



Benefit Handbook

THE HARVARD PILGRIM HMO FOR SELF-INSURED MEMBERS *MASSACHUSETTS*

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

INTRODUCTION

Welcome to the Harvard Pilgrim HMO for Self-Insured Members (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. Harvard Pilgrim Health Care (Harvard Pilgrim or HPHC) administers the plan's benefits on behalf of your Plan Sponsor.

Your health care under the Plan is administered by HPHC through its affiliated network of Primary Care Providers, specialists and other Plan Providers. This is a self-insured health benefits plan for the Plan Sponsor's employees and their dependents. The Plan Sponsor has assumed financial responsibility for this Plan's health care benefits. This type of funding, known as self-funding, allows the Plan Sponsor to self-insure the health care costs associated with its employees with its own resources. HPHC will perform benefits and claims administration, and case management services on behalf of the Plan Sponsor as outlined in this Benefit Handbook and your Schedule of Benefits. HPHC is not, however, the insurer of your coverage.

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

You must choose a Primary Care Provider (PCP) for yourself and each of your family members when you enroll in the Plan. When you enroll, the Plan provides the covered health care services described in this Handbook, the Schedule of Benefits, the Prescription Drug Brochure (if applicable) and any riders. These services must be provided or arranged by your PCP, except as described in section *I.D.1. Your PCP Manages Your Health Care*.

As a Member, you can take advantage of a wide range of helpful online tools and resources. For instance, **HPHConnect** offers you a secure place to help manage your health care. You are able to check your Schedule of Benefits and Benefit Handbook, review prescription drug and medical claim histories, change PCPs, compare hospitals and much more! For details on how to register for an **HPHConnect** 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 a PCP
- Your Benefit Handbook
- Your benefits
- Your enrollment
- Your claims
- Pharmacy management procedures
- Provider Information
- Requesting a Provider Directory
- Requesting a Member Kit

- Requesting ID cards
- Registering a complaint

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

Deaf and hard-of-hearing Members who use a Teletypewriter (TTY) may communicate directly with the Member Services Department by calling our TTY machine at **1-800-637-8257**.

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

**Harvard Pilgrim Health Care
Member Services Department
1600 Crown Colony Drive
Quincy, MA 02169
Phone: 1-888-333-4742
www.harvardpilgrim.org**

Clinical Review Criteria. Harvard Pilgrim Health Care uses clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our clinical review criteria applicable to a service or procedure for which coverage is requested. Clinical review criteria may be obtained by calling **1-888-888-4742 ext. 38723**.

Exclusions or Limitations for Preexisting Conditions. The Plan does not impose any restrictions, limitations or exclusions related to preexisting conditions on your Covered Benefits.

[Spanish]

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

[Russian]

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

[Arabic]

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

[Portuguese]

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

[French]

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

[Greek]

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

[Haitian Creole]

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

[Italian]

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

[Traditional Chinese]

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

[Lao]

ຂະນາສິກ ອັງ ຂລາຍ ທີ່ ບໍ່ ທາກ ມາສາ ອັງກິດ ບໍ່ ຜົນກໍ່ ສາມາດ ຕິດ ຕໍ່ ກັບ ພະນັກ ບໍລິການ ສູນ ຄຳ ຂອງ ໂຄງ ການ ຮັກສາ ສຸຂະພາບ Harvard Pilgrim ໄດ້ ໂດຍ ໂທ ໂປ ຫາ 1-888-333-4742 ຄື້ ອີ້ ຄາຍ ຄຳ ຕອບ ຂອງ ຄຳ ຖາມ ຕ່າງໆ ຂອງ ຕົນ. ໂຄງ ການ ນີ້ ອີ້ ສະບັ ບໍລິການ ຜ່ານ ມາສາ ໃນ ຂລາຍ ກວ່າ 120 ມາສາ ໂດຍ ບໍ່ ສິດ ຄ່າ ບໍລິການ ໂຄງ ອັງ ສິ້ມ.

[Cambodian]

សមាជិកដែលមិនចេះនិយាយភាសាអង់គ្លេស ក៏អាចទូរស័ព្ទទៅភារិយាល័យផ្នែកសេវាមជ្ឈមណ្ឌលសមាជិកនៃ ស្ថានការសុខភាព Harvard Pilgrim Health Care លេខ 1-888-333-4742 ដើម្បីឲ្យគេភ្លើយសំនួរចំពោះជំនួញ។ ។ ស្ថានការសុខភាពនេះមានផ្តល់ជូនសេវាបកប្រែភាសាដោយ ឥតគិតថ្លៃ រហូតដល់ 120 ភាសា ។

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

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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 The Harvard Pilgrim HMO for Self-Insured Members .

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 outpatient pharmacy coverage) and any applicable riders make up the agreement stating the terms of the Plan. If you have any questions about Dependent eligibility, we recommend that you see your Plan Sponsor for information.

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 Harvard Pilgrim and the Plan. It's also your guide to the most important things you need to know, including:

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

You can view your Benefit Handbook, Schedule of Benefits, Prescription Drug Brochure (if your Plan includes outpatient pharmacy coverage) and any applicable riders online by using **HPHConnect** 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 identifies the Plan's PCPs, specialists, hospitals and other providers you must use for most services. It lists providers by state and town, specialty, and languages spoken. You may view the Provider Directory online at our web site, 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**.

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

The online Provider Directory provides links to several physician profiling sites including one maintained by the Commonwealth of Massachusetts Board of Registration in Medicine at www.massmedboard.org.

Please Note: Plan Providers 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. If your PCP leaves the network for any reason, we will make every effort to notify you at least 30 days in advance, and will help you find a new Plan physician. Under certain circumstances you may be eligible for transition services if your provider leaves the network (please see section *I.E. SERVICES PROVIDED BY A DISENROLLED OR NON-PLAN PROVIDER* for details).

C. MEMBER OBLIGATIONS

1. Choose a Primary Care Provider (PCP)

When you enroll in the Plan you must choose a Primary Care Provider (PCP) for yourself and each

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covered person in your family. You may choose a different PCP for each family member. If you do not choose a PCP when you first enroll, or if the PCP you select is not available, we will assign a PCP to you.

A PCP may be a physician, a physician assistant or a nurse practitioner specializing in one or more of the following specialties: internal medicine, adult medicine, adolescent medicine, geriatric medicine, pediatrics or family practice. PCPs are listed in the Provider Directory. You can access our website at www.harvardpilgrim.org or call the Member Services Department to confirm that the PCP you select is available.

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

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

2. Obtain Referrals to Specialists

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

If you need to see a specialist, you must contact your PCP for a Referral prior to the appointment. In most cases, a Referral will be given to a Plan Provider who is affiliated with the same hospital as your PCP or who has a working relationship with your PCP. Referrals to Plan Providers may be given orally or in writing.

3. Show Your Identification Card

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

4. Share Costs

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

- Copayments
- Coinsurance

- Deductibles

Your specific Member Cost Sharing responsibilities are listed in your Schedule of Benefits. See the *Glossary* for more information on Copayments, Coinsurance, and Deductibles.

Your coverage may include an Out-of-Pocket Maximum. An Out-of-Pocket Maximum is the total amount of Member Cost Sharing (Deductible, Copayments or Coinsurance payments) for which a Member or a family is responsible in a Plan Year. Member Cost Sharing for certain services may be excluded from the Out-of-Pocket Maximum.

Once the Out-of-Pocket Maximum has been reached, no further Copayment, Deductible or Coinsurance amounts will be payable by the Member for the services to which the Out-of-Pocket Maximum applies for the remainder of the Plan Year. The Plan will then pay 100% of the Allowed Amount for the rest of the Plan Year for those services. Once a family Out-of-Pocket Maximum has been met in a Plan 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.

Certain expenses do not apply to either the individual or family Out-of-Pocket Maximum. Your Schedule of Benefits will list the services amounts that do not apply to the Out-of-Pocket Maximum. In addition, 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, the 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, that Member will have no additional Member Cost Sharing for the remainder of the Plan Year for the services to which the Out-of-Pocket Maximum applies.
- b) If any number of Members in a covered family collectively meet the family Out-of-Pocket Maximum, all Members of the covered family will have no additional Member Cost Sharing for the remainder of the Plan Year for the services to which the Out-of-Pocket Maximum applies.

If a Member changes to Family Coverage from Individual Coverage or to Individual Coverage from Family Coverage within a Plan Year, expenses that Member incurred for covered services toward the Out-of-Pocket Maximum under the prior

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coverage will apply toward the Out-of-Pocket Maximum under their new coverage. If the incurred Out-of-Pocket Maximum amount is greater than the new Out-of-Pocket Maximum, the Member will have no additional cost sharing for that Plan Year for the services to which the Out-of-Pocket Maximum applies.

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

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

D. HOW TO OBTAIN CARE

IMPORTANT POINTS TO REMEMBER

- 1) You and each Member of your family must select a PCP.
- 2) In order to receive Covered Benefits you must use Plan Providers, except as noted below.
- 3) If you need care from a specialist, you must contact your PCP for a Referral. For exceptions, see *I.D.7. Services That Do Not Require a Referral*.
- 4) In the event of a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. You do not need a Referral for Medical Emergency services.

1. Your PCP Manages Your Health Care

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

- Care in a Medical Emergency.
- Care when you are temporarily traveling outside the Service Area as described below. The Service Area is the state in which you live.
- Care received by a student Dependent attending school outside of the Enrollment Area. (Please see section *V. Student Dependent Coverage* for the requirements that apply to this coverage.)
- Mental health care, for which you must call the Behavioral Health Access Center at

1-888-777-4742. The telephone number for the Behavioral Health Access Center is also listed on your ID card. Please see section *III. Covered Benefits, Mental Health Care (Including the Treatment of Substance Abuse Disorders)* for information on this benefit.

- Special services that do not require a Referral that are listed in section *I.D.7. Services That Do Not Require a Referral*.

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

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

2. Referrals for Hospital and Specialty Care

When you need hospital or specialty care, you must first call your PCP, who will coordinate your care. Your PCP generally uses one hospital for inpatient care. This is where you will need to go for coverage, unless it is Medically Necessary for you to get care at a different hospital.

When you need specialty care, your PCP will refer you to a Plan Provider who is affiliated with the hospital your PCP uses. This helps your PCP coordinate and maintain the quality of your care. Please ask your PCP about the Referral networks that he or she uses.

If the services you need are not available through your PCP's referral network, your PCP may refer you to any Plan Provider. If you or your PCP has difficulty finding a Plan Provider who can provide the services you need, we will assist you. For help finding a medical provider, please call **1-888-333-4742**. For help finding a mental health care provider, please call **1-888-777-4742**. If no Plan Provider has the expertise needed to meet your medical needs, we will assist you in finding an appropriate Non-Plan Provider.

Plan Providers with recognized expertise in specialty pediatrics are covered with a Referral from your PCP. Pediatric mental health care may be obtained

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by calling the Behavioral Health Access Center at **1-888-777-4742**.

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

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

There are certain specialized services for which you will be directed to a Center of Excellence for care. Please see section *I.D.4. Centers of Excellence* for more information.

Certain specialty services may be obtained without involving your PCP. For more information please see section *I.D.7. Services That Do Not Require a Referral*.

3. Using Plan Providers

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

- 1) The service was received in a Medical Emergency. (Please see section *I.D.5. Medical Emergency Services* for information on your coverage in a Medical Emergency.)
- 2) The service was received while you were outside of the Service Area and coverage is available under (1) the benefit for temporary travel or (2) the benefit for student Dependents attending school outside the Enrollment Area. Please see sections *I.D.6. Coverage for Services When You Are Temporarily Traveling Outside the Service Area* and *V. Student Dependent Coverage* for information on these benefits.
- 3) No Plan Provider has the professional expertise needed to provide the required service. In this case, services by a Non-Plan Provider must be authorized in advance by us, unless one of the exceptions above applies.
- 4) Your physician is disenrolled as a Plan Provider or you are a new Member of the Plan, and one of the exceptions stated in section *I.E. SERVICES PROVIDED BY A DISENROLLED*

OR NON-PLAN PROVIDER applies. Please refer to that section for the details of these exceptions.

To find out if a provider is in the Plan network, see the Provider Directory. The Provider Directory is available online at www.harvardpilgrim.org or by calling our Member Services Department at **1-888-333-4742**.

4. Centers of Excellence

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

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

- Weight loss surgery (bariatric surgery)

Important Notice: No coverage is provided for the service listed above unless it is received from a Plan Provider that has been designated as a Center of Excellence. To verify a Provider’s status, see the Provider Directory. The Provider Directory is available online at www.harvardpilgrim.org or 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. Medical Emergency Services

In a Medical Emergency, including an emergency mental health condition, you should go to the nearest emergency facility or call 911 or other local emergency number. A Referral from your PCP is not needed. Your emergency room Member Cost Sharing is listed in your Schedule of Benefits. Please remember that if you are hospitalized, you must call the Plan at **1-888-333-4742** within 48 hours or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to the Plan or

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PCP by an attending emergency physician no further notice is required. Your PCP will help to arrange for any follow-up care you may need.

6. Coverage for Services When You Are Temporarily Traveling Outside the Service Area

When you are temporarily traveling outside the Service Area the Plan covers urgently needed Covered Benefits for sickness or injury. You do not have to call your PCP before getting care. However, the following services are not covered:

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

The "Service Area" is the state in which you live.

If you are hospitalized, you must call HPHC 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 HPHC or your PCP by an attending emergency physician no further notice is required. Your PCP will help to arrange for any follow-up care you may need.

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

Please Note: We must have your current address on file in order to correctly process claims for care outside the Service Area. To change your address, please call our Member Services Department at **1-888-333-4742**.

7. Services That Do Not Require a Referral

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

i. Family Planning Services:

- Contraceptive monitoring

- Family planning consultation, including pregnancy testing
- Tubal ligation (if a covered benefit - please see your Schedule of Benefits)
- Voluntary termination of pregnancy (if a covered benefit - please see your Schedule of Benefits)

ii. Outpatient Maternity Services

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

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

iii. Gynecological Services

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

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

iv. Dental Services:

- Emergency Dental Care
- Extraction of teeth impacted in bone (if a covered benefit - please see your Schedule of Benefits)
- Preventive dental care for children (if a covered benefit - please see your Schedule of Benefits)

v. Other Services:

- Acupuncture treatment for injury or illness (if a covered benefit - please see your Schedule of Benefits)
- Spinal manipulative therapy (if a covered benefit - please see your Schedule of Benefits)

- Routine eye examination (if a covered benefit - please see your Schedule of Benefits)

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

1. Disenrollment of Primary Care Provider (PCP)

If your PCP is disenrolled as a Plan Provider for reasons unrelated to fraud or quality of care, we will use our best efforts to provide you with written notice at least 30 days prior to the date of your PCP's disenrollment. That notice will also explain the process for selecting a new PCP. You may be eligible to continue to receive coverage for services provided by the disenrolled PCP, under the terms of this Handbook and your Schedule of Benefits, for at least 30 days after the disenrollment date. If you are undergoing an active course of treatment for an illness, injury or condition, we may authorize additional coverage through the acute phase of illness, or for up to 90 days (whichever is shorter).

2. Pregnancy

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

3. Terminal Illness

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

4. New Membership

If you are a new Member, the Plan 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 30 days from your effective date of coverage if:

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

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.

5. 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 notice of disenrollment 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 disenrolled;
- Adhere to the quality assurance standards of the Plan and to provide us with necessary medical information related to the care provided; and
- Adhere to our policies and procedures, including procedures regarding Referrals, obtaining prior authorization and providing Covered Benefits pursuant to a treatment plan, if any, approved by us.

6. Clinical Review Criteria

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

7. Provider Fees For Special Services (Concierge Services)

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

In considering arrangements with physicians for special services, you should understand exactly what

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

II. Glossary

This section lists words with special meaning within the Handbook.

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

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

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

1. Plan Providers. If a Covered Benefit is provided by a Plan Provider, the Allowed Amount is the contracted rate HPHC has agreed to pay Plan Providers. The Plan Providers are not permitted to charge the Member any amount for Covered Benefits, except the applicable Member Cost Sharing amount for the service, in addition to the Allowed Amount.
2. Non-Plan Providers. Most services that are Covered Benefits under your Plan must be provided by a Plan Provider to be covered by HPHC. However, there are exceptions. These include: (i) care in a Medical Emergency; (ii) care while traveling outside of the Service Area; and (iii) care for students attending school outside of the Plan's Enrollment Area.

If services provided by a Non-Plan Provider are Covered Benefits under your Plan, the Allowed Amount for such services depends upon where the Member receives the service, as explained below.

- a. If a Member receives Covered Benefits from a Non-Plan Provider

in the states of Massachusetts, New Hampshire, Maine, Rhode Island, Vermont or Connecticut, the Allowed Amount is defined as follows:

An amount that is consistent, in the judgment of the Plan, with the normal range of charges by health care Providers for the same, or similar, products or services provided to a Member. If the Plan has appropriate data for the area, the Plan will determine the normal range of charges in the geographic area where the product or services were provided to the Member. If the Plan does not have data to reasonably determine the normal range of charges where the products or services were provided, the Plan will utilize the normal range of charges in Boston, Massachusetts. Where services are provided by non-physicians but the data on provider charges available to the Plan is based on charges for services by physicians, the Plan will, in its discretion, make reasonable reductions in its determination of the allowable charge for such non-physician Providers.

b. If a Member receives Covered Benefits from a Non-Plan Provider outside of Massachusetts, New Hampshire, Maine, Rhode Island, Vermont or Connecticut, the Allowed Amount is defined as follows:

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

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

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

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

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

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

For mental health services and substance use disorder services the Allowed Amount will be reduced from the amount payable for physician services by 25% for Covered Benefits provided by a psychologist and by 35% for Covered Benefits provided by a masters level counselor.

Pricing of the Allowed Amount will be conducted by UnitedHealthcare, Inc. UnitedHealthcare, updates the

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CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.

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

Anniversary Date The date 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 applicable) 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.

Behavioral Health Access Center The organization, designated by HPHC, that is responsible for arranging for the provision of services for Members in need of mental health care (including the treatment of substance abuse disorders). Except in a Medical Emergency, you must call the Behavioral Health Access Center at 1-888-777-4742 before receiving such services. The telephone number is also listed on your ID card.

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 for physical therapy services, once you reach your 30 visit limit for that Plan Year, no additional benefits for that service will be covered by the Plan.

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

Coinsurance A percentage of the Allowed Amount for certain Covered Benefits that must be paid by the Member. Coinsurance amounts applicable to your Plan are stated in your Schedule of Benefits.

✓ FOR EXAMPLE: If the Coinsurance for a service is 20%, you pay 20% of the Allowed Amount while the Plan pays the remaining 80%.

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

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

Your Plan may have two levels of Copayments that apply to outpatient services. These are known as Tier 1 Copayments and Tier 2 Copayments. The Tier 1 Copayment is lower than the Tier 2 Copayment. Your specific Copayment amounts, and the services to which they apply, are listed in your Schedule of Benefits.

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

Covered Benefit 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 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 in a Plan Year. Deductible amounts are incurred on the date of service. If a Deductible applies to your plan, it will be stated in the Schedule of Benefits.

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

Deductible Rollover A Deductible Rollover allows a Member to apply any Deductible amount incurred for covered services during the last three (3) months of a Plan Year toward the Deductible for the next Plan 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 charges were incurred. 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

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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. Eligibility requirements are documented as part of the contract between the Plan Sponsor and HPHC. Please see your Plan Sponsor's Benefits Office for details on the agreement between HPHC and your Plan Sponsor.

Enrollment Area A list of cities and towns where Plan Providers are available to manage Members' care. Members, except for a Dependent child attending an accredited educational institution or a child under a Qualified Medical Support Order, must maintain residence in the Enrollment Area, and live there at least nine months a year. We may add or delete cities and towns to the Enrollment Area from time to time.

Experimental, Unproven, or Investigational Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests, will be deemed Experimental, Unproven, or Investigational by us under this Benefit Handbook for use in the diagnosis or treatment of a particular medical condition if any the following is true:

a. The product or service is not recognized in accordance with generally accepted medical standards as being safe and effective for the use in the evaluation or treatment of the condition in question. In determining whether a service has been recognized as safe or effective in accordance with generally accepted evidence-based medical standards, primary reliance will be placed upon data from published reports in authoritative medical or scientific publications that are subject to established peer review by qualified medical or scientific

experts prior to publication. In the absence of any such reports, it will generally be determined a service, procedure, device or drug is not safe and effective for the use in question.

b. In the case of a drug, the drug has not been approved by the United States Food and Drug Administration (FDA). (This does not include off-label uses of FDA approved drugs).

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

Harvard Pilgrim Health Care, Inc. (HPHC) Harvard Pilgrim Health Care, Inc. is an insurance company that provides, arranges or administers health care benefits for Members through a network of Plan Providers. Under self insured plans such as this one, HPHC adjudicates and pays claims, and manages benefits on behalf of the Plan Sponsor.

Individual Coverage Coverage for a Subscriber only. No coverage for Dependents is provided.

Licensed Mental Health Professional For services provided in Massachusetts a Licensed Mental Health Professional is any one of the following: a licensed physician who specializes in the practice of psychiatry; a licensed psychologist; a licensed independent clinical social worker; a licensed nurse mental health clinical specialist; a licensed marriage and family therapist; or a licensed mental health counselor. For services provided outside of Massachusetts, a Licensed Mental Health Professional is an independently licensed clinician with at least a masters degree in a clinical mental health discipline from an accredited educational institution and at least two years of clinical experience. The term "clinical mental health discipline" includes the following: psychiatry; psychology, clinical social work; marriage and family therapy; clinical counseling; developmental psychology; pastoral counseling; psychiatric nursing; developmental or educational psychology; counselor education; or any other discipline deemed acceptable by the Plan.

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

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

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

Member Any Subscriber or Dependent covered 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.

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

Non-Plan Provider Providers of health care services that are not under contract with us to provide care to Members.

Out-of-Pocket Maximum An Out-of-Pocket Maximum is a limit on the amount of Member Cost Sharing (Deductibles, Copayments and Coinsurance) that a Member must pay for certain Covered Benefits in a Plan Year. Member Cost Sharing for some services may be excluded from the Out-of-Pocket Maximum. For example, Copayments for prescription drugs generally do not count toward your Out-of-Pocket Maximum. If your Plan includes an Out-of-Pocket Maximum, your Schedule of Benefits will list the services that do not apply to the Out-of-Pocket Maximum.

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

✓ FOR EXAMPLE: If your Plan has an individual Out-of-Pocket Maximum of \$1,000, this is the most Member Cost Sharing you would pay in a Plan Year for services to which the Out-of-Pocket Maximum applies. For example, as long as the services you received are not excluded from the Out-of-Pocket Maximum, you could combine \$500 in Deductible expenses, \$100 in Copayments, and \$400 in Coinsurance payments to reach the \$1,000 Out-of-Pocket Maximum.

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

A physical condition may impact an individual's emotional well-being or

mental health. However such impact is not considered in determining whether or not a Physical Functional Impairment exists. Only the physical consequences of a condition are considered.

Plan This package of health care benefits known as The Harvard Pilgrim HMO for Self-Insured Members 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 of health care services in the Enrollment Area that are under contract to provide care to Members of your Plan. Plan Providers include, but are not limited to physicians, podiatrists, psychologists, psychiatrists, nurse practitioners, physician's assistants, psychiatric social workers, certified psychiatric nurses, psychotherapists, licensed independent clinical social workers, licensed nurse mental health clinical specialist, nurse midwives, nurse anesthetists, and licensed mental health counselors, and early intervention specialists who are credentialed and certified by the Massachusetts Department of Public Health. 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.

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. Please see your Schedule of Benefits for your Plan Year information.

✓ 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. Please see your Schedule of Benefits for your specific Plan Year information.

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. Please see your Schedule of Benefits for your Plan Year information.

✓ 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. Please see your Schedule of Benefits for your specific Plan Year information.

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

Prior Carrier Credit A credit given for the first Plan Year of coverage under the Plan for any amounts incurred by the Member toward the Deductible or the Out-of-Pocket Maximum under your current Plan Sponsor's prior health insurance plan. The Prior Carrier Credit will be applied to the Deductible or the Out of Pocket Maximum of this Plan if the following requirements were met:

- You were enrolled in your Plan Sponsor's prior plan on the termination date of coverage; and
- Your coverage became effective with us on the same day as the Plan Sponsor's plan.

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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.

Qualified Medical Child Support Order (QMCSO) A court order providing for coverage of a child under a group health plan that meets the requirements of the Employee Retirement Income Security Act (ERISA). A child Dependent enrolled under a QMCSO is subject to all the terms and conditions stated in this Handbook, the Schedule of Benefits, the Prescription Drug Brochure (if applicable) and any applicable riders.

Referral An instruction from your PCP that gives you the ability to see another Plan Provider for services that may be out of your PCP's scope of practice. Please see section III. *Covered Benefits* for other requirements of coverage.

✓ FOR EXAMPLE: If you need to visit a specialist, such as a dermatologist or cardiologist, you must contact your PCP first. Your PCP will refer you to a specialist who is a Plan Provider. Your PCP will generally refer you to a specialist with whom he or she is affiliated or has a working relationship.

Rehabilitative Therapies

Rehabilitative Therapies 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, Rehabilitative Therapies 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. The Schedule of Benefits states the Copayments, Coinsurance or Deductible you must pay and any limitations on coverage.

Service Area The state in which a Member lives. When you are in the Service Area you must call your PCP for care. Exceptions apply (1) to Medical Emergencies and (2) when you need one of the services in *I.D.7. Services That Do Not Require a Referral* listed in section I. *How the Plan Works*.

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

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

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

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

Urgent Care Medically Necessary services for a condition that requires prompt medical attention but is not a Medical Emergency. Urgent Care is usually care needed because of an unforeseen illness, injury or condition that occurs and does not give reasonable time to obtain care through your PCP or a Plan Provider.

For the purposes of claims and appeals, Urgent Care refers to a claim or appeal for services in which a Member's medical condition: 1) could, if delayed, seriously jeopardize the Member's life or health or ability to regain maximum function, or 2)

would, if delayed, result in severe pain that cannot be adequately managed without the care or treatment requested

III. Covered Benefits

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

Basic Requirements for Coverage

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

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

Benefit	Description
1 . Acupuncture Treatment for Injury or Illness	<p>The Plan covers acupuncture treatment for illness or injury, including, electro-acupuncture, that is provided for the treatment of neuromusculoskeletal pain.</p> <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p>
2 . Ambulance Transport	<p>Emergency Ambulance Transport</p> <p>If you have a Medical Emergency (including an emergency mental health condition), your Plan covers ambulance transport to the nearest hospital that can provide you with Medically Necessary care.</p> <p>Non-Emergency Ambulance Transport</p> <p>You're also covered for non-emergency ambulance transport between hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary. Services must be arranged by a Plan Provider.</p> <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p>

Benefit	Description
<p>3 . Autism Spectrum Disorders Treatment</p>	<p>Coverage is provided for the diagnosis and treatment of Autism Spectrum Disorders, as defined below. Covered Services include the following:</p> <ul style="list-style-type: none"> • Diagnosis of Autism Spectrum Disorders. This includes Medically Necessary assessments, evaluations, including neuropsychological evaluations, genetic testing or other tests to diagnose whether an individual has one of the Autism Spectrum Disorders. • Professional services by Plan Providers. This includes care by physicians, Licensed Mental Health Professionals, speech therapists, occupational therapists, and physical therapists. • Habilitative and rehabilitative care, including, but not limited to, applied behavior analysis supervised by a board certified behavior analyst as defined by law. • Prescription drug coverage (if you have the Plan's optional coverage for outpatient prescription drugs). If you have the Plan's outpatient prescription drug coverage, please see your Prescription Drug Brochure for information on this benefit. <p>Autism Spectrum Disorders include any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. These include Autistic Disorder; Asperger's Disorder; and Pervasive Developmental Disorders Not Otherwise Specified.</p> <p>Applied behavior analysis is defined as the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior. It includes the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.</p> <p>There is no coverage for services related to autism spectrum disorders 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.</p> <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p>
<p>4 . Cardiac Rehabilitation Therapy</p>	<p>The Plan covers cardiac rehabilitation. Coverage includes only Medically Necessary services for Members with established coronary artery disease or unusual and serious risk factors for such disease.</p>
<p>5 . Chemotherapy and Radiation Therapy - Other than Inpatient</p>	<p>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.</p> <p>For services received in a Physician's office, see the benefit for Physician and Other Professional Office Visits.</p>

Benefit	Description
6 . Clinical Trials for the Treatment of Cancer or Other Life-Threatening Diseases	
	<p>The Plan covers services for Members enrolled in a qualified clinical trial of a treatment for any form of cancer or other life-threatening disease under the terms and conditions provided under federal law. All of the requirements for coverage under the Plan apply to coverage under this benefit. The following services are covered under this benefit: (1) all services that are Medically Necessary for treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the Plan; and (2) the reasonable cost of an investigational drug or device that has been approved for use in the clinical trial to the extent it is not paid for by its manufacturer, distributor or provider.</p>
7 . Dental Services	
	<p>Important Notice: The Plan does not provide dental insurance. It covers only the limited Dental Care described below. No other Dental Care is covered.</p> <p>Cleft Palate:</p> <p>For coverage of orthodontic and dental care related to the treatment of cleft lip or cleft palate for children under the age of 18, please see section <i>III. Covered Benefits, Reconstructive Surgery</i>, for information on this benefit.</p> <p>Emergency Dental Care:</p> <p>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:</p> <ul style="list-style-type: none"> • 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 <p>Extraction of Teeth Impacted in Bone:</p> <p>The Plan covers extraction of teeth impacted in bone. Only the following services are covered:</p> <ul style="list-style-type: none"> • Extraction of teeth impacted in bone • Pre-operative and post-operative care, immediately following the procedure • Anesthesia • X-rays <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p> <p>Preventive Dental Care for Children:</p> <p>The Plan covers two preventive dental exams per Plan Year for children under the age limit listed in the Schedule of Benefits. Only the following services are covered:</p> <ul style="list-style-type: none"> • Cleaning

Benefit	Description
<p>Dental Services (Continued)</p>	<ul style="list-style-type: none"> • Fluoride treatment • Teaching plaque control • X-rays <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p>
<p>8 . Diabetes Services and Supplies</p>	<p>Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care:</p> <p>The Plan covers outpatient self-management education and training for the treatment of diabetes, including medical nutrition therapy services, used to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes. Services must be provided on an individual basis and be provided by a Plan Provider. Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care.</p> <p>The following items are also covered:</p> <p>Diabetes Equipment:</p> <ul style="list-style-type: none"> • Blood glucose monitors • Dosage gauges • Injectors • Insulin pumps (including supplies) and infusion devices • Lancet devices • Therapeutic molded shoes and inserts • Visual magnifying aids • Voice synthesizers <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p> <p>Pharmacy Supplies:</p> <ul style="list-style-type: none"> • Blood glucose strips • Insulin, insulin needles and syringes • Lancets • Oral agents for controlling blood sugar • Urine and ketone test strips <p>For coverage of pharmacy items listed above, you must get a prescription from your Plan Provider and present it at a participating pharmacy. You can find participating pharmacies online at www.harvardpilgrim.org by clicking Pharmacy Program or by calling the Member Services Department at 1-888-333-4742.</p> <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p>

Benefit	Description
<p>9 . Dialysis</p>	<p>The Plan covers dialysis on an inpatient, outpatient or at home basis. When federal law permits Medicare to be the primary payer, you must apply for Medicare and also pay any Medicare premium. When Medicare is primary (or would be primary if the Member were timely enrolled), the Plan will cover only those costs that exceed what would be payable by Medicare.</p> <p>Coverage for dialysis in the home includes non-durable medical supplies, and drugs and equipment necessary for dialysis.</p> <p>HPHC must approve dialysis services if you are temporarily traveling outside Massachusetts. The Plan will cover dialysis services for up to 30 days of travel per Plan Year. You must make arrangements in advance with your Plan Provider.</p>
<p>10 . Drug Coverage</p>	<p>You have limited coverage for prescription drugs under this Benefit Handbook, which is described in subsection 1, below. You may also have the Plan’s optional coverage for outpatient prescription drugs and certain medical supplies you purchase at a pharmacy. Subsection 2, below, explains how to determine whether you have the Plan’s optional pharmacy coverage and how to learn the details of the optional pharmacy plan.</p> <p>1) Your Coverage under this Benefit Handbook</p> <p>This Benefit Handbook covers drugs administered to you by a medical professional in either of the following circumstances:</p> <ul style="list-style-type: none"> • Drugs Received During Inpatient Care. The drug is administered to you while you are an inpatient at a hospital, Skilled Nursing Facility or other medical facility at which Covered Benefits are provided to you on an inpatient basis; or • Drugs that Cannot be Self-Administered. The drug cannot be self-administered and is given to you either (a) in a doctor’s office or other outpatient medical facility, or (b) at home while you are receiving home health care services covered by the Plan. <p>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 home health care services, the words “cannot be self-administered” will include circumstances in which a family member or friend is trained to administer the drug and ongoing supervision by skilled medical personnel is required.</p> <p>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.</p> <p>This Benefit Handbook may also provide coverage for: (a) certain diabetes supplies; (b) syringes and needles you purchase at a pharmacy; and (c) certain orally administered medications for the treatment of cancer. Please see the benefits for “Diabetes Services and Supplies” and “Hypodermic Syringes and Needles” for the details of those benefits.</p> <p>Please Note: Your Plan may cover orally administered medications for the treatment of cancer with no Member Cost Sharing. Please contact the Member Services Department to confirm the Member Cost Sharing that applies to this benefit.</p>

Benefit	Description
<p>Drug Coverage (Continued)</p>	<p>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 or weight loss; and (3) any drug that is obtained at an outpatient pharmacy except (a) covered diabetes supplies and (b) syringes and needles, as explained above.</p> <p>2) Optional Outpatient Pharmacy Coverage</p> <p>In addition to the coverage under this Benefit Handbook, you may also have the Plan’s optional outpatient pharmacy benefit. That benefit provides coverage for most prescription drugs and certain medical supplies purchased at an outpatient pharmacy.</p> <p>Please Note: Not all Plans cover this benefit.</p> <p>If you have outpatient pharmacy coverage, your Member Cost Sharing for prescription drugs will be listed on your ID Card. If your Plan includes outpatient pharmacy coverage, please see the Prescription Drug Brochure for a detailed explanation of your benefits.</p>
<p>11 . Durable Medical Equipment (DME)</p>	<p>The Plan covers DME when Medically Necessary and ordered by a Plan Provider. The Plan will rent or buy all equipment. The cost of the repair and maintenance of covered equipment is also covered.</p> <p>In order to be covered, all equipment must be:</p> <ul style="list-style-type: none"> • 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. <p>Coverage is only available for:</p> <ul style="list-style-type: none"> • The least costly equipment adequate to allow you to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports; and • One item of each type of equipment . No back-up items or items that serve a duplicate purpose are covered. For example, the Plan covers a manual or an electric wheelchair, not both. <p>Covered equipment and supplies include:</p> <ul style="list-style-type: none"> • Canes • Certain types of braces • Crutches • Hospital beds • Oxygen and oxygen equipment • Respiratory equipment • Walkers • Wheelchairs <p>Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan.</p>

Benefit	Description
Durable Medical Equipment (DME) (Continued)	
	<p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p>
12 . Early Intervention Services	
	<p>The Plan covers early intervention services provided for Members until three years of age. Covered services include:</p> <ul style="list-style-type: none"> • Nursing care • Physical, speech, and occupational therapy • Psychological counseling • Screening and assessment of the need for services <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p>
13 . Emergency Room Care	
	<p>If you have a Medical Emergency, you are covered for care in a hospital emergency room. Please remember the following:</p> <ul style="list-style-type: none"> • If you need follow-up care after you are treated in an emergency room, you must call your PCP. Your PCP will provide or arrange for the care you need. • If you are hospitalized, you must call HPHC 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 HPHC or PCP by an attending emergency physician no further notice is required
14 . Family Planning Services	
	<p>The Plan covers family planning services, including the following:</p> <ul style="list-style-type: none"> • Contraceptive monitoring • Family planning consultation • Pregnancy testing • Genetic counseling • FDA approved birth control drugs, implants or devices.* • Professional services relating to the injection of birth control drugs and the insertion or removal of birth control implants or devices. <p>*If you are covered under a Grandfathered plan, coverage for FDA approved birth control drugs, implants or devices that must be obtained at an outpatient pharmacy may only be covered if your plan includes optional outpatient pharmacy coverage. Please see your Schedule of Benefits or talk to your Employer Group to determine if you are covered under a Grandfathered plan that limits this coverage.</p> <p>Please Note: An exclusion for Family Planning Services may apply when coverage is provided by a religious diocese, as allowed by law. Please check with your Employer Group to see if this exclusion applies to your Plan.</p>
15 . Foot Orthotics	
	<p>The Plan covers foot orthotics up to the Benefit Limit listed in the Schedule of Benefits.</p> <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p>

Benefit	Description
<p>16 . Hearing Aids</p>	<p>The Plan covers hearing aids up to the limit listed in your Schedule of Benefits. A hearing aid is defined as any instrument or device, excluding a surgical implant, designed, intended or offered for the purpose of improving a person’s hearing.</p> <p>The Plan will pay the full cost of each medically necessary hearing aid up to the limit listed in your Schedule of Benefits, minus any applicable cost sharing. If you purchase a hearing aid that is more expensive than the limit listed in your Schedule of Benefits, you will be responsible for the additional cost. No back-up hearing aids that serve a duplicate purpose are covered. Covered services and supplies related to your hearing aid are not subject to the dollar limit listed in your Schedule of Benefits.</p> <p>Covered services include the following:</p> <ul style="list-style-type: none"> • One hearing aid per hearing impaired ear • Except for batteries, any necessary parts, attachments or accessories, including ear moldings; and • Services provided by a licensed audiologist, hearing instrument specialist or licensed physician that are necessary to assess, select, fit, adjust or service the hearing aid. <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p>
<p>17 . Home Health Care</p>	<p>If you are homebound for medical reasons, you are covered for home health care services listed below. To be eligible for home health care, your Plan Provider must determine that skilled nursing care or physical therapy is an essential part of active treatment. There must also be a defined medical goal that your Plan Provider expects you will meet in a reasonable period of time.</p> <p>When you qualify for home health care services as stated above, the Plan covers the following services when Medically Necessary:</p> <ul style="list-style-type: none"> • Durable medical equipment and supplies (must be a component of the home health care being provided) • Medical social services • Nutritional counseling • Physical therapy • Occupational therapy • Services of a home health aide • Skilled nursing care • Speech therapy <p>Care on a “short-term intermittent basis” means care that is provided fewer than eight hours per day, on a less than daily basis, up to 35 hours per week. If you receive more than one type of skilled service in the home, these this time limits apply applies to all services combined.</p>

Benefit	Description
<p>18 . Hospice Services</p>	<p>The Plan covers hospice services for terminally ill Members who need the skills of qualified technical or professional health personnel for palliative care. Care may be provided at home or on an inpatient basis. Inpatient respite care is covered for the purpose of relieving the primary caregiver and may be provided up to 5 days every 3 months not to exceed 14 days per Plan Year. 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:</p> <ul style="list-style-type: none"> • 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
<p>19 . Hospital – Inpatient Services</p>	<p>The Plan covers acute hospital care including, but not limited to, the following inpatient services:</p> <ul style="list-style-type: none"> • Semi-private room and board • Doctor visits, including consultation with specialists • Medications • Laboratory and x-ray services • Intensive care • Surgery, including related services • Anesthesia, including the services of a nurse-anesthetist • Radiation therapy • Physical therapy • Occupational therapy • Speech therapy <p>In order to be eligible for coverage, the following service must be received at a Center of Excellence:</p> <ul style="list-style-type: none"> • Weight loss surgery (bariatric surgery) <p>Please see section <i>I.D.4. Centers of Excellence</i> for more information.</p>
<p>20 . House Calls</p>	<p>The Plan covers house calls.</p>

Benefit	Description
21 . Human Organ Transplant Services	
	<p>The Plan covers human organ transplants, including bone marrow transplants for a Member with metastasized breast cancer in accordance with the criteria of the Massachusetts Department of Public Health.</p> <p>The Plan covers the following services when the recipient is a Member of the Plan:</p> <ul style="list-style-type: none"> • Care for the recipient • Donor search costs through established organ donor registries • Donor costs that are not covered by the donor's health plan <p>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.</p>
22 . Hypodermic Syringes and Needles	
	<p>The Plan covers hypodermic syringes and needles to the extent Medically Necessary.</p> <p>You must get a prescription from your PCP or Plan Provider and present it at a participating pharmacy for coverage. You can get more information on participating pharmacies online at www.harvardpilgrim.org. Click Pharmacy Program or by calling the Member Services Department at 1-888-333-4742.</p> <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p>
23 . Infertility Services and Treatment	
	<p>Infertility is defined as the inability of a woman aged 35 or younger to conceive or produce conception during a period of one year. In the case of a woman over age 35, the time period is reduced to 6 months. If a woman conceives but is unable to carry the pregnancy to live birth, the time she attempted to conceive prior to that pregnancy is included in the one year or 6 month period, as applicable. The Plan covers the following diagnostic services for infertility:</p> <ul style="list-style-type: none"> • Consultation • Evaluation • Laboratory tests <p>The Plan covers the following infertility treatment:</p> <ul style="list-style-type: none"> • Therapeutic artificial insemination (AI), including related sperm procurement and banking • Donor egg procedures, including related egg and inseminated egg procurement, processing and banking • Assisted hatching • Gamete intrafallopian transfer (GIFT) • Intra-cytoplasmic sperm injection (ICSI) • Intra-uterine insemination (IUI) • In-vitro fertilization and embryo transfer (IVF) • Zygote intrafallopian transfer (ZIFT) • Preimplantation genetic diagnosis (PGD) • Microsurgical epididymal sperm aspiration (MESA) • Testicular sperm extraction (TESE)

Benefit	Description
Infertility Services and Treatment (Continued)	
	<ul style="list-style-type: none"> • Sperm collection, freezing and up to one year of storage is also covered for male Members in active infertility treatment. • Cryopreservation of eggs <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p> <p>Important Notice: We use clinical guidelines to evaluate whether the use of infertility treatment is Medically Necessary. If you are planning to receive infertility treatment we recommend that you review the current guidelines. To obtain a copy, please call 1-888-888-4742 ext. 38723.</p>
24 . Laboratory and Radiology Services	
	<p>The Plan covers diagnostic laboratory and x-ray services, including Advanced Radiology, on an outpatient basis. The term “Advanced Radiology” means CT scans, PET Scans, MRI and MRA, and nuclear medicine services. Coverage includes:</p> <ul style="list-style-type: none"> • The facility charge and the charge for supplies and equipment • The charges of anesthesiologists, pathologists and radiologists <p>In addition, the Plan covers the following:</p> <ul style="list-style-type: none"> • Human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish bone marrow transplant donor suitability (including testing for A, B, or DR antigens, or any combination, consistent with rules, regulations and criteria established by the Department of Public Health). • Diagnostic screenings and tests including: hereditary and metabolic screening at birth; tuberculin tests; lead screenings; hematocrit, hemoglobin or other appropriate blood tests, human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish bone marrow transplant donor suitability, and urinalysis. • Mammograms, including a baseline mammogram for women between the ages of thirty-five and forty, and an annual mammogram for women forty years of age and older
25 . Low Protein Foods	
	<p>The Plan covers food products modified to be low-protein ordered for the treatment of inherited diseases of amino acids and organic acid up to the limit stated in your Schedule of Benefits.</p>
26 . Maternity Care	
	<p>The Plan covers the following maternity services:</p> <ul style="list-style-type: none"> • Routine outpatient prenatal care, including evaluation and progress screening, physical exams, recording of weight and blood pressure monitoring • Prenatal genetic testing (office visits require a referral) • Delivery, including a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean section. Any decision to shorten the inpatient stay for the mother and her newborn child will be made by the attending physician and the mother. If early discharge is decided, the mother will be entitled to a minimum of one home visit. • Newborn care. Coverage is limited to routine nursery charges for a healthy newborn unless the child is enrolled in the Plan. Please see section VIII.E. <i>ADDING A DEPENDENT</i> for more enrollment information.

Benefit	Description
Maternity Care (Continued)	
	<ul style="list-style-type: none"> • Routine outpatient postpartum care for the mother, including lactation consultations, up to six weeks after delivery
27 . Medical Formulas	
	<p>The Plan covers the following up to the limit stated in your Schedule of Benefits:</p> <ul style="list-style-type: none"> • Non-prescription enteral formulas for home use for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction and inherited diseases of amino acids and organic acids. • Prescription formulas for the treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia or methylmalonic acidemia in infants and children or to protect the unborn fetuses of pregnant women with phenylketonuria.
28 . Mental Health Care (Including the Treatment of Substance Abuse Disorders)	
	<p>The Plan covers both inpatient and outpatient mental health care to the extent Medically Necessary as outlined below. As used in this section the term "mental health care" includes the Medically Necessary treatment of substance abuse disorders.</p> <p>For coverage of mental health care (including the treatment of substance abuse disorders), you must call the Behavioral Health Access Center at 1-888-777-4742. All mental health care must be arranged through the Behavioral Health Access Center and provided by a contracted Plan Provider. (The only exception applies to care required in a Medical Emergency.) The Behavioral Health Access Center phone line is staffed by licensed mental health clinicians. A clinician will assist you in determining the type of care you need, finding an appropriate Plan Provider, and arranging the services you require.</p> <p>The Plan requires consent to the disclosure of information regarding services for mental disorders to the same extent it requires consent for disclosure of information for other medical conditions. Any determination of Medical Necessity for mental health care will be made in consultation with a Licensed Mental Health Professional.</p> <p>Minimum Requirements for Covered Providers</p> <p>To be eligible for coverage under this benefit, all services must be provided either (1) at the office of a Licensed Mental Health Professional, or (2) at a facility licensed or approved by the health department or mental health department of the state in which the service is provided. (In Massachusetts those departments are the Department of Public Health and the Department of Mental Health, respectively.) To qualify, a facility must be both licensed as, and function primarily as, a health or mental health care facility. A facility that is also licensed as an educational or recreational institution will not meet this requirement unless the predominate purpose of the facility is the provision of mental health care services.</p> <p>To qualify for coverage, all services rendered outside of a state licensed or approved facility must be provided by an independently Licensed Mental Health Professional. For services provided in Massachusetts, a Licensed Mental Health Professional must be one of the following types of providers: a licensed physician who specializes in the practice of psychiatry; a licensed psychologist; a licensed independent clinical social worker; a licensed nurse mental health clinical specialist; a licensed marriage and family therapist; or a licensed mental health counselor. For services provided outside of Massachusetts, a</p>

Benefit	Description
Mental Health Care (Including the Treatment of Substance Abuse Disorders) (Continued)	
	<p>Licensed Mental Health Professional is an independently licensed clinician with at least a Masters degree in a clinical mental health discipline from an accredited educational institution and at least two years of clinical experience. The term "clinical mental health discipline" includes the following: psychiatry; psychology; clinical social work; marriage and family therapy; clinical counseling; developmental psychology; pastoral counseling; psychiatric nursing; developmental or educational psychology; counselor education; or any other discipline deemed acceptable by the Plan.</p> <p>Benefits</p> <p>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. (The only exception is conditions for which only a "V Code" designation applies, which means that the condition is not attributable to a mental disorder.)</p> <p>Please refer to your Schedule of Benefits It will tell you the Member Cost Sharing and any benefit limits that apply to the coverage of these services.</p> <p>Covered mental health services include the following:</p> <p>a) Mental Health Care Services</p> <p>Subject to the Member cost sharing and any benefit limits stated in your Schedule of Benefits, the Plan provides coverage through the Behavioral Health Access Center for the following Medically Necessary mental health care services:</p> <ol style="list-style-type: none"> 1) Inpatient Services <ul style="list-style-type: none"> • Hospitalization, including detoxification 2) Intermediate Care Services <ul style="list-style-type: none"> • Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization • Intensive outpatient programs, partial hospitalization and day treatment programs 3) Outpatient Services <ul style="list-style-type: none"> • Care by a Licensed Mental Health Professional • Detoxification • Medication management • Psychological testing and neuropsychological assessment.
29 . Ostomy Supplies	
	<p>The Plan covers ostomy supplies up to the Benefit Limit listed in the Schedule of Benefits. Only the following supplies are covered:</p> <ul style="list-style-type: none"> • Irrigation sleeves, bags and catheters • Pouches, face plates and belts • Skin barriers

Benefit	Description
<p>30 . Physician and Other Professional Office Visits</p>	<p>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:</p> <ul style="list-style-type: none"> • Routine physical examinations, including routine gynecological examination and annual cytological screenings • Follow-up care provided by an obstetrician or gynecologist for obstetrical or gynecological conditions identified during maternity care or an annual gynecological visit • Immunizations, including childhood immunizations as recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention and the American Academy of Pediatrics • Well baby and well child care, including physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and developmental screening, and assessment at the following intervals: <ul style="list-style-type: none"> • At least six visits per Plan Year are covered for a child from birth to age one. • At least three visits per Plan Year are covered for a child from age one to age two. • At least one visit per Plan Year is covered for a child from age two to age six • School, camp, sports and premarital examinations • Health education and nutritional counseling • Sickness and injury care • Vision and Hearing screenings • Medication management • Consultations concerning contraception and hormone replacement therapy • Chemotherapy • Radiation therapy <p>Please Note: Most plans 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.</p>
<p>31 . Prosthetic Devices</p>	<p>The Plan covers prosthetic devices when ordered by a Plan Provider. The cost of the repair and maintenance of a covered device is also covered.</p> <p>In order to be covered, all devices must be able to withstand repeated use. Coverage is only available for:</p> <ul style="list-style-type: none"> • The least costly prosthetic device adequate to allow you to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports; and • One item of each type of prosthetic device. No back-up items or items that serve a duplicate purpose are covered. <p>Covered prostheses include:</p> <ul style="list-style-type: none"> • Breast prostheses, including replacements and mastectomy bras • Prosthetic arms and legs • Prosthetic eyes

Benefit	Description
<p>Prosthetic Devices (Continued)</p>	<p>Prosthetic devices are covered up to the Benefit Limit listed in the Schedule of Benefits. The Benefit Limit does not apply to:</p> <ul style="list-style-type: none"> • Breast prostheses (including replacements and mastectomy bras) • Prosthetic arms and legs <p>Both the Benefit Limit and any Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan.</p> <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p>
<p>32 . Reconstructive Surgery</p>	<p>The Plan covers reconstructive and restorative surgical procedures as follows:</p> <ul style="list-style-type: none"> • 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.) <p>Benefits are also provided for post mastectomy care, including coverage for:</p> <ul style="list-style-type: none"> • Protheses 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. <p>Coverage is also provided for the treatment of cleft lip and cleft palate for children under the age of 18, including coverage for:</p> <ul style="list-style-type: none"> • Medical, dental, oral, and facial surgery, including surgery performed by oral and plastic surgeons, and surgical management and follow-up care related to such surgery; • Orthodontic treatment; • Preventative and restorative dentistry to ensure good health and adequate dental structures to support orthodontic treatment or prosthetic management therapy; • Speech therapy; • Audiology services; and • Nutrition services. <p>Please Note: (Not all Plans cover this benefit. Please contact your Human Resources Department to confirm whether coverage is provided and under what circumstances.)</p>

Benefit	Description
Reconstructive Surgery (Continued)	
	<p>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.</p> <p>There is no coverage for Cosmetic Services or surgery except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care as described above.</p> <p>Important Notice: We use clinical guidelines to evaluate whether different types of reconstructive and restorative procedures are Medically Necessary. If you are planning to receive such treatment, you may review the current guidelines. To obtain a copy, please call 1-888-888-4742 ext. 38732.</p>
33 . Rehabilitation Hospital Care	
	<p>The Plan covers care in a facility licensed to provide rehabilitative care on an inpatient basis. Coverage is provided when you need daily rehabilitative therapies that must be provided in an inpatient setting. Rehabilitative therapies include cardiac rehabilitation therapy, physical therapy, pulmonary rehabilitation therapy, occupational therapy and speech therapy. The Benefit Limit is listed in the Schedule of Benefits.</p>
34 . Rehabilitation Therapy – Outpatient	
	<p>The Plan covers the following outpatient rehabilitation therapies:</p> <ul style="list-style-type: none"> • Occupational therapy • Physical therapy • Pulmonary rehabilitation therapy <p>Outpatient rehabilitation therapies are covered up to the Benefit Limit listed in the Schedule of Benefits. Services are covered only:</p> <ul style="list-style-type: none"> • If, in the opinion of your Plan Provider, there is likely to be significant improvement in your condition within the period of time benefits are covered; and • When needed to improve your ability to perform Activities of Daily Living. <p>Activities of Daily Living do not include special functions needed for occupational purposes or sports.</p> <p>Rehabilitation therapies are also covered under your inpatient hospital and home health benefits.</p> <p>Please Note: Outpatient physical and occupational therapies for children under the age of 3 are covered to the extent Medically Necessary. The benefit limit stated in the Schedule of Benefits does not apply.</p>
35 . Scopic Procedures – Outpatient Diagnostic	
	<p>The Plan covers diagnostic scopic procedures and related services received on an outpatient basis.</p> <p>Diagnostic scopic procedures are those for visualization, biopsy and/or polyp removal. Scopic procedures are:</p> <ul style="list-style-type: none"> • Colonoscopy • Endoscopy • Sigmoidoscopy

Benefit	Description
36 . Skilled Nursing Facility Care	
	<p>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.</p>
37 . Speech-Language and Hearing Services	
	<p>The Plan covers diagnosis and treatment of speech, hearing and language disorders to the extent Medically Necessary by speech-language pathologists and audiologists.</p>
38 . Spinal Manipulative Therapy (including care by a chiropractor)	
	<p>The Plan covers musculoskeletal adjustment or manipulation up to the Benefit Limit listed in the Schedule of Benefits.</p> <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p>
39 . Surgery - Outpatient	
	<p>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.</p> <p>There are certain specialized services for which you will be directed to a Center of Excellence for care. See section <i>I.D.4. Centers of Excellence</i> for more information.</p>
40 . Temporomandibular Joint Dysfunction Services	
	<p>The Plan covers medical treatment of Temporomandibular Joint Dysfunction (TMD). Only the following services are covered:</p> <ul style="list-style-type: none"> • Initial consultation with a physician • Physical therapy, (subject to the visit limit for outpatient physical therapy listed in the Schedule of Benefits) • Surgery • X-rays <p>Important Notice: No Dental Care is covered for the treatment of Temporomandibular Joint Dysfunction (TMD).</p>
41 . Vision Services	
	<p>Routine Eye:</p> <p>The Plan covers routine eye examinations.</p> <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p> <p>Vision Hardware for Special Conditions:</p> <p>The Plan provides coverage for contact lenses or eyeglasses needed for the following conditions:</p> <ul style="list-style-type: none"> • Keratonconus. One pair of contact lenses is covered per Plan Year. The replacement of lenses, due to a change in the Member's condition, is limited to 3 per affected eye per Plan 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

Benefit	Description
Vision Services (Continued)	
	<p>Member's prescription of .50 diopters or more within 90 days of the surgery is also covered up to a limit of \$140.</p> <ul style="list-style-type: none"> • Post cataract surgery without lens implant (aphakes). One pair of eyeglass lenses or contact lenses is covered per Plan Year. Coverage up to \$50 per Plan 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. • 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 after the date of surgery. For Members who have not previously worn eyeglasses or contact lenses, the Plan covers eyeglass lenses up to \$50 toward the purchase of the frame or pair of contact lenses. <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p>
42 . Voluntary Sterilization	
	<p>The Plan covers voluntary sterilization, including tubal ligation and vasectomy.</p> <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p>
43 . Voluntary Termination of Pregnancy	
	<p>The Plan covers voluntary termination of pregnancy.</p> <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p>
44 . Wigs and Scalp Hair Protheses	
	<p>The Plan covers wigs and scalp hair protheses when needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis or permanent hair loss due to injury up to the Benefit Limit listed in the Schedule of Benefits.</p> <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p>

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	<ol style="list-style-type: none"> 1. Acupuncture services, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). 2. Acupuncture services that are outside the scope of standard acupuncture treatment, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits), including services for preventive, maintenance, or wellness care, thermography, hair analysis, heavy metal screening or mineral studies, massage or soft-tissue techniques, diagnostic services, x-rays or services related to menstrual cramps. 3. Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments. 4. Aromatherapy, treatment with crystals and alternative medicine. 5. Health resorts, spas, recreational programs, camps, wilderness programs (therapeutic outdoor programs), outdoor skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs. 6. Massage therapy. 7. Myotherapy.
2 . Dental Services	<ol style="list-style-type: none"> 1. Dental Care, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). 2. All services of a dentist for Temporomandibular Joint Dysfunction (TMD). 3. Extraction of teeth, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). 4. Preventive dental care for children, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). 5. Dentures
3 . Durable Medical Equipment and Prosthetic Devices	<ol style="list-style-type: none"> 1. Any devices or special equipment needed for sports or occupational purposes. 2. Any home adaptations, including, but not limited to home improvements and home adaptation equipment. 3. Myoelectric and bionic arms and legs, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). 4. Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. 5. Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.

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Exclusion	Description
4 . Experimental, Unproven or Investigational Services	<ol style="list-style-type: none"> 1. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.
5 . Foot Care	<ol style="list-style-type: none"> 1. Foot orthotics, except for the treatment of severe diabetic foot disease or when specifically listed as a Covered Benefit. (Please see your Schedule of Benefits). 2. Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members with diabetes.
6 . Maternity Services	<ol style="list-style-type: none"> 1. Delivery outside the Service Area after the 37th week of pregnancy, or after you have been told that you are at risk for early delivery. 2. Planned home births. 3. Routine pre-natal and post-partum care when you are traveling outside the Service Area.
7 . Mental Health Care	<ol style="list-style-type: none"> 1. Biofeedback. 2. 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; (2) to resolve problems of school performance; or (3) to treat learning disabilities. 3. Methadone maintenance. 4. Sensory integrative praxis tests. 5. Services for any condition with only a "V Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder. 6. 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. 7. Services or supplies for the diagnosis or treatment of mental health and substance abuse disorders that, in the reasonable judgment of the Behavioral Health Access Center, are any of the following: <ul style="list-style-type: none"> • Not consistent with prevailing national standards of clinical practice for the treatment of such conditions. • Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome. • Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. 8. Services related to autism spectrum disorders 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.

Exclusion	Description
<p>8 . Physical Appearance</p>	<ol style="list-style-type: none"> 1. Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care. 2. Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. 3. Liposuction or removal of fat deposits considered undesirable. 4. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). 5. Skin abrasion procedures performed as a treatment for acne. 6. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. 7. Treatment for spider veins.
<p>9 . Procedures and Treatments</p>	<ol style="list-style-type: none"> 1. Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial X-ray. 2. Spinal manipulative therapy (including care by a chiropractor), except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). 3. Commercial diet plans, weight loss programs and any services in connection with such plans or programs. 4. Gender reassignment surgery and all related drugs and procedures, unless covered under a separate rider. 5. If a service is listed as requiring that it be provided at a Center of Excellence, no coverage will be provided under this Handbook if that service is received from a Provider that has not been designated as a Center of Excellence. Please see section <i>I.D.4. Centers of Excellence</i> for more information. 6. 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). 7. Physical examinations and testing for insurance, licensing or employment. 8. Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. 9. Testing for central auditory processing. 10. Group diabetes training, educational programs or camps.

Exclusion	Description
10 . Providers	<ol style="list-style-type: none"> 1. Charges for services provided after the date on which your membership ends. 2. Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit under this Handbook. 3. Charges for missed appointments. 4. Concierge service fees. (See section <i>I.E.7. Provider Fees For Special Services (Concierge Services)</i> for more information.) 5. Follow-up care after an emergency room visit, unless provided or arranged by your PCP. 6. Inpatient charges after your hospital discharge. 7. Provider's charge to file a claim or to transcribe or copy your medical records. 8. Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
11 . Reproduction	<ol style="list-style-type: none"> 1. Any form of Surrogacy or services for a gestational carrier. 2. Infertility drugs if a member is not in a Plan authorized cycle of infertility treatment. 3. Infertility drugs, if infertility services are not a Covered Benefit. 4. Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage. 5. Infertility treatment for Members who are not medically infertile. 6. Infertility treatment, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). 7. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). 8. Sperm collection, freezing and storage except as described in the section <i>III. Covered Benefits, Infertility Services and Treatment</i>. 9. Sperm identification when not Medically Necessary (e.g., gender identification). 10. The following fees: wait list fees, non-medical costs, shipping and handling charges etc. 11. Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). 12. Voluntary termination of pregnancy, unless either: (1) the life of the mother is in danger or (2) voluntary termination of pregnancy is specifically listed as a Covered Benefit in your Schedule of Benefits.
12 . Services Provided Under Another Plan	<ol style="list-style-type: none"> 1. Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. 2. Costs for services for which payment is required to be made by a Workers' Compensation plan or an Employer under state or federal law.

Exclusion	Description
13 . Types of Care	<ol style="list-style-type: none"> 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. Home health care services that extend beyond care on a short-term intermittent basis. Care on a "short-term intermittent basis" means care that is provided fewer than eight hours per day, on a less than daily basis, up to 35 hours per week. If you receive more than one type of skilled service in the home, these time limits apply to all services combined. 5. Pain management programs or clinics. 6. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. 7. Private duty nursing. 8. Sports medicine clinics. 9. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
14 . Vision and Hearing	<ol style="list-style-type: none"> 1. Eyeglasses, contact lenses and fittings, except as listed in this Benefit Handbook. 2. Hearing aids, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). 3. Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TTD. 4. Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of myopia, hyperopia and astigmatism. 5. Routine eye examinations, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits).
15 . All Other Exclusions	<ol style="list-style-type: none"> 1. Any service or supply furnished in connection with a non-Covered Benefit. 2. Beauty or barber service. 3. Any drug or other product obtained at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage. Exceptions may apply for diabetes services and hypodermic syringes and needles if covered under your Plan. See section <i>III. Covered Benefits</i> of this Handbook for details. 4. Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription. 5. Guest services. 6. Services for non-Members. 7. Services for which no charge would be made in the absence of insurance. 8. Services for which no coverage is provided in this Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure (if applicable). 9. Services that are not Medically Necessary.

Exclusion	Description
All Other Exclusions (Continued)	
	<p>10. Services your PCP or a Plan Provider has not provided, arranged or approved except as described in the sections <i>I.D.1. Your PCP Manages Your Health Care</i> and <i>I.D.3. Using Plan Providers</i>.</p> <p>11. Taxes or governmental assessments on services or supplies.</p> <p>12. Transportation other than by ambulance.</p> <p>13. The following products and services:</p> <ul style="list-style-type: none"> • 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. Student Dependent Coverage

If your Dependent child goes to school away from home, he or she may continue to receive Plan benefits. Plan coverage works one of two ways for student Dependents, depending on where they go to school.

Your Dependent child must meet the eligibility criteria in section VIII. *Eligibility* in order to continue coverage as a student Dependent. The Plan may require reasonable evidence that a Member meets these requirements.

A. STUDENTS INSIDE THE ENROLLMENT AREA

If your Dependent child goes to school inside the Enrollment Area, he or she can choose a PCP near school. This PCP manages your child's care just as your PCP does for you.

The Enrollment Area is where Members, except for a Dependent child going to school, must live to be eligible for enrollment. The Enrollment Area includes the places where Plan Providers are available to care for Members. You may obtain a list of the cities and of the current Enrollment Area from member Services. We may revise the Enrollment Area from time to time.

B. STUDENTS OUTSIDE THE ENROLLMENT AREA

If your Dependent child goes to school outside the Enrollment Area, the Plan provides special coverage. This is because there are no nearby Plan PCPs who can manage your child's care while he or she is going to school.

This special coverage allows a student Dependent to receive most Covered Benefits while away at school. This includes the continuation of treatment that began before the student left the Enrollment Area. All the rules and limits on coverage listed in the Benefit Handbook and Schedule of Benefits apply to these benefits, except that your Dependent child does not need to get care through his or her PCP.

Please Note: Your Dependent child is entitled to all the benefits in this Handbook and Schedule of Benefits when he or she returns to the Enrollment Area and receives care from Plan Providers.

C. BENEFITS FOR OUT-OF-AREA STUDENT COVERAGE

For student Dependents who attend school outside the Enrollment Area, the Plan covers Medically Necessary

services, as described below, when related to a specific illness or condition.


Any Member Cost Sharing amounts will be applied as listed in your Schedule of Benefits.

1. Outpatient Medical Services

The Plan covers all of the outpatient medical services covered under this Handbook, except for the following:

- a) Routine examinations and preventive care, including immunizations
- b) Preventive dental care, if a Covered Benefit
- c) Home health care, including maternity home care programs and house calls
- d) Maintenance or replacement of prosthetic devices or durable medical equipment
- e) Procedures, including follow-up care, that can be delayed until the Member returns to the Enrollment Area without damage to the Member's health

Some plans include coverage for preventive dental care. Preventive dental care is only covered within the Enrollment Area from Plan Providers.

 FOR EXAMPLE: If your Dependent child needed a physical exam or routine eye exam, these services would NOT be covered until he or she returns to the Enrollment Area and can see a Plan Provider. However, if your child needed to continue coverage for a condition that required ongoing treatment while away at school, e.g., physical therapy, this would be covered as stated in your Schedule of Benefits.

2. Inpatient Services

The Plan covers inpatient services listed in this Handbook, except for services that can be delayed until the Member returns to the Enrollment Area without damage to the Member's health. You or your student Dependent must call the Plan at **1-888-333-4742** within 48 hours of hospitalization or as soon as you can. This telephone number can also be found on your ID card.

3. Mental Health Care (Including the Treatment of Substance Abuse Disorders)

The Plan provides access to a national network of providers of mental health care (including the treatment of substance abuse disorders). If a student Dependent needs such services, he or she must call the

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Behavioral Health Access Center at **1-888-777-4742**. This number is staffed by licensed mental health clinicians. The staff of the Behavioral Health Access Center will assist in finding the appropriate providers and arranging required services while away at school.

The coverage for out-of-area mental health care (including the treatment of substance abuse disorders) is the same as that provided for services received inside the Enrollment Area. Please see section *III. Covered Benefits, Mental Health Care (Including the Treatment of Substance Abuse Disorders)* for additional information on the benefits for mental health care.

VI. Reimbursement and Claims Procedures

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

- In a Medical Emergency; or
- When you are temporarily traveling outside Massachusetts.

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

A. BILLING BY PROVIDERS

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

- 1) Bill us on a standard health care claim form (such as the CMS 1500 or the UB04 form); and
- 2) Send it to the address listed on the back of your Plan ID card.

B. REIMBURSEMENT FOR BILLS YOU PAY

If you pay a provider who is not a Plan Provider for a Covered Benefit, the Plan will reimburse you less your applicable Member Cost Sharing. Please send any request for reimbursement for claims you have paid to the appropriate address below:

Claims for Mental Health Care:

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

Pharmacy Claims:

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

All Other Claims:

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

To obtain reimbursement for a bill you have paid, other than for pharmacy items, you must provide us with all of the following information:

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

- The name and address of the person or facility providing the services for which a claim is made and their tax identification number
- The Member's diagnosis or ICD 9 code
- The date the service was rendered
- The CPT code (or a brief description of the illness or injury) for which payment is sought
- The amount of the provider's charge
- Proof that you have paid the bill

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

1. International Claims

If you are requesting reimbursement for services received while outside of the United States you must submit an International Claim Form. The form can be obtained online at www.harvardpilgrim.org or by calling the Member Services Department. In addition to the International Claim Form you will need to submit an itemized bill and proof of payment. We may also require you to provide additional documentation, including, but not limited to: (1) records from financial institutions clearly demonstrating that you have paid for the services that are the subject of the claim; and (2) the source of funds used for payment.

2. Pharmacy Claims

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

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 optional outpatient pharmacy coverage. Please see your Prescription Drug Brochure (if applicable) for more information

Members can contact the MedImpact help desk at **1-800-788-2949** regarding pharmacy claims.

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

VII. Appeals and Complaints

This section explains the 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 Associate prior to filing an appeal. (A Member Services Associate can be reached toll free at (888) 333-4742 or at (800) 637-8257 for TTY service.) The Member Services Associate 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 Services Associate, 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 VII.C.2. *External Review*.

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

1. Initiating Your Appeal

To initiate your appeal, you or your representative can mail or FAX a letter to 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 VII.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.

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

For all appeals, except those involving mental health care (including the treatment of substance abuse disorders), please send your request to the following address:

**Appeals and Grievances Analyst
Customer Service Department
1600 Crown Colony Drive
Quincy, MA 02169
Telephone: 1-888-333-4742
Fax: 1-617-509-3085
www.harvardpilgrim.org**

If your appeal involves mental health care (including the treatment of substance abuse disorders), please send it to the following address:

**HPHC Behavioral Health Access Center
c/o United Behavioral Health
Appeals Department
100 East Penn Square, Suite 400
Philadelphia, PA 19107
Telephone: 1-888-777-4742
Fax: 1-888-881-7453**

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 the appeal process. 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.

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There are two types of appeal processes, the standard process, which applies to most denied claims and the expedited appeal process which is only available for claims involving claims for Urgent Care 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 will review Pre-Service Appeals and send a written decision within 30 days of the date the appeal was received by HPHC. HPHC will review Post-Service Appeals and send a written decision within 60 days of the date the appeal was received by HPHC. These time limits may be extended by mutual agreement between you and HPHC.

After we receive all the information needed to make a decision, your 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 HPHC’s final decision under the appeal process. If HPHC’s decision is not fully in your favor, the decision will also include a description of other options for further review of your appeal. These are also described in section C, below.

If your appeal involves a decision on a medical issue, the Appeals and Grievances Analyst will obtain the opinion of a qualified physician or other appropriate medical specialist. The health care professional conducting the review must not have

either participated in any prior decision concerning the appeal or be the subordinate of the original reviewer. Upon request, your Appeals and Grievances Analyst will provide you with a copy, free of charge, of any written clinical criteria used to decide your appeal and; where required by law, the identity of the physician (or other medical specialist) consulted concerning the decision.

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

3. The Expedited Appeal Process

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

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

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

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

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

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

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

Important Notice: If you are filing an expedited appeal with 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 VII.C.2. *External Review*, for information on how to file for external review.

and Grievances Analyst at the following address or fax number:

**Appeals and Grievances Analyst
Customer Service Department
1600 Crown Colony Drive
Quincy, MA 02169
Telephone: 1-888-333-4742
Fax: 1-617-509-3085**

C. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED

If your appeal is denied by HPHC 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 through the Plan Sponsor. Please contact your Appeals and Grievances Analyst or your Plan Sponsor for information on whether reconsideration of your appeal is available under your Plan. Your HPHC Appeals and Grievances Analyst can be reached at **1-888-333-4742**.

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

2. External Review

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

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

You, your representative, or a provider acting on your behalf, may request external review by sending a completed "Request for Voluntary Independent External Review" form by mail or fax to your Appeals

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

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

In submitting a request for external review, you understand that if HPHC 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. You must pay the \$25 external review filing fee (up to \$75 per year if you file more than one request). The fee will be returned to you if your appeal is approved by the IRO. The fee may be waived upon a showing of undue financial hardship.
- c. 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

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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.

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 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, except mental health care (including the treatment of substance abuse disorders) complaints, please call or write to us at:

**Customer Service Department
Harvard Pilgrim Health Care
1600 Crown Colony Drive
Quincy, MA 02169
Telephone: 1-888-333-4742
Fax: 1-617-509-3085
www.harvardpilgrim.org**

For a complaint involving mental health care (including the treatment of substance abuse disorders), please call or write to us at:

**HPHC Behavioral Health Access Center
c/o United Behavioral Health
Appeals Department
100 East Penn Square, Suite 400
Philadelphia, PA 19107
Telephone: 1-888-777-4742
Fax: 1-888-881-7453**

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

VIII. Eligibility

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.

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 of Dependents and effective dates of coverage.

A. MEMBER ELIGIBILITY

1. Residence Requirement

To be eligible for coverage under this Plan, you must live, and maintain a permanent residence, within the Enrollment Area at least nine months of a year. This does not apply to a Dependent child who is:

- Enrolled as a full-time student attending an accredited educational institution, or
- Enrolled as a Dependent child under a Qualified Medical Child Support Order. Dependents who enroll under a Qualified Medical Support Order whose permanent residence is outside the Enrollment Area will be subject to the limitations described in section *VIII.H. COVERAGE FOR MEMBERS WHO LIVE OUTSIDE THE ENROLLMENT AREA.*

If you have any questions about these requirements, you may call the Member Services Department.

2. Subscriber Eligibility

To be a Subscriber under this Plan, you must:

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

3. Dependent Eligibility

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

B. EFFECTIVE DATE - NEW AND EXISTING DEPENDENTS

Please see your Plan Sponsor for information on enrollment and effective dates of coverage. Please also see section *VIII.I. 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 section *VIII.I. SPECIAL ENROLLMENT RIGHTS* for additional rights upon adoption of a child.

D. CHANGE IN STATUS

It is your responsibility to inform your Plan Sponsor and us 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 care outside the Service Area.

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. NEWBORN COVERAGE

A newborn infant of a Member is eligible for coverage under the Plan from the moment of birth. Please see section *VIII.E. ADDING A DEPENDENT* for information on enrollment procedures. Please see

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section VIII.I. *SPECIAL ENROLLMENT RIGHTS* for additional rights upon the birth of a child.

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

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

H. COVERAGE FOR MEMBERS WHO LIVE OUTSIDE THE ENROLLMENT AREA

You must live within the Enrollment Area to be eligible for full benefits under this Handbook. The only exception applies to student Dependents enrolled in an accredited educational institution located outside the Enrollment Area. All other Members, including Members covered under a Qualified Medical Child Support Order (QMCSO), who live outside of the Enrollment Area are only eligible for coverage of services required in a Medical Emergency as described in section I.D.5. *Medical Emergency Services*. The benefits available to Members traveling outside Massachusetts, described in section I.D.6. *Coverage for Services When You Are Temporarily Traveling Outside the Service Area* are not available to Members who live outside of the Member Enrollment Area.

Please Note: Members who live outside the Enrollment Area may obtain full coverage for the Covered Benefits provided under this Handbook from Plan Providers within the Enrollment Area.

Please refer to section V. *Student Dependent Coverage* for coverage available to eligible student Dependents who are enrolled in an accredited institution outside the Enrollment Area.

I. 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, the employee may be able to enroll himself or herself and 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.

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 from the Plan Sponsor within 60 days after the employee or Dependent is determined to be eligible for such premium assistance.

IX. 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 the 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. See *D. CONTINUATION OF COVERAGE REQUIRED BY LAW* for more information.

Please Note: We 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. MEMBERSHIP TERMINATION FOR CAUSE

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

- Providing false or misleading information to the Plan on an application for membership or in an attempt to obtain benefits for which you or a Dependent are not eligible;
- Committing or attempting to commit fraud to obtain benefits for which the Member is not eligible under this Handbook;
- Obtaining or attempting to obtain benefits under this Handbook for a person who is not a Member; or

- The commission of acts of physical or verbal abuse by a Member, which pose a threat to providers, or other Members and which are unrelated to the Member's physical or mental condition.

Termination of membership for providing false information shall be effective immediately upon notice to a Member. Termination of membership for the other causes will be effective fifteen (15) days after notice.

D. 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 due to: 1) separation from employment; 2) reduction of work hours; or 3) loss of dependency status.

X. When You Have Other Coverage

This section explains how benefits under this Benefit Handbook will be coordinated with other insurance benefits available to pay for health services that a Member has received. Benefits are coordinated among insurance carriers to prevent duplicate recovery for the same service.

Nothing in this section should be interpreted to provide coverage for any service or supply that is not expressly covered under this Handbook.

A. BENEFITS IN THE EVENT OF OTHER INSURANCE

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

Coordination of benefits will be based upon the Allowed Amount 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.

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

In the case of health benefit plans that contain provisions for the coordination of benefits, the following rules shall decide which health benefit plans are primary or secondary:

1. Dependent/Non-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. A Dependent Child Whose Parents Are Not Separated or Divorced

The order of benefits is determined as follows:

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

3. 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.

4. 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. WORKERS' COMPENSATION/GOVERNMENT PROGRAMS

If HPHC has information indicating that services provided to you are covered under Workers' Compensation, Employer's liability or other program of similar purpose, or by a federal, state or other government agency, payment may be suspended for such services until a determination is made whether payment will be made by such program. If payment is made for services for an illness or injury covered under Workers' 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 any 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 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.

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

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. 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 only to the extent payments would exceed what would be payable by Medicare.

XI. Plan Provisions and Responsibilities

A. IF YOU DISAGREE WITH RECOMMENDED TREATMENT

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

Nothing in this subsection shall be deemed to provide benefits for any product or service not expressly stated as a Covered Benefit under this Plan.

B. LIMITATION ON LEGAL ACTIONS

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

C. 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, home-owners' 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 drug and alcohol abuse rehabilitation and mental health care 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 HPHC Notice of Privacy Practices through the Harvard Pilgrim Web site, www.harvardpilgrim.org or by calling the Member Services Department at 1-888-333-4742.

D. SAFEGUARDING CONFIDENTIALITY

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

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

HPHC discloses Members' personal information only: (1) in connection with the delivery of care or administration of benefits, such as utilization review, quality assurance activities and third-party reimbursement by other payers, including self-insured

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

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

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

E. NOTICE

Any notice to a Member may be sent to the last address of the Member on file with HPHC. Notice to HPHC, other than a request for a Member appeal, should be sent to:

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

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

F. MODIFICATION OF THIS HANDBOOK

This Benefit Handbook, the Schedule of Benefits, the Prescription Drug Brochure (if applicable), and any applicable riders or amendments 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.

G. 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, 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.

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 our facility(ies) or the disability of service providers. If the Plan cannot provide or arrange services due to a major disaster, it is not responsible for the costs or outcome of this inability.

I. EVALUATION OF NEW TECHNOLOGY

The Plan 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, Investigational or Unproven. The team researches the safety and effectiveness of these new technologies by reviewing published peer reviewed medical reports and literature, consulting with expert practitioners, and benchmarking. The team presents its recommendations to internal policy committees responsible for making decisions regarding coverage of the new technology under the Plan. The evaluation process includes:

- Determination of the FDA approval status of the device/product/drug in question,

THE HARVARD PILGRIM HMO FOR SELF-INSURED MEMBERS - MASSACHUSETTS

- 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. CERTIFICATE OF CREDITABLE COVERAGE

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

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

If requested by your Plan Sponsor, HPHC will send you a Certificate of Creditable Coverage upon termination of membership. You may also call the Member Services Department at any time within two years from the date coverage ended to request a free copy of the Certificate from HPHC.

K. UTILIZATION REVIEW PROCEDURES

HPHC uses the following utilization review procedures described below to evaluate the medical necessity of selected health care services utilizing clinical criteria, and to facilitate clinically appropriate, cost-effective management of your care.

- Prospective utilization review (prior authorization) of selected elective inpatient admissions (including admissions to acute rehabilitation hospitals and skilled nursing facilities), surgical day care, and outpatient/ambulatory procedures to determine whether proposed services meet clinical criteria for coverage. Prospective utilization review determinations will be made within two working days of obtaining all necessary information. In the case of a determination to approve an admission, procedure or service, HPHC will give notice to the

requesting provider 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 two working days. 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 of authorized admissions to inpatient rehabilitation hospitals, skilled nursing facilities and skilled home health services. 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, we will notify the provider rendering the service by telephone within 24 hours of the decision and will send a written or electronic confirmation of the telephone notification to you and the provider within one working day. In the case of an adverse determination, we will notify the provider rendering the service by telephone within 24 hours of the decision and will send a written or electronic confirmation of the telephone notification to you and the provider within one working day thereafter. In the case of ongoing services, coverage will be continued without liability to you until you have been notified of the 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 may be used in situations where services were provided before authorization was obtained.

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**. For information about decisions concerning mental health care (including the treatment of substance abuse services), you may call the Behavioral Health Access Center at **1-888-777-4742**.

In the event of an adverse determination involving clinical review, your treating provider may discuss your case with a physician reviewer or may seek reconsideration from 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 section VII. *Appeals and Complaints*. Your right to appeal does not depend on whether or not your provider sought reconsideration.

L. QUALITY ASSURANCE PROGRAMS

The goal of our quality program is to ensure the provision of consistently excellent health care, health information and service to our Members, enabling them to maintain and improve their physical and behavioral health and well-being. Some components of the quality program are directed to all Members and others address specific medical issues and providers.

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

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

Please Note: Some Plan Sponsors do not cover all these disease management programs. Please check with your Plan Sponsor for a description of programs available under your Plan.

M. 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.

N. PROCESS TO DEVELOP CLINICAL GUIDELINES AND UTILIZATION REVIEW CRITERIA

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

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.

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

HPHC Clinician Advisory Committees, comprised of actively practicing physicians from throughout the network, serve as the forum for the discussion of specialty-specific clinical programs and initiatives, and provide guidance on strategies and initiatives to evaluate or improve care and service.

XII. MEMBER RIGHTS & RESPONSIBILITIES

Members have a right to receive information about HPHC, its services, its practitioners and providers, and Members' rights and responsibilities.

Members have a right to be treated with respect and recognition of their dignity and right to privacy.

Members have a right to participate with practitioners in decision-making regarding their health care.

Members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

Members have a right to voice complaints or appeals about HPHC or the care provided.

Members have a right to make recommendations regarding the organization's members' rights and responsibilities policies.

Members have a responsibility to provide, to the extent possible, information that HPHC and its practitioners and providers need in order to care for them.

Members have a responsibility to follow the plans and instructions for care that they have agreed on with their practitioners.

Members have a responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

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