obtain Prior Approval for the extraction of teeth impacted in bone. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. **General Anesthesia for Dentistry:** The Plan covers general anesthesia and associated facility charges for dental procedures rendered in a Hospital for certain conditions. The following conditions are covered: • Members, including infants, with physical, intellectual or medically compromising conditions in which general anesthesia is Medically Necessary. • Members for which local anesthesia is ineffective due to acute infection, anatomic variation or allergy. • Extremely uncooperative, fearful, anxious, or uncommunicative children or adolescents with dental needs that can not be postponed and for whom lack of treatment may result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidty. • Members with extensive oral-facial or dental trauma for which local anesthesia would be ineffective or compromised.

Benefit	Description
Dental Services (Continued)	
	Prior Approval Required: Prior Approval is required for general anesthesia for dentistry. You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
11 . Diabetes Services and Supplies	
	Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care: The Plan covers outpatient self-management education and training programs provided by the ambulatory diabetes education facilities authorized by the Diabetes Control Project within the Maine Bureau of Health for the treatment of diabetes, including medical nutrition therapy services, used to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes. Services must be provided on an individual basis. Benefits also include medical eye exams (dilated retinal exams) and preventive foot care. Diabetes equipment and supplies are also covered. Some equipment and supplies listed below may be furnished by a Durable Medical Equipment (DME) provider or a pharmacy. Your Member Cost Sharing is based on who furnishes the equipment and/or supplies. The following items are covered: **Diabetes Equipment (covered under your DME benefit):** • Blood glucose monitors • Continuous glucose monitors • Dosage gauges • Injectors • Insulin pumps (including supplies) and infusion devices • Lancet devices • Therapeutic molded shoes and inserts • Visual magnifying aids • Voice synthesizers Please see the "Durable Medical Equipment (DME)" benefit for more information. **Pharmacy Supplies (covered at a pharmacy):** • Blood glucose strips • Certain blood glucose monitors • Certain insulin pumps (including supplies) and infusion devices • Flash glucose monitors (including supplies) • Insulin, insulin needles and syringes • Lancets • Oral agents for controlling blood sugar • Urine and ketone test strips

Benefit	Description
Diabetes Services and Supplies (Continued)	
	For coverage of pharmacy items listed above, you must have the Plan's outpatient prescription drug benefit and you must get a prescription from your Provider and present it at a participating pharmacy. You can find participating pharmacies by logging into **your secure online account** at **www.harvardpilgrim.org** or by calling the Member Services Department at **1-888-333-4742**. Please see the "Drug Coverage" benefit for more information. **Prior Approval Required:** You must obtain Prior Approval for certain diabetic equipment and supplies. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. **Please Note:** Not all Plans provide coverage for outpatient prescription drugs, including pharmacy supplies, through HPHC. If your Plan provides coverage for outpatient prescription drugs through HPHC, please refer to your prescription drug brochure for additional information.
12 . Dialysis	
	The Plan covers dialysis on an inpatient, outpatient or at home basis. When federal law permits Medicare to be the primary payer, you must apply for Medicare and also pay any Medicare premium. When Medicare is , the Plan will cover only those costs that exceed what would be payable by Medicare. Coverage for dialysis in the home includes non-durable medical supplies, and drugs and equipment necessary for dialysis. **Prior Approval Required:** You must obtain Prior Approval for any planned inpatient admission or for any service provided in the home. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
13 . Donor Breast Milk	
	Your plan may cover donor breast milk. Please see your Schedule of Benefits to determine if your plan includes this benefit.
14 . Drug Coverage	
	1. Drug Coverage under this Benefit Handbook This Benefit Handbook covers the following: a.) **Medical Drugs:**Drugs Received During Outpatient or Home Care. A Medical Drug is a drug prescribed to treat a medical, mental health or substance use disorder condition that is administered to you either (1) in a doctor's office or other outpatient medical facility, or (2) at home while you are receiving home care services or receiving drugs administered by home infusion services. Medical Drugs cannot be self-administered. The words "cannot be self-administered" mean that the active participation of skilled medical personnel is always required to take the drug. When a Member is receiving drugs in the home, the words "cannot be self-administered" will also include circumstances in which a family member or friend is trained to administer the drug and ongoing supervision by skilled medical personnel is required.

Benefit	Description
Drug Coverage (Continued)	
	An example of a drug that cannot be self-administered is a drug that must be administered intravenously. Examples of drugs that can be self-administered are drugs that can be taken in pill form and drugs that are typically self-injected by the patient. Please see your Schedule of Benefits for your Medical Drug Member Cost Sharing. **Prior Approval Required:** You must obtain Prior Approval for select Medical Drugs. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-888–333–4742**. Please see section *I.F. PRIOR APPROVAL* for more information. b.) **Drugs and supplies required by law:** Some drugs or supplies required by law may only be available through a pharmacy. Coverage may be provided for: • Certain diabetes supplies Please see the "Diabetes Services and Supplies" benefit for the details. No coverage is provided under this Benefit Handbook for: (1) drugs that have not been approved by the United States Food and Drug Administration; (2) drugs the Plan excludes or limits, including, but not limited to, drugs for cosmetic purposes; and (3) any drug that is obtained at an outpatient pharmacy except as explained above. **2. Outpatient Prescription Drug Coverage** In addition to the coverage provided under this Benefit Handbook, you may also have HPHC's outpatient prescription drug rider. That rider covers most prescription drugs purchased at an outpatient pharmacy. If you have outpatient prescription drug coverage, see the Prescription Drug Brochure for more information, including information on Prior Approval requirements. See your ID card for your Member Cost Sharing.
15 . Durable Medical Equipment (DME)	
	The Plan covers DME when Medically Necessary and ordered by a Provider. The Plan may rent or buy the equipment you need. The cost of the repair and maintenance of covered equipment is also covered. In order to be covered, all equipment must be: • Able to withstand repeated use; • Not generally useful in the absence of disease or injury; • Normally used in the treatment of an illness or injury or for the rehabilitation of an abnormal body part; and • Suitable for home use. Coverage is only available for: • The least costly equipment adequate to allow you to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports; and • One item of each type of equipment 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.

Benefit	Description
Durable Medical Equipment (DME) (Continued)	
	Covered equipment and supplies include: • Canes • Certain diabetes supplies and equipment (See the "Diabetes Services and Supplies" benefit for details) • Certain types of braces • Crutches • Hospital beds • Oxygen and oxygen equipment • Respiratory equipment • Walkers • Wheelchairs Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan. **Prior Approval Required:** You must obtain Prior Approval for positive airway pressure devices, including CPAP and BIPAP devices, and power wheelchairs. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
16 . Early Intervention Services	
	The Plan covers early intervention services for children with an identified developmental disability or delay. Coverage is provided for children from birth up to 3 years of age. The Plan covers early intervention services up to the Benefit Limit stated in your Schedule of Benefits. Coverage under this benefit is only available for services rendered by the following types of providers: • Occupational therapists • Physical therapists • Speech-language pathologists • Clinical social workers
17 . Emergency Room Care	
	If you have a Medical Emergency, you are covered for care in a Hospital emergency room. Please remember the following: • If you need follow-up care after you are treated in an emergency room, you must get your care from a Plan Provider for coverage to be at the In-Network benefit payment level. • If you are hospitalized, you must call the Plan at **1-888-333-4742** within 48 hours or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to the Plan by an attending emergency Physician no further notice is required.

Benefit	Description
18 . Family Planning Services	
	The Plan covers family planning services, including the following: • Contraceptive monitoring • Family planning consultation • Pregnancy testing • Genetic counseling • Professional services relating to the injection of birth control drugs and the insertion or removal of birth control implants or devices.* **Please Note:** *An exclusion for contraceptives may apply when coverage is provided by a religious Plan Sponsor, as allowed by law. Please see your Schedule of Benefits. "Your Plan does not cover contraceptive methods" will display under "Preventive Services and Tests" when contraceptives are excluded from coverage.
19 . Fertility Treatment	
	This fertility treatment benefit applies to members who meet the definition of a fertility patient under Maine Fertility Care statute or its implementing regulations 24-A MRSA §4320-U. A fertility patient is defined as an individual or couple with infertility, an individual or couple who is at increased risk of transmitting a serious inheritable genetic or chromosomal abnormality to a child or an individual unable to conceive as an individual or with a partner because the individual or couple does not have the necessary gametes for conception. The Plan covers the following diagnostic services for fertility: • Consultation • Evaluation • Laboratory tests • Preimplantation genetic testing (PGT) When a Member meets Medical Necessity Guidelines, the Plan will cover the following fertility treatment. Only the following services are included: • Therapeutic donor insemination, including related sperm procurement and storage. • Donor egg procedures, and related egg and inseminated egg procurement, processing and storage • Donor oocyte (DO/IVF) • Donor embryo/frozen embryo transfer (DO/FET) • Frozen embryo transfer (FET) • Assisted hatching • Gamete intrafallopian transfer (GIFT) • Intra-cytoplasmic sperm injection (ICSI) • Intra-uterine insemination (IUI) up to three cycles per lifetime • In-vitro fertilization (IVF) including in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate who is a Member of the Plan • Zygote intrafallopian transfer (ZIFT) • Miscrosurgical epididiymal sperm aspiration (MESA) • Testicular sperm extraction (TESE)

Benefit	Description
Fertility Treatment (Continued)	
	• Sperm collection, freezing and storage is also covered for male Members in active fertility treatment. • Cryopreservation of eggs, sperm, and embryos when the Member is in active fertility treatment. **Please Note:** Storage of gametes, embryos and reproductive material is covered from the time of cryopreservation for a period of 5 years. Benefits for any combination of in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), or fresh or frozen embryo transfer (FET) are limited to two cycles per lifetime. **Important Notice:** We use evidence based clinical criteria to evaluate whether the use of fertility treatment is Medically Necessary. Fertility treatments evolve and new treatments may be developed. If you are planning to receive fertility treatment we recommend that you review the current Medical Necessity Guidelines online at **www.harvardpilgrim.org**. To obtain a copy, please call Member Services at **1-888-333-4742**. **Prior Approval Required:** Prior Approval is required for all fertility treatment. Your Plan Provider will seek Prior Approval for you.
20 . Gender Affirming Services	
	The Plan covers gender affirming services for the treatment of gender dysphoria to the extent Medically Necessary and in accordance with Medical Necessity Guidelines. Coverage includes surgery, related physician and mental health visits, and outpatient prescription drugs if you have outpatient prescription drug coverage under this Plan. If you are planning to receive gender affirming services, you should review the current Medical Necessity Guidelines that identifies covered services under this benefit. To receive a copy of the Medical Necessity Guidelines, please call the Member Services Department at **1-888-333-4742** or go to our website at **www.harvardpilgrim.org**. Procedures required in preparation for, as a component of, as a follow-up to, or as revision to a covered treatment are also covered. See the benefit for "Mental Health and Substance Use Disorder Treatment" for more information. Benefits for gender affirming services are in addition to other benefits provided under the Plan. HPHC does not consider gender affirming surgery to be reconstructive surgery to correct a Physical Functional Impairment or Cosmetic Services. Coverage for reconstructive surgery or Cosmetic Services is limited to the services described under the Reconstructive Surgery benefit in this Benefit Handbook. **Prior Approval Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The prior approval process is initiated by calling **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.

Benefit	Description
21 . Hearing Aids	
	The Plan may cover the purchase of hearing aids for each hearing impaired ear in accordance with the following conditions: • The Member's hearing loss must be documented by a Physician or state-licensed audiologist. • The hearing aid must be purchased from a state licensed audiologist or hearing aid dealer. Coverage of hearing aids is provided up to the Benefit Limit stated in your Schedule of Benefits. **Prior Approval Required:** You must obtain Prior Approval for cochlear implants. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.
22 . Home Health Care	
	If you are homebound for medical reasons, you are covered for home health care services listed below for at least 90 days in a continuous 12 month period. To be eligible for home health care, your Provider must determine that skilled nursing care or physical therapy is an essential part of active treatment. There must also be a defined medical goal that your Provider expects you will meet. When you qualify for home health care services as stated above, the Plan covers the following services: • Durable medical equipment and supplies (must be a component of the home health care being provided) • Laboratory services • Medical and surgical supplies • Medical social services • Nutritional counseling • Palliative care • Physical therapy • Professional office visits • Occupational therapy • Services of a home health aide • Skilled nursing care • Speech therapy • X-rays **Prior Approval Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.

Benefit	Description
23 . Hospice Services	
	The Plan covers hospice services for terminally ill Members who need the skills of qualified technical or professional health personnel for palliative care. Care may be provided at home or on an inpatient basis. Inpatient respite care is covered for the purpose of relieving the primary caregiver. Inpatient care is also covered in an acute Hospital or extended care facility when it is Medically Necessary to control pain and manage acute and severe clinical problems that cannot be managed in a home setting. Covered Benefits include: • Care to relieve pain • Counseling • Drugs that cannot be self-administered • Durable medical equipment appliances • Home health aide services • Medical supplies • Nursing care • Physician services • Occupational therapy • Physical therapy • Speech therapy • Respiratory therapy • Respite care • Social services • Volunteer services • Bereavement services **Prior Approval Required:** You must obtain Prior Approval for hospice care. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section*I.F. PRIOR APPROVAL* for more information.
24 . Hospital – Inpatient Services	
	The Plan covers acute Hospital care including, but not limited to, the following inpatient services: • Semi-private room and board, or private room and board when Medically Necessary • Doctor visits, including consultation with specialists • Palliative care • Medications • Laboratory, radiology and other diagnostic services • Intensive care • Surgery, including related services • Anesthesia, including the services of a Nurse-anesthetist • Radiation therapy • Physical therapy • Occupational therapy

Benefit	Description
Hospital – Inpatient Services (Continued)	
	• Speech therapy • Medically Necessary breast reduction surgery and symptomatic varicose vein surgery **Please Note:** In Massachusetts, Maine, Rhode Island and New Hampshire, there are certain specialized services that must be received from designated Plan Providers, referred to as "Centers of Excellence" to receive In-Network coverage. Please see section *I.D.4. Centers of Excellence* for further information. **Prior Approval Required:** You must obtain Prior Approval for any planned inpatient admission. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
25 . House Calls	
	The Plan covers house calls.
26 . Human Organ Transplant Services	
	The Plan covers Medically Necessary human organ transplants, including bone marrow transplants for a Member with metastasized breast cancer in accordance with the criteria of the National Cancer Institute. The Plan covers the following services when the recipient is a Member of the Plan: • Care for the recipient • Donor search costs through established organ donor registries • Donor costs that are not covered by the donor's health plan If a Member is a donor for a recipient who is not a Member, then the Plan will cover the donor costs for the Member, when they are not covered by the recipient's health plan. **Prior Approval Required:** You must obtain Prior Approval for any planned inpatient admission. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section —*I.F. PRIOR APPROVAL* for more information.
27 . Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)	
	The Plan covers laboratory and radiology services (including Advanced Radiology), and other diagnostic services on an outpatient basis. The term "Advanced Radiology" means CT scans, PET Scans, MRI and MRA, and nuclear medicine services. Coverage includes: • The facility charge and the charge for supplies and equipment. • Charges of anesthesiologists, pathologists and radiologists. • Human leukocyte antigen testing necessary to establish bone marrow transplant donor suitability. The Plan provides coverage up to $150 toward the cost of human leukocyte antigen testing necessary to establish bone marrow transplant donor suitability. All charges above $150 will be the responsibility of the Member. The test must be performed in a nationally accredited laboratory. A Member seeking coverage for bone marrow suitability testing under this benefit must, at the time of testing, sign a consent form that authorizes the

Benefit	Description
Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers) (Continued)	
	results of the test to be used for participation in the National Marrow Donor Program, or its successor organization. The consent form must acknowledge the Member's willingness to be a bone marrow donor if a suitable match is found. Only one test is covered in a Member's lifetime. In addition, the Plan covers the following: • Diagnostic screening and tests, including blood tests and screenings mandated by state law. • Screening mammograms at least once a year for women 40 years of age and over, and non-routine mammograms. A screening mammogram also includes an additional radiological procedure recommended by a Provider when the initial radiologic procedure results are not definitive. Non-routine mammograms are covered when Medically Necessary. • Comprehensive ultrasound screening of the entire breast. • Magnetic resonance imaging of an entire breast or breasts in accordance with guidelines established by the American Cancer Society. **Please Note:** Your Plan will cover certain preventive services and tests with no Member Cost Sharing. Please see your Schedule of Benefits for the coverage that applies to your Plan. **Prior Approval Required:** You must obtain Prior Approval for computerized axial tomography (CAT and CT and CTA scans); Magnetic resonance imaging (MRI and MRA scans); Nuclear cardiac studies; and Positron emission tomography (PET scans). If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
28 . Low Protein Foods	
	The Plan covers special modified low protein food products prescribed by a licensed Physician for a person with an inborn error of metabolism up to the limit stated in your Schedule of Benefits. **Prior Approval Required:** Prior Approval is required for low protein foods and nutritional supplements when used in conjunction with enteral tube feedings. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information
29 . Maternity Care	
	The Plan covers the following maternity services: • Routine outpatient prenatal care, including evaluation and progress screening, physical exams, recording of weight and blood pressure monitoring. • Prenatal genetic testing. • Delivery, including a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean section. Any decision to shorten the inpatient stay for the mother and her newborn child will be made by the attending Physician and the mother. • Routine newborn care, including Hospital nursery care, Physician services, vaccines and immunizations, and vitamins prior to discharge.

Benefit	Description
Maternity Care (Continued)	
	• Routine outpatient postpartum care for the mother up to six weeks after delivery. **Please Note:** Your Plan will cover certain preventive services and tests with no Member Cost Sharing. Please see your Schedule of Benefits for coverage that applies to your Plan. **Prior Approval Required:** You must obtain Prior Approval for any planned inpatient admission or when a newborn is admitted to a neonatal intensive care unit. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
30 . Medical Formulas	
	The Plan covers the following up to the limit stated in your Schedule of Benefits: 1) Metabolic formulas prescribed by a licensed Physician for a person with an inborn error of metabolism 2) Amino acid-based elemental infant formula for children two years of age and under without regard to the method of delivery of the formula to the extent Medically Necessary as defined below. Coverage will be provided when a licensed Physician has diagnosed, and through medical evaluation has documented, one of the following conditions: • Symptomatic allergic colotis or proctitis • Laboratory or biopsy-proven allergic or eosinophilic gastroenteritis • A history of anaphylaxis • Gastroesophageal reflux disease that is non-responsive to standard medical therapies • Severe vomiting or diarrhea resulting in clinically significant dehydration requiring medical treatment • Cystic fibrosis • Malabsorption of cow milk-based or soy milk-based infant formula In addition to meeting the conditions stated in the definition of Medically Necessary, amino acid-based elemental infant formula will be considered Medically Necessary when the following conditions are met: • The amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater; and • Other commercial infant formulas including cow milk-based and soy milk-based formulas have been tried and have failed or are contraindicated We may require that a licensed Physician confirm and document at least annually that the formula remains Medically Necessary. **Prior Approval Required:** You must obtain Prior Approval for outpatient formulas and enteral nutrition. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.

Benefit	Description
31 . Mental Health and Substance Use Disorder Treatment	
	The Plan covers Medically Necessary mental health and substance use disorder treatment in an inpatient, outpatient or home setting, whichever is most appropriate for your care. Please also see the "Autism Spectrum Disorders Treatment" and "Gender Affirming Services" benefits for more information. In a Medical Emergency you should go to the nearest emergency facility or call 911 or your local emergency number. If you are admitted, you must call the Plan at 1–888–333–4742 within 48 hours or as soon as you can. This telephone number is also on your ID card. If an attending emergency physician contacts us or your PCP, then no further notice is needed. Please see *Glossary* for more information on Medical Emergency Services. The Plan will provide coverage for the care of all conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders or International Classification of Diseases (ICD). Services for all other conditions not identified above will be covered to the extent Medically Necessary. Please also see the "Autism Spectrum Disorders Treatment" and "Gender Affirming Services" benefits for more information. Please refer to your Schedule of Benefits for the Member Cost Sharing that apply to the coverage of these services, **Mental Health and Substance Use Disorder Treatment** Subject to your Member Cost Sharing stated in your Schedule of Benefits, the Plan provides coverage for the following Medically Necessary mental health and substance use disorder treatment: 1. **Inpatient Services** • Mental health services • Substance use disorder treatment • Detoxification services 2. **Intermediate Care Services** • Acute residential treatment (including detoxification) • Partial hospitalized programs (PHP) • Intensive outpatient programs (IOP) 3. **Outpatient Services** • Care by a licensed mental health professional (including online counseling through secure digital messaging) • Crisis intervention services (crisis care stabilization) • In-home family stabilization • Substance use disorder treatment • Detoxification services • Medication management • Methadone maintenance • Psychological testing and neuropsychological testing • Repetitive Transcranial Magnetic Stimulation (rTMS). **Prior Approval Required:** You must obtain Prior Approval for the following services:

Benefit	Description
Mental Health and Substance Use Disorder Treatment (Continued)	
	• **Psychological and neuropsychological testing** • **Applied Behavior Analysis (ABA) services for the treatment of Autism** • **Repetitive Transcranial Magnetic Stimulation (rTMS)** If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
32 . Observation Services	
	The Plan covers observation services including short term treatment, assessment and reassessment for up to 48 hours in an acute care facility (i.e. Hospital). Observation services determine if a Member needs to be admitted for additional treatment or if the Member is able to be discharged from the Hospital.
33 . Ostomy Supplies	
	The Plan covers ostomy supplies up to the Benefit Limit listed in the Schedule of Benefits. Only the following supplies are covered: • Irrigation sleeves, bags and catheters • Pouches, face plates and belts • Skin barriers
34 . Palliative Care	
	The Plan covers palliative care in conjunction with inpatient, home health care, hospice and physician services. Member Cost Sharing for palliative care is included in the cost sharing associated with these services. Palliative care is a medical specialty that supports improved quality of life for Members with chronic or serious illness. Care is focused on providing relief from symptoms and the stress of illness. Palliative care can be provided at any stage of illness, along with treatment for your condition while remaining under the care of your regular provider. This care is offered alongside curative or other treatments you may be receiving. Palliative care may include physician services, nursing care, home health care, pain and symptom management, medication management, rehabilitation therapies (occupational, physical, speech and pulmonary), behavioral health services and durable medical equipment.
35 . Physician and Other Professional Office Visits	
	Physician services, including services of all covered medical professionals, can be obtained on an outpatient basis at a Physician's office or a Hospital. These services may include: • Routine physical examinations, including annual gynecological examination (screening Pap tests, routine pelvic and clinical breast examinations) and annual digital rectal test for the early detection of prostate cancer between ages 50 and 72 • Follow-up care provided by an obstetrician or gynecologist for obstetrical or gynecological conditions identified during maternity care or annual gynecological visit • Immunizations, including childhood immunizations as recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention and the American Academy of Pediatrics

Benefit	Description
Physician and Other Professional Office Visits (Continued)	
	• Second opinions • Well baby and well child care • Health education, including nutritional counseling and smoking cessation counseling for medical, mental health or substance use disorder conditions • Palliative care • Sickness and injury care • Vision and Hearing screenings • Medication management • Chemotherapy • Radiation therapy • Inhalation therapy • Infusion therapy • Allergy injections **Please Note:** Your Plan will cover certain preventive services and tests with no Member Cost Sharing. If the primary purpose for an office visit is for the delivery of preventive health services, no Member Cost Sharing will be applied. However, if the primary purpose for the office visit is for something other than the delivery of preventive health services, Member Cost Sharing will be applied. Please see your Schedule of Benefits for the coverage that applies to your Plan.
36 . Preventive and Well-Care Services	
	The Plan covers preventive and well-care services in accordance with Federal law. Please see your Schedule of Benefits for additional information.
37 . Prosthetic Devices	
	The Plan covers prosthetic devices when ordered by a Provider. The cost of the repair and maintenance of a covered device is also covered. In order to be covered, all devices must be able to withstand repeated use. Coverage is only available for: • The least costly prosthetic device (excluding prosthetic arms and legs) adequate to allow you to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports; and • One item of each type of prosthetic device that meets a Member's medical need. No back-up items or items that serve a duplicate purpose are covered. Covered prostheses include: • Breast prostheses, including replacements and mastectomy bras • Prosthetic arms and legs which are the most appropriate model that meets the Member's medical needs (including myoelectric and bionic arms and legs that adequately allow you to perform Activities of Daily Living.) **Please Note:** Some plans cover one additional prosthetic device for Members under the age of 18 that is determined to be the most appropriate model to meet the Member’s needs for sports or recreational

Benefit	Description
Prosthetic Devices (Continued)	
	purposes. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. • Prosthetic eyes • Wigs and scalp hair prostheses, up to the Benefit Limit listed in the Schedule of Benefits if a Covered Benefit, when needed for hair loss suffered as a result of the treatment for any form of cancer or leukemia or for certain pathologic conditions such as alopecia areata, alopecia totalis, alopecia medicamentosa or permanent loss of scalp hair due to injury. Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan. **Prior Approval Required:** You must obtain Prior Approval for upper and lower prosthetic arms and legs. If you use a Plan Provider located within the Service Area, he or she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
38 . Reconstructive Surgery	
	The Plan covers reconstructive and restorative surgical procedures as follows: • Reconstructive surgery is covered when the surgery can reasonably be expected to improve or correct a Physical Functional Impairment resulting from an Accidental Injury, illness, congenital anomaly, birth injury or prior surgical procedure. If reconstructive surgery is performed to improve or correct a Physical Functional Impairment, as stated above, Cosmetic Services that are incidental to that surgery are also covered. After a Physical Functional Impairment is corrected, no further Cosmetic Services are covered by the Plan. • Restorative surgery is covered to repair or restore appearance damaged by an Accidental Injury. (For example, this benefit would cover repair of a facial deformity following an automobile Accident.) Benefits are also provided for post mastectomy care, including coverage for: • Prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient; • Reconstruction of the breast on which the mastectomy was performed; and • Surgery and reconstruction of the other breast to produce a symmetrical appearance. Benefits include coverage for procedures that must be done in stages, as long as you are an active member. Membership must be effective on all dates on which services are provided. There is no coverage for Cosmetic Services or surgery except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an Accidental Injury, (3) post-mastectomy care as described above and (4) gender affirming procedures and related services when Medically Necessary.

Benefit	Description
Reconstructive Surgery (Continued)	
	Important Notice: We use clinical guidelines to evaluate whether different types of reconstructive and restorative procedures are Medically Necessary. If you are planning to receive such treatment, you may review the current Medical Necessity Guidelines. To obtain a copy, please call **1-888-333-4742.** **Prior Approval Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
39 . Rehabilitation Hospital Care	
	The Plan covers care in a facility licensed to provide rehabilitative care on an inpatient basis. Coverage is provided when you need daily Rehabilitation Services that must be provided in an inpatient setting. Rehabilitation Services include cardiac rehabilitation therapy, physical therapy, pulmonary rehabilitation therapy, occupational therapy and speech therapy. The Benefit Limit is listed in the Schedule of Benefits. **Prior Approval Required:** You must obtain Prior Approval for rehabilitation hospital care. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
40 . Rehabilitation and Habilitation Services – Outpatient	
	The Plan covers the following outpatient Rehabilitation and Habilitation Services: • Cardiac rehabilitation therapy • Occupational therapy • Physical therapy • Pulmonary rehabilitation therapy • Speech therapy Outpatient Rehabilitation and Habilitation Services are covered up to the Benefit Limit listed in the Schedule of Benefits. Services are covered only: • If, in the opinion of your Provider, there is likely to be significant improvement in your condition within the period of time benefits are covered; and • When needed to improve your ability to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports. Rehabilitation and Habilitation Services are also covered under your inpatient Hospital and home health benefits. When such therapies are part of an approved home care treatment plan they are available as described under in section *III. Covered Benefits* under *, Home Health Care*. **Prior Approval Required:** You must obtain Prior Approval for coverage of outpatient physical, occupational, and speech therapy. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.

Benefit	Description
Rehabilitation and Habilitation Services – Outpatient (Continued)	
	Please Note: Outpatient physical, occupational, and speech therapies for children up to the age of 3 are covered to the extent Medically Necessary. The benefit limit stated in the Schedule of Benefits does not apply.
41 . Scopic Procedures – Outpatient Diagnostic	
	The Plan covers diagnostic scopic procedures and related services received on an outpatient basis. Diagnostic scopic procedures are those for visualization, biopsy and/or polyp removal. Scopic procedures are: • Colonoscopy • Endoscopy • Sigmoidoscopy In addition, the Plan covers any screening colonoscopy or sigmoidoscopy and any other colorectal cancer examination and laboratory test recommended by a Plan Provider in accordance with the most recently published colorectal cancer screening guidelines of a national cancer society. Coverage includes colorectal cancer screening for individuals at average risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society or individuals at high risk for colorectal cancer.
42 . Skilled Nursing Facility Care	
	The Plan covers care in a health care facility licensed to provide skilled nursing care on an inpatient basis. Coverage is provided only when you need daily skilled nursing care that must be provided in an inpatient setting. The Benefit Limit is listed in the Schedule of Benefits. **Prior Approval Required:** You must obtain Prior Approval for Skilled Nursing Facility care. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
43 . Surgery - Outpatient	
	The Plan covers outpatient surgery, including related services. Outpatient surgery is defined as any surgery or procedure in a day surgery department, ambulatory surgery department or outpatient surgery center. **Please Note:** In Massachusetts, Maine, Rhode Island and New Hampshire, there are certain specialized services that must be received from designated Plan Providers, referred to as "Centers of Excellence" to receive In-Network coverage. Please see section *I.D.4. Centers of Excellence* for further information. **Prior Approval Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section*I.F. PRIOR APPROVAL* for more information.

Benefit	Description
44 . Telemedicine Virtual Visit Services	
	The Plan covers Medically Necessary telemedicine virtual visit services for the purpose of evaluation, diagnosis, consultation, monitoring, or treatment of a Member's physical health, oral health, mental health, or substance use disorder condition. Telemedicine virtual visit services include the use of synchronous or asynchronus audio, video, electronic media or other telecommunications, technology including (a) interactive audio video technology; (b) remote patient monitoring devices; (c) audio-only telephone; (d) online adaptive interviews; and (e) telemonitoring. Your Provider must be appropriately licensed in the state in which you are located when receiving telemedicine services. Member Cost Sharing for telemedicine virtual visit services will be the same or less than the Member Cost Sharing for the same type of service if it had been provided through an in-person consultation. Please refer to your Schedule of Benefits for specific information on Member Cost Sharing you may be required to pay.
45 . Temporomandibular Joint Dysfunction Services	
	The Plan covers medical treatment of Temporomandibular Joint Dysfunction (TMD). Only the following services are covered: • Consultation with a Physician • Physical therapy (subject to the visit limit for outpatient physical therapy listed in the Schedule of Benefits) • Surgery • X-rays **Important Notice:** No Dental Care is covered for the treatment of Temporomandibular Joint Dysfunction (TMD). **Prior Approval Required:** You must obtain Prior Approval for surgery under this benefit. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
46 . Travel Reimbursement Benefit	
	The Plan may reimburse you for travel expenses related to Covered Benefits that are restricted by law in the state where you reside. Examples may include voluntary termination of pregnancy and gender affirming surgery for minors. You may be eligible for this benefit when: • your Plan includes coverage for the services you will be receiving. • you reside in a state where access to the Covered Benefit is not available because state law restricts a Provider from providing you with the service. • you are required to travel at least 100 miles from your residence to obtain the Covered Benefit. When the above criteria are met, you may be reimbursed for certain transportation and lodging expenses. These services must be "primarily for and essential to" receiving medical care (per Internal Revenue Code (IRC) § 213(d)). Reimbursement is for you and one companion when necessary to enable you to receive the Covered Benefit, as follows: 1. **Round trip transportation** including air, train, bus, taxi and ride-sharing service, car rental, tolls, and parking expenses will be

Benefit	Description
Travel Reimbursement Benefit (Continued)	
	reimbursed for travel between your home and the location at which you receive the Covered Benefit. • Travel by air and train is limited to commercially scheduled coach-class tickets and will not count toward a daily travel maximum if one has been established by your employer. • Mileage is based on the current Internal Revenue Service (IRS) medical mileage reimbursement, which includes gasoline. 2. **Lodging** expenses will be reimbursed up to $50 per person per night (up to $100 if you travel with a companion) when the medical care is provided by a physician in a licensed hospital (or in a medical care facility which is related to, or the equivalent of, a licensed hospital). **Please Note:** Reimbursement for travel expenses for transportation and lodging is only available for the Member receiving the Covered Benefit and one companion. In accordance with the IRC, companion coverage is allowed only when the assistance of a companion is necessary for the Member to receive the covered medical services (e.g., parental consent is required, there is sedation that causes the Member to require assistance). PLR 8516025; IRS Pub. 502. To be eligible for this benefit, you must attest to satisfying the eligibility criteria above, travel expenses incurred, and, if applicable, the necessity of companion travel. You will need to complete a reimbursement form that includes this attestation information and provide the Plan with proof of membership and proof of payment. Please see section *V. Reimbursement and Claims Procedures* for information on how to submit for reimbursement. To obtain a reimbursement form, please contact Member Services at **1-888-333-4742** or by going to **www.harvardpilgrim.org**. **Important Notice:** Failure to adhere to reimbursement requirements explained above may result in your reimbursement being considered taxable income. **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.
47 . Urgent Care Services	
	The Plan covers Urgent Care services that you receive at (1) a convenience care clinic (retail health clinics), (2) an urgent care center, or (3) a Hospital urgent care center. (1) **Convenience care clinics:** Convenience care clinics provide treatment for minor illnesses and injuries. They are usually staffed by non-Physician providers, such as Nurse practitioners, and are located in stores, supermarkets, or pharmacies. To see a list of convenience care clinics covered by the Plan, please refer to your Provider Directory and search under "convenience care." (2) **Urgent care centers:**Urgent care centers provide treatment for illnesses and injuries that require urgent attention but are not life threatening. Urgent care centers are independently owned and operated centers that are considered standalone facilities, not departments of a Hospital.They are staffed by doctors, Nurse practitioners, and Physician assistants. To see a list of urgent care centers covered by the Plan, please refer to your Provider Directory and search under "urgent care."

Benefit	Description
Urgent Care Services (Continued)	
	(3) **Hospital urgent care centers:** Some Hospitals provide treatment for urgent care services as part of the Hospital's outpatient services. A Hospital urgent care center may be located within a Hospital, or at a satellite location separate from the Hospital. These urgent care centers are owned and operated by the Hospital and are considered a department of the Hospital. They are staffed by doctors, nurse practicioners, and physician assistants and provide treatment for illnesses and injuries that require urgent attention but are not life threatening. Because the services provided are considered outpatient Hospital services, only the Hospitals are listed in the Provider Directory. These services may require higher Member Cost Sharing than urgent care services received at independent urgent care centers. **Please note:** Hospital urgent care center services are treated differently than similar services received in a Hospital emergency room. For information on services received in a Hospital emergency room, please see the Emergency Room Care benefit above, and in your Schedule of Benefits. Please refer to your Schedule of Benefits for the Member Cost Sharing applicable to each type of Urgent Care service. Coverage for Urgent Care is provided for services that are required to prevent deterioration to your health resulting from an unforeseen Sickness or injury. Covered services include, but are not limited to, the following: • Care for minor cuts, burns, rashes or abrasions, including suturing • Treatment for minor illnesses and infections, including earaches • Treatment for minor sprains or strains Whenever possible, you should contact your PCP prior to obtaining Urgent Care. Your PCP may be able to provide the services you require at a lower out-of-pocket cost. **Important Notice:** Urgent care is not emergency care. You should call 911 or go directly to a Hospital emergency room if you suspect you are having a Medical Emergency. These include heart attack or suspected heart attack, shock, major blood loss, or loss of consciousness. Please see section *I.D.7. Medical Emergency Services* for more information.
48 . Vision Services	
	Urgent Eye Care: The Plan covers urgent eye care services. Urgent eye care services are services provided to treat conditions, illnesses or diseases of the eye that if not treated within 24 hours present a serious risk of harm. **Routine Eye Examinations:** The Plan may cover routine eye examinations. **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. **Vision Hardware for Special Conditions:** The Plan provides coverage for contact lenses or eyeglasses needed for the following conditions:

Benefit	Description
Vision Services (Continued)	
	• Keratoconus. One pair of contact lenses is covered per Plan Year or Calendar Year. The replacement of lenses, due to a change in the Member's condition, is limited to 3 per affected eye per Plan Year or Calendar Year. • Post cataract surgery with an intraocular lens implant (pseudophakes). Coverage is limited to $140 per surgery toward the purchase of eyeglass frames and lenses. The replacement of lenses due to a change in the Member's prescription of .50 diopters or more within 90 days of the surgery is also covered up to a limit of $140. • Post cataract surgery without lens implant (aphakes). One pair of eyeglass lenses or contact lenses is covered per Plan Year or Calendar Year. Coverage up to $50 per Plan Year or Calendar Year is also provided for the purchase of eyeglass frames. The replacement of lenses due to a change in the Member's condition is also covered. Replacement of lenses due to wear, damage, or loss, is limited to 3 per affected eye per Plan Year or Calendar Year. • Post retinal detachment surgery. For a Member who wore eyeglasses or contact lenses prior to retinal detachment surgery, the Plan covers the full cost of one lens per affected eye up to one Plan Year or Calendar Year after the date of surgery. For Members who have not previously worn eyeglasses or contact lenses, the Plan covers either (1) a pair of eyeglass lenses and up to $50 toward the purchase of the frames, or (2) a pair of contact lenses. **Early Refills for Prescription Eye Drops:** If you have prescription drug coverage, the plan covers one early refill of prescription eye drops if the following criteria are met: • At least 70% of the authorized days of use must have elapsed; • The original prescription must indicate that a specific number of refills are authorized; and • The refill request must not exceed the number of refills on the original prescription. **Please Note:** Not all Plans include prescription drug coverage. If you have outpatient prescription coverage, your Member Cost Sharing for prescription drugs purchased at a pharmacy will be listed on your ID Card. Additional details on prescription drug coverage and limitations can be found in the Prescription Drug Brochure or on our website at **www.harvardpilgrim.org**.
49 . Voluntary Sterilization	
	The Plan may cover voluntary sterilization, including tubal ligation and vasectomy. **Please Note:** Not all Plans cover male sterilization. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.
50 . Voluntary Termination of Pregnancy	
	The Plan may cover voluntary termination of pregnancy. **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.

IV. Exclusions

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

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

Exclusion	Description
1 . Alternative Treatments	
	1. Acupuncture care except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. 2. Acupuncture services that are outside the scope of standard acupuncture care. 3. Alternative or holistic services and all procedures, laboratories and nutritional supplements associated with such treatments. 4. Any of the following types of programs: Health resorts, spas, recreational programs, camps, wilderness programs (therapeutic outdoor programs), outdoor skills programs, life skills programs, therapeutic or educational boarding schools, and relaxation or lifestyle programs. Please note: Covered Benefits received while a Member is participating in a program, such as a wilderness program, may be reimbursed if the Provider separately identifies and submits bills for Medically Necessary services that are Covered Benefits and all other terms of coverage under the Plan are met, including any applicable provider network and Member Cost Sharing requirements. 5. Aromatherapy, treatment with crystals and alternative medicine. 6. Massage therapy when performed by anyone other than a licensed physical therapist, physical therapy assistant, occupational therapist, or certified occupational therapy assistant. 7. Myotherapy. 8. Services by a naturopath that are not covered by other Providers under the Plan.
2 . Clinical Trials	
	Coverage is not provided for the following: 1. The investigational item, device, or service itself; or 2. For services, tests or items that are provided solely to satisfy data collection and analysis for the clinical trial and that are not used for the direct clinical management of your condition.
3 . Dental Services	
	1. Temporomandibular Joint Dysfunction (TMD) care, except the specific medical treatments listed as Covered Benefits in this Benefit Handbook. 2. Dental Care, except the specific dental services listed in this Benefit Handbook, your Schedule of Benefits, and any associated Riders. 3. Extraction of teeth, except when specifically listed as a Covered Benefit. (Please see your Schedule of Benefits and any associated riders to determine if your Plan provides coverage for this benefit.)

Exclusion	Description
4 . Durable Medical Equipment and Prosthetic Devices	
	1. Any devices or special equipment needed for sports or occupational purposes except when specifically listed as a Covered Benefit. 2. Any home adaptations, including, but not limited to home improvements and home adaptation equipment. 3. Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. 4. Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.
5 . Experimental, Unproven or Investigational Services	
	1. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.
6 . Foot Care	
	1. Foot orthotics, except for the treatment of severe diabetic foot disease or systemic circulatory diseases. 2. Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members diagnosed with diabetes or systemic circulatory diseases.
7 . Maternity Services	
	1. Planned home births. 2. Services provided by a doula
8 . Mental Health and Substance Use Disorder Treatment	
	1. Educational services or testing, except services covered under the benefit for Early Intervention Services. No benefits are provided: (1) for educational services intended to enhance educational achievement; or (2) to resolve problems of school performance. 2. Mental health care that is (1) provided to Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health. 3. Sensory integrative praxis tests.
9 . Physical Appearance	
	1. Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) reconstructive surgery to repair or restore appearance damaged by an Accidental Injury and (3) post-mastectomy care, and (4) gender affirming procedures and related services when Medically Necessary. 2. Electrolysis or laser hair removal, except for what is Medically Necessary as part of gender affirming services. 3. Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. 4. Liposuction, except for what is Medically Necessary as part of gender affirming services, or removal of fat deposits considered undesirable. 5. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). 6. Skin abrasion procedures performed as a treatment for acne.

Exclusion	Description
Physical Appearance (Continued)	
	7. Treatments and procedures related to appearance including but not limited to abdominoplasty; chemical peels; collagen injections; dermabrasion; implantations (e.g. cheek, calf, pectoral, gluteal); lip reduction/enhancement; panniculectomy; removal of redundant skin; and silicone injections (e.g. for breast enlargement), except for what is Medically Necessary as part of gender affirming services or another Covered Benefit. 8. Treatment for skin wrinkles and skin tags or any treatment to improve the appearance of the skin. 9. Treatment for spider veins. 10. Wigs, except when specifically listed as a Covered Benefit. (Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.). 11. Wigs and scalp hair prostheses when hair loss is due to male pattern baldness, female pattern baldness, or natural or premature aging.
10 . Procedures and Treatments	
	1. Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than the initial x-ray. 2. Chiropractic care, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. 3. Commercial diet plans, weight loss programs and any services in connection with such plans or programs. Please note: Your employer may participate in other wellness and health improvement incentive programs offered by HPHC. Please review all your Plan documents for the amount of incentives, if any, available under your Plan. 4. Early intervention services, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. 5. Group diabetes educational programs or camps. 6. If a service received in Massachusetts, Maine, Rhode Island or New Hampshire is listed as requiring that it be provided at a Center of Excellence, no In-Network coverage will be provided under this Handbook if that service is received in Massachusetts, Maine, Rhode Island or New Hampshire from a Provider that has not been designated as a Center of Excellence. Please see the Benefit Handbook section *"Centers of Excellence"* for more information. 7. Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). 8. Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

Exclusion	Description
Procedures and Treatments (Continued)	
	9. Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. 10. Testing for central auditory processing.
11 . Providers	
	1. Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and Hospital or other facility charges, that are related to any care that is not a Covered Benefit under this Handbook. 2. Charges for services which were provided after the date on which your membership ends. 3. Charges for missed appointments. 4. Concierge service fees. (See section *I.I. PROVIDER FEES FOR SPECIAL SERVICES (CONCIERGE SERVICES)* for more information.) 5. Inpatient charges after your Hospital discharge. 6. Provider's charge to file a claim or to transcribe or copy your medical records. 7. Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
12 . Reproduction	
	1. Services for a surrogate or gestational carrier who is not a Member of the Plan. 2. Birth control drugs, implants and devices. This exclusion may apply when coverage is provided by a religious organization, as allowed by law. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. 3. Infertility drugs if a member is not in a Plan authorized cycle of infertility treatment. 4. Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage. 5. Intrauterine insemination (IUI) services provided in the home. 6. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). 7. Sperm collection, freezing and storage except as described in section *III. Covered Benefits* 8. Sperm identification when not Medically Necessary (e.g., gender identification). 9. The following fees: wait list fees, non-medical costs, shipping and handling charges etc. 10. Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. 11. Voluntary termination of pregnancy, unless necessary to preserve the life or health of a Member, or unless it is specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.

Exclusion	Description
13 . Services Provided Under Another Plan	
	1. Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. 2. Costs for services covered by third party liability, other insurance coverage, and which are required to be covered by a Workers' Compensation plan or an employer under state or federal law, unless a notice of controversy has been filed with the Workers' Compensation Board contesting the work-relatedness of the claimant's condition and no decision has been made by the Board, if applicable.
14 . Telemedicine	
	1. Provider fees for technical costs for the provision of telemedicine services. 2. Telemedicine services involving e-mail, or fax. 3. Telemedicine services involving audio-only telephone, except where telemedicine is technologically unavailable at a scheduled time and is medically appropriate for the corresponding covered health services.
15 . Types of Care	
	1. Custodial care 2. Rest or domiciliary care. 3. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. 4. Pain management programs or clinics. 5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. 6. Private duty nursing. 7. Sports medicine clinics. 8. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
16 . Vision and Hearing	
	1. Eyeglasses, contact lenses and fittings, except as listed in this Benefit Handbook and any associated Riders. 2. Hearing aids, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. 3. Over the counter hearing aids. 4. Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism. 5. Routine eye examinations, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.

Exclusion	Description
17 . All Other Exclusions	
	1. Any drug or other product obtained at an outpatient pharmacy, except for pharmacy supplies covered under the benefit for diabetes services, unless your Plan includes outpatient pharmacy coverage. 2. Any service or supply furnished in connection with a non-Covered Benefit. 3. Any service or supply (with the exception of contact lenses) purchased from the internet. 4. Any service, supply or medication when there is a less intensive Covered Benefit or more cost-effective alternative that can be safely and effectively provided, in accordance with applicable Medical Necessity Guidelines. 5. Any service, supply or medication, including physical examinations and testing, required by a third party that is not otherwise Medically Necessary (examples of a third party are an employer, an insurance company, a school, a camp or court). 6. Beauty or barber service. 7. Cost of organs that are sold rather than donated to recipients. 8. Diabetes equipment replacements when solely due to manufacturer warranty expiration. Digital therapeutics. 9. Donated or banked breast milk, unless specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. 10. Externally powered exoskeleton assistive devices and orthoses. 11. Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law and prescribed for Members who meet HPHC policies for enteral tube feedings. 12. Guest services. 13. Medical equipment, devices or supplies except as listed in this Benefit Handbook. 14. Medical services that are provided to Members who are confined or committed to jail, house of correction, prison, or custodial facility of the Department of Youth Services. 15. Reimbursement for travel expenses, except (1) when specifically listed as a Covered Benefit, and (2) as described in this Benefit Handbook. Excluded services include, but are not limited to: • Alcohol and tobacco. • Childcare expenses. • Entertainment. • Expenses for anyone other than you and your companion. • First class, business class and other luxury transportation services. • Lodging other than at a hotel or motel. • Lost wages. • Meals.

Exclusion	Description
All Other Exclusions (Continued)	
	• Personal care and hygiene items. • Telephone calls. • Tips and gratuities. 16. Services for non-Members. 17. Services for which no charge would be made in the absence of insurance. 18. Services for which no coverage is provided in this Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure. Services provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor. 19. Services that are not Medically Necessary. 20. Taxes or governmental assessments on services or supplies. 21. Transportation, except for emergency ambulance transport, and non-emergency medical transport needed to transfer between hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary or when specifically listed as a Covered Benefit. 22. Voice modification surgery, except when Medically Necessary for gender affirming services. 23. The following products and services: • Air conditioners, air purifiers and filters, dehumidifiers and humidifiers. • Car seats. • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners. • Electric scooters. • Exercise equipment. • Home modifications including but not limited to elevators, handrails and ramps. • Hot tubs, jacuzzis, saunas or whirlpools. • Mattresses. • Medical alert systems. • Motorized beds. • Pillows. • Power-operated vehicles. • Stair lifts and stair glides. • Strollers. • Safety equipment. • Vehicle modifications including but not limited to van lifts. • Telephone. • Television.

V. Reimbursement and Claims Procedures

The information in this section applies when you wish to file a claim or seek reimbursement following receipt of Covered Benefits. In most cases, you should not receive bills from Plan Providers.

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

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

You can obtain information about your applicable Member Cost Sharing online at **www.harvardpilgrim.org** or by calling the Member Services Department at **1-888-333-4742**

A. HOW TO FILE A CLAIM (PROOF OF LOSS)

Proof of loss is administered under this Handbook by filing a claim on health care reimbursement claims forms. Such forms may be obtained online at **www.harvardpilgrim.org** or by calling HPHC's Member Services Department at **1-888-333-4742**.

Standard health care industry claim forms, known as the CMS 1500 and the UB-04 will also be accepted. Such forms are also available at most Hospitals and Physician's offices. In order to be paid by the Plan, all claims must be filed in writing or electronically. (Providers should contact HPHC for instructions concerning electronic filing.) Claims for services must be submitted to the following addresses:

Pharmacy Claims:

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

All Other Claims:

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

If you request a health care reimbursement claim form from HPHC's Member Services Department, one will be provided to you within 15 days.

Please note: Prior Approval is required to receive full coverage for certain services. Please see section *I.F. PRIOR APPROVAL* for more information on these requirements. For services that require Prior Approval from HPHC, please have your Provider call **1-800-708-4414**.

B. REIMBURSEMENT FOR BILLS YOU PAY

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

- The Member's full name and address
- The Member's date of birth
- The Member's Plan ID number (on the front of the Member's Plan ID card)
- The Member's signature
- The name and address of the person or facility providing the services for which a claim is made and their Tax Identification Number (TIN) or National Provider Identification (NPI) number
- The Member's diagnosis description, diagnosis code, or ICD 10 code
- The date the service was rendered

- The CPT code (or a brief description of the illness or injury) for which payment is sought
- The amount of the provider's charge
- Proof that you have paid the bill (if reimbursement is sought)
- Other insurance information

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

A medical reimbursement form can be obtained online at **www.harvardpilgrim.org** or by calling the Member Services Department at **1-888-333-4742**.

1. International Claims

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

2. Pharmacy Claims

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

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

The following information must be on the Prescription Claim Form:

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

Important Notice: Reimbursement for prescription drugs will only be made if your plan includes our optional outpatient pharmacy coverage. Please see your Prescription Drug Brochure (if applicable) for more information.

If you have a question regarding your reimbursement, you should contact the Member Services Department at **1-888-333-4742**.

C. TIME LIMITS ON FILING CLAIMS

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

D. TIME LIMITS FOR THE REVIEW OF CLAIMS

HPHC will generally review claims within the time limits stated below. Under some circumstances these time limits may be extended by the Plan upon notice to Members. Unless HPHC notifies a Member that an extension is required, the review time for the types of claims outlined below will be as follows:

- **Pre-service claims.** A pre-Service claim is one in which coverage is requested for a health care service that the Member has not yet received. Pre-service claims will generally be processed within 15 days after receipt of the claim by HPHC.
- **Post-service claims.** A post-service claim requests coverage of a health care service that the Member has already received. Post-service claims will generally be processed within 30 days after the receipt of the claim by HPHC.
- **Urgent Care claims**. Urgent Care claims will generally be processed within 72 hours of receipt of the claim by HPHC. An Urgent Care claim is one in which the use of the standard time period for processing pre-service claims:
    1. Could seriously jeopardize a Member's life or health or ability to regain maximum function; or
    2. Would result in severe pain that cannot be adequately managed without the care or treatment requested.

  If a physician with knowledge of the Member's medical condition determines that one of the above criteria has been met, the claim will be treated as an Urgent Care claim by HPHC.

E. PAYMENT LIMITS

The Plan limits the amount payable for services that are not rendered by Plan Providers. The most the Plan will pay for such services is the Allowed Amount, unless it is a Surprise Bill. If a service is provided by a Non-Plan Provider, you are responsible for any amount

in excess of the Allowed Amount. You may have to pay the balance if the claim is for more than the Allowed Amount, unless it is a Surprise Bill.

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

F. NOTICE OF CLAIM

The Member is not required to give notice to HPHC prior to the filing of a claim, except for the Prior Approval requirements applicable to certain services. Please see section *I.F. PRIOR APPROVAL* for more information.

G. MISCELLANEOUS CLAIMS PROVISIONS

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

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

VI. Appeals and Complaints

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

A. BEFORE YOU FILE AN APPEAL

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 Services Representative before filing an appeal. A Member Service Representative can be reached toll-free at **1–888–333-4742** or call **711** for TTY service. The Member Service Representative will investigate the claim and either resolve the problem or explain why the claim is being denied. If you are dissatisfied with the response of the Member Service Representative, you may file an appeal using the procedures outlined below.

B. MEMBER APPEAL PROCEDURES

Any Member who is dissatisfied with a decision on the coverage of services may appeal to HPHC. Appeals may be filed by a Member or a Member's authorized representative, including 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.

A Member may also appeal a rescission of coverage. A rescission of coverage is defined in section *2. External Review*.

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

1. Initiating Your Appeal

To initiate your appeal, you or your representative can mail or fax a letter to us or call us about the coverage you are requesting and why you feel the denial should be overturned. If your appeal qualifies as an expedited appeal, you may contact us by telephone. See section *VI.B.3. The Expedited Appeal Process*, for the expedited review procedure.

You must file your appeal within 180 days after you receive notice that a claim has been denied. 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.

An "Authorized Representative" may also submit an appeal on your behalf. A provider for which you are receiving active treatment, and who is acting as your Authorized Representative, must notify you in writing at least 14 days prior to filing an appeal on your behalf, and within 7 days after filing or withdrawing an appeal on your behalf.

You have the right to object to a provider filing an appeal on your behalf at any time. Additionally, you may notify the Plan that you intend take the place of the provider as a party to the appeal.

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

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

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

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

When we receive your appeal, we will assign an Appeals and Grievances Analyst to coordinate your appeal throughout the entire appeal process. We will send you an acknowledgement letter identifying your Appeals and Grievances Analyst. That letter will include detailed information on appeal processes. Your Appeals and Grievances Analyst is available to answer any questions you may have about your appeal. Please feel free to contact your Appeals and Grievances Analyst if you have any questions or concerns at any time during the appeal process.

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

2. The Standard Appeal Process

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

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

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

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

After we receive all the information needed to make a decision, your Appeals and Grievances Analyst will inform you, in writing, whether your appeal is approved or denied. 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; (4) the identification of any medical or vocational expert consulted in reviewing your appeal; and (5) any other information required by law. This decision is the final decision under the appeal process. If the appeal decision is not fully in your favor, the decision will also include a description of other options for further review of your appeal. These are also described in section C, below.

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

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

3. The Expedited Appeal Process

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

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

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

You or your Authorized Representative may request an expedited review.

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

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

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

Important Notice: If you are filing an expedited appeal with HPHC, you may also file a request for expedited external review at the same time. You do not have to wait until HPHC completes your expedited

appeal to file for expedited external review. Please see the section *2. External Review*, for information on how to file for external review.

C. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED

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

1. Reconsideration of an Appeal Decision

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

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

2. External Review

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

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

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

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

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

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

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

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

a. You must request external review within four (4) calendar months of the date you receive notice that your appeal has been denied. If we send a notice of the denial of an appeal by First Class Mail, we will assume receipt of that notice five (5) days after the date of mailing.

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

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

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

   - Denials of coverage based on benefit limitations stated in your Plan documents

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

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

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

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

3. Legal Action

You may also seek legal action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) if your Plan is governed by ERISA. Please note that any legal action under section 502(c) of ERISA must be brought within the time period stated in section *X.A. LIMITATION ON LEGAL ACTIONS*. Please note that governmental plans are not subject to ERISA.

D. THE FORMAL COMPLAINT PROCESS

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

HPHC Member Services Department
Harvard Pilgrim Health Care
1 Wellness Way
Canton, MA 02021
Telephone: 1-888-333-4742
Fax: 1–617–509-3085
www.harvardpilgrim.org

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

VII. Eligibility

Important Notice: Your membership in the Plan is effective on the date of enrollment by your Plan Sponsor . Because your Plan Sponsor may notify HPHC of enrollment changes retroactively, we may not have current information concerning membership status. Only your Plan Sponsor can confirm membership status.

This section describes requirements concerning eligibility under the Plan. It is important to understand that eligibility of Dependents and effective dates of coverage are determined by the Plan Sponsor. Please see your Plan Sponsor for descriptions of eligibility for Dependents and effective dates of coverage.

A. ELIGIBILITY

1. Subscriber Eligibility

To be a Subscriber under this Plan, you must:

1) Be an employee of an 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.

2. Dependent Eligibility

Please see your Plan Sponsor for a description of Dependent eligibility as agreed upon by your Plan Sponsor and HPHC. Please also see section *VII.F. SPECIAL ENROLLMENT RIGHTS*.

B. EFFECTIVE DATE - NEW DEPENDENTS AND EXISTING DEPENDENTS

Please see your Plan Sponsor for information on enrollment and effective dates of coverage. Please also see section *VII.F. SPECIAL ENROLLMENT RIGHTS*.

C. EFFECTIVE DATE - ADOPTIVE DEPENDENTS

An adoptive child who has been living with you, and for whom you have been receiving foster care payments, may be covered from the date the petition to adopt is filed. An adoptive child who has not been living with you may be covered from the date of placement in your home for purposes of adoption by a licensed adoption agency. Please see your Plan Sponsor for information on Dependent eligibility and effective dates of coverage.

D. 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; and death of a Member.

Please Note: We must have your current address on file in order to correctly process claims for Out-of-Network care.

E. 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 the Plan Sponsor's 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.

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

F. SPECIAL ENROLLMENT RIGHTS

If an employee declines enrollment for the employee and his or her Dependents (including his or her spouse) because of other health insurance coverage, the employee may be able to enroll himself or herself, along with his or her Dependents in this Plan if the employee or his or her Dependents lose eligibility for that other coverage (or if the employer stops contributing toward the employee's or Dependents' other coverage). However, you must request enrollment from the Plan Sponsor within 30 days after the other coverage ends (or after the employer stops contributing toward the employee's or Dependents' other coverage). In addition, if an employee has a new Dependent as a result of marriage, birth, adoption or placement for adoption, or if a court order is issued changing custody of a child, the employee may be able to enroll along with his or her Dependents. However, you must request enrollment from the Plan Sponsor within 30 days after the marriage, birth, adoption or placement for adoption, or court order changing custody of a child.

Special enrollment rights may also apply to persons who lose coverage under Medicaid or the Children's

Health Insurance Program (CHIP) or become eligible for state premium assistance under Medicaid or CHIP. An employee or Dependent who loses coverage under Medicaid or CHIP as a result of the loss of Medicaid or CHIP eligibility may be able to enroll in this Plan, if enrollment is requested from the Plan Sponsor within 60 days after Medicaid or CHIP coverage ends. An employee or Dependent who becomes eligible for group health plan premium assistance under Medicaid or CHIP may be able to enroll in this Plan if enrollment is requested within 60 days after the employee or Dependent is determined to be eligible for such premium assistance.

G. NEWBORN COVERAGE

A newborn infant of a Member is eligible for coverage under the Plan from the moment of birth. Please see section *VII.E. ADDING A DEPENDENT* for information on enrollment procedures. Please see section *VII.F. SPECIAL ENROLLMENT RIGHTS* for additional rights upon the birth of a child.

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

If your membership happens to begin while you are hospitalized, coverage starts on the day membership is effective. Please see your Plan Sponsor for information on enrollment and effective date of coverage. All other terms and conditions of coverage under this Handbook will apply.

For In-Network coverage, you must be hospitalized in an In-Network Hospital.

If you are hospitalized at an Out-of-Network Hospital, you must notify HPHC by calling **1-800-708-4414** for medical services. Please see section *I.F. PRIOR APPROVAL* for more information.

VIII. Termination and Transfer to Other Coverage

Important Notice: HPHC may not have current information concerning membership status. Plan Sponsors may notify HPHC of enrollment changes retroactively. As a result, the information HPHC has may not be current. Only your Plan Sponsor can confirm membership status.

A. TERMINATION BY THE SUBSCRIBER

You may end your membership under this Plan with your Plan Sponsor's approval. HPHC must receive a completed Enrollment/Change form from your Plan Sponsor to end your membership.

B. TERMINATION FOR LOSS OF ELIGIBILITY

A Member's coverage will end under this Plan if the Plan Sponsor's contract with HPHC is terminated. A Member's coverage may also end under this Plan for failing to meet any of the specified eligibility requirements.

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

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

PLEASE NOTE: HPHC may not have current information concerning membership status. Plan Sponsors may notify us of enrollment changes retroactively. As a result, the information we have may not be current. Only your Plan Sponsor can confirm membership status.

C. TERMINATION FOR NON-PAYMENT BY THE PLAN SPONSOR

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

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

D. MEMBERSHIP TERMINATION FOR CAUSE

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

- Misrepresentation of a material fact on an application for membership;
- 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, HPHC or other Members and which are unrelated to the Member's physical or mental condition.

Termination of membership for providing false information shall be effective immediately upon notice to a Member. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Termination of membership for the other causes will be effective fifteen (15) days after notice.

E. CONTINUATION OF COVERAGE REQUIRED BY LAW

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

IX. When You Have Other Coverage

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

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

A. BENEFITS IN THE EVENT OF OTHER INSURANCE

Benefits under this Handbook, Schedule of Benefits, and Prescription Drug Brochure (if applicable) will be coordinated to the extent permitted by law with other plans covering health benefits, including: motor vehicle insurance, medical payment policies, homeowners' insurance, governmental benefits (including Medicare), and all Health Benefit Plans. The term "Health Benefit Plan" means all group HMO and other group prepaid health plans, medical or Hospital service corporation plans, commercial health insurance and self-insured health plans. There is no coordination of benefits with Medicaid plans or with Hospital indemnity benefits.

Coordination of benefits will be based upon the Allowed Amount, or Recognized Amount, if applicable, for any service that is covered at least in part by any of the plans involved. If benefits are provided in the form of services, or if a provider of services is paid under a capitation arrangement, the reasonable value of these services will be used as the basis for coordination. No duplication in coverage of services will occur among plans. For prescription drug claims, we will coordinate benefits pursuant to our secondary payer allowed amount in all cases.

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

In the case of Health Benefit Plans that contain provisions for the coordination of benefits, the following rules will determine which health benefit plans are primary or secondary:

1. Employee/Dependent

The benefits of the plan that covers the person as an employee or Subscriber are determined before those of the plan that covers the person as a Dependent.

2. Dependent Children

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

The order of benefits is determined as follows:

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

ii. Dependent Child/Separated or Divorced Parents

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

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

3. Active Employee or Retired or Laid-Off Employee

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

4. COBRA or State Continuation

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

5. Longer/Shorter Length of Coverage

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

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

B. PROVIDER PAYMENT WHEN PLAN COVERAGE IS SECONDARY

When your Plan coverage is secondary to your 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.

C. WORKER'S COMPENSATION/GOVERNMENT PROGRAMS

If HPHC has information indicating that services provided to you are covered under Worker's Compensation, employer's liability or other program of similar purpose, or by a federal, state or other government agency, payment may be suspended for such services until a determination is made whether payment will be made by such program, unless a notice of controversy has been filed with the Workers' Compensation Board contesting the work-relatedness of the claimant's condition and no decision has been made by the Board, if applicable. 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.

D. SUBROGATION AND REIMBURSEMENT FROM RECOVERY

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

If another person or entity is, or is alleged to 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 to recover against such person or entity for the value of the services paid for or provided by the Plan. The Plan will also have the right to be reimbursed from any recovery a Member obtains from such person or entity for 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 or allegedly caused the injury or illness, his/her liability carrier, or your own auto insurance carrier, in cases of uninsured or underinsured motorist coverage. The Plan's right to reimbursement from any recovery will apply even if the recovery the Member receives for the illness or injury is designated or described as being for injuries other than health care expenses or does not fully compensate the Member for his or her damages, fees or costs. Neither the "make whole rule" nor the "common fund doctrine" apply to the Plan's rights of subrogation and/or reimbursement from recovery. The Plan's reimbursement will be made from any recovery the Member receives from an insurance company or any third party and the plan's reimbursement from any such recovery will not be reduced by any attorney's fees, costs or expenses of any nature incurred by, or for, the Member in connection with the Member's receiving such recovery, and the Plan will have no liability for any such attorney's fees, costs or expenses.

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

E. MEDICAL PAYMENT POLICIES

For Members who are entitled to benefits under the medical payment benefit of a motor vehicle, motorcycle, boat, homeowners, hotel, restaurant or other insurance policy, such coverage shall become primary to the coverage under this Benefit Handbook for services rendered in connection with a covered

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

F. MEMBER COOPERATION

You agree 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, c) the prompt assignment to the Plan of any monies 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. You further agree to do nothing to prejudice or interfere with the Plan's rights to subrogation or coordination of benefits.

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

G. 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.

H. MEMBERS ELIGIBLE FOR MEDICARE

When a Member is enrolled in Medicare and receives Covered Benefits that are eligible for coverage by Medicare as the primary payor, the claim must be submitted to Medicare before payment by the Plan. the Plan will be liable for any amount eligible for coverage that is not paid by Medicare. The Member shall take such action as is required to assure payment by Medicare, including presenting his or her Medicare card at the time of service.

For a Member who is eligible for Medicare by reason of End Stage Renal Disease, the Plan will be the primary payor for Covered Benefits during the "coordination period" specified by federal regulations at 42 CFR Section 411.162. Thereafter, Medicare will be the primary payor. When Medicare is primary, (or would be primary if the Member were timely enrolled) the Plan will pay for services covered under Medicare Part B only to the extent payments would exceed what would be payable by Medicare. The Plan will estimate the amount that would be payable by Medicare and pay secondary benefits accordingly. The Plan may apply the same terms when Medicare is primary by reason of age or disability (or would be primary if the Member were timely enrolled).

X. Plan Provisions and Responsibilities

A. LIMITATION ON LEGAL ACTIONS

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

B. ACCESS TO INFORMATION

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

- use in connection with the delivery of care under this Handbook or in the administration of this Handbook, including utilization review and quality assurance;
- 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;
- use in education within HPHC facilities; and
- where required or permitted by law.

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

C. SAFEGUARDING CONFIDENTIALITY

HPHC values individuals' privacy rights and is committed to safeguarding protected health information (PHI) and personal information (PI). To support this commitment, HPHC has established a number of Privacy and Security policies, including those describing the administration of its privacy and security programs, requirements for staff training, and permitted uses and disclosures of PHI and PI. We may collect, use, and disclose financial and medical information about you when doing business with you or with others. We do this in accordance with our privacy policies and applicable state and federal laws. HPHC also requires its business partners who administer health care coverage to you on our behalf to protect your information in accordance with applicable state and federal laws.

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

D. NOTICE

Any Member mailings, including but not limited to, notices, plan documents, invoices, and Activity Statements will be sent to the Member's last address on file with HPHC. It is the Member's responsibility to notify HPHC of an address change to ensure mailed materials are sent to the appropriate address. HPHC is not responsible for mailed materials being sent to the incorrect address if a Member has not updated his/her address with HPHC prior to the materials being mailed out. Notice to HPHC, other than a request for Member appeal, should be sent to:

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

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

E. MODIFICATION OF THIS HANDBOOK

This Benefit Handbook, the Schedule of Benefits, the Prescription Drug Brochure (if applicable) and any applicable riders comprise the entire Plan as agreed to by HPHC and the Plan Sponsor. They can only be amended by HPHC and the Plan Sponsor as stated below. No other action by HPHC or the Plan Sponsor, including the deliberate non-enforcement of any benefit limit shall be deemed to waive or alter any part of these documents.

This Benefit Handbook, the Schedule of Benefits, the Prescription Drug Brochure (if applicable), and any applicable riders and amendments may be amended by agreement, in writing, between HPHC and the Plan Sponsor or, if required by law, by HPHC upon

written notice to the Plan Sponsor. Amendments do not require the consent of Members.

F. HPHC'S RELATIONSHIP WITH PLAN PROVIDERS

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

G. WELLNESS INCENTIVES

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

H. IN THE EVENT OF A MAJOR DISASTER

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

I. EVALUATION OF NEW TECHNOLOGY

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

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

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

J. UTILIZATION REVIEW PROCEDURES

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

- **Prospective Utilization Review (Prior Approval).** HPHC reviews selected inpatient admissions, surgical day care, outpatient/ambulatory procedures, and Medical Drugs prior to the provision of such services to determine whether they meet Medical Necessity Guidelines. Please see section *I.F. PRIOR APPROVAL* for further information on HPHC's Prior Approval requirements, including procedures for which Prior Approval is required. Prior Approval determinations will be made within 72 hours or two working days, whichever is less, after obtaining all necessary information. In the case of a determination to approve an admission, procedure or service, we will give notice via the HPHC provider portal within 24 hours of the decision and will send written confirmation to you and the provider within 72 hours or two working days, whichever is less. If a determination is not made within 72 hours, the request for Prior Approval is granted. In the case of a determination to deny or reduce benefits ("an adverse determination"), HPHC will notify the provider rendering the service by telephone within 24 hours of the decision and will send a

written or electronic confirmation of the telephone notification to you and the provider within one working day thereafter.

- **Concurrent Utilization Review.** HPHC reviews selected ongoing admissions to inpatient Hospitals, rehabilitation Hospitals, including acute care Hospitals, skilled nursing facilities and skilled home health services to assure that services being provided meet Medical Necessity Guidelines for coverage. Concurrent review decisions will be made within one working day of obtaining all necessary information. In the case of a determination to approve additional services or an adverse determination, we will notify the provider rendering the service by telephone within 24 hours of the decision. We will send a written or electronic confirmation of the telephone notification to you and the provider within one working day In the case of ongoing services, coverage will be continued without liability to you until you have been notified of an adverse determination.

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

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

If you wish to determine the status or outcome of a clinical review decision you may call the Member Services Department toll free at **1-888-333-4742**.

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

K. QUALITY ASSURANCE PROGRAMS

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

- **Verification of Provider Credentials** – HPHC credentials our contracted providers by obtaining, verifying and assessing the qualifications to provide care or services by obtaining evidence of licensure, education, training and other experience and/or qualifications.
- **Verification of Facility Credentials** – HPHC credentials our contracted providers by reviewing licensures and applicable certifications based on facility type.
- **Quality of Care Complaints** – HPHC follows a systematic process to investigate, resolve and monitor Member complaints regarding medical care received by a contracted provider.
- **Evidence Based Practice** – HPHC compiles clinical guidelines, based upon the most current evidence-based standards, to assist clinicians by providing an analytical framework for the evaluation and treatment of common health conditions.
- **Performance monitoring** – HPHC participates in collecting data to measure outcomes related to the Health Care Effectiveness Data and Information Set (HEDIS) to monitor health care quality across various domains of evidence-based care and practice.
- **Quality program evaluation**- Annually HPHC develops, plans and implements initiatives to improve clinical service and quality for our members. The Quality Program is documented, tracked and evaluated against milestones and target objectives. The full program description and review is available on our website at **https://www.harvardpilgrim.org/public/about-us/quality**.

L. 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 our management for review and final implementation decisions.

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

HPHC uses Medical Necessity Guidelines 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 annually, or more often if needed to accommodate current standards of practice. This process applies to clinical criteria for both physical and mental health services.

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

Medical Necessity 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.

N. NON-ASSIGNMENT OF BENEFITS

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

O. NEW TO MARKET DRUGS

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

Please Note: Not all Plans provide coverage for outpatient prescription drugs through HPHC. If your Plan does not provide coverage for outpatient prescription drugs through HPHC, coverage under this benefit handbook is limited to Medical Drugs. If your Plan provides coverage for outpatient prescription drugs through HPHC, please refer to your prescription drug brochure for additional information.

P. PAYMENT RECOVERY

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

XI. MEMBER RIGHTS & RESPONSIBILITIES

You have a right to receive information about:

- HPHC's services.
- Plan practitioners and Providers.
- Your rights and responsibilities.

You have a right:

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

You have a responsibility to:

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

HPHC Insurance Company, Inc.

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