

Plan Information

For Non-Municipal Accounts

All inquiries relating to the following information should be referred directly to the Plan Sponsor. If there is any conflict between this document and the official plan document, the plan document will govern.

NAME OF PLAN: Trustees of Boston College Employee Medical Plan

PLAN NUMBER: 501

TYPE OF PLAN: The Plan is a group health plan (a type of welfare benefit plan that is subject to the provisions of ERISA)

NAME AND ADDRESS OF PLAN SPONSOR:

Trustees of Boston College
140 Commonwealth Avenue
More Hall 325
Chestnut Hill, MA 02467

EMPLOYER IDENTIFICATION NUMBER: 04-2103545

WHO PAYS FOR COVERAGE PROVIDED BY THE PLAN:

The health care coverage under the Plan is paid partly by funds contributed by Trustees of Boston College and partly by Trustees of Boston College employee contributions.

For details concerning employee contributions, contact the Plan Administrator.

PLAN YEAR:

The financial records of the Plan are kept on a Plan year basis, which is the twelve-month period beginning July 1st and ending June 30th.

GRANDFATHERED OR NONGRANDFATHERED STATUS:

Is the Plan Grandfathered under the Patient Protection and Affordable Care Act:

Check one: Yes: _____ No: X

If "Yes" is checked, the following Statement applies: This group health Plan believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the address below. You may also contact the Employee Benefit Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

PLAN ADMINISTRATOR:

The Plan is administered by Trustees of Boston College. The Plan Administrator's address is:

Trustees of Boston College
140 Commonwealth Avenue
More Hall 325
Chestnut Hill, MA 02467

The Plan Administrator has the discretionary authority to control and manage the operation and administration of the Plan, to construe and interpret the Plan, and to make determinations regarding its application.

The administration of the Plan shall be under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator shall have the discretion to determine all matters relating to eligibility, coverage and benefits under the Plan and the Plan Administrator shall have discretion to determine all matters relating to the interpretation and operation of the Plan. Any determination by the Plan Administrator shall be final and binding, in the absence of clear and convincing evidence that the Plan Administrator acted arbitrarily and capriciously.

PROVIDER NETWORK AND CLAIMS PROCESSING:

An organization has been designated to handle benefit management services such as claims processing, benefit administration, case management and other services as the designee of the Plan Administrator and to arrange for a network of health care providers whose services are covered under this Plan. This organization's name and address is:

Harvard Pilgrim Health Care
1600 Crown Colony Drive
Quincy, MA 02169

Plan benefits are provided by the Plan Sponsor on a self-insured basis. Harvard Pilgrim Health Care is not an underwriter or insurer of the Plan.

LOSS OF BENEFITS:

Circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of any benefits are described in your Handbook.

AGENT FOR LEGAL PROCESSING:

For disputes arising under the Plan, service for legal process may be made at:

Office of the General Counsel
Donaldson House
140 Commonwealth Avenue
Chestnut Hill, MA 02467

ELIGIBILITY, ENROLLMENT AND TERMINATION OF COVERAGE:

Please see your Plan Sponsor for descriptions of eligibility for dependents and effective dates of coverage.

AMENDMENT AND TERMINATION OF THE PLAN:

The Plan Sponsor has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the Plan Sponsor shall not have any obligation whatsoever to maintain the Plan for any given length of time, and the Plan Sponsor may at any time amend or terminate the Plan, in whole or in part, with respect to any or all of its participants and/or beneficiaries. Any such amendment or termination shall be effected by a written instrument signed by an authorized officer of the Plan Sponsor. No vested rights of any nature are provided under the Plan.

CLAIM PROCESSING AND RECONSIDERATION OF BENEFIT APPEAL DECISIONS:

Under ERISA claims and appeals must be decided within a reasonable time, subject to the certain maximum limits summarized as follows:

Initial claims. After receipt of the claim, the claim must be decided no later than:

- As soon as possible but no later than 72 hours for urgent care claims
- 15 days for pre-service claims
- 30 days for post-service claims

Claimants have 180 days to appeal a denied claim.

Appeals of denied claims. After receipt of the request for review, the appeal must be decided no later than:

- As soon as possible but no later than 72 hours for urgent care claims
- 30 days for pre-service claims
- 60 days for post-service claims

Claims and appeals will be decided within the period required by ERISA.

The information below describes your right to reconsideration if an appeal for benefits has been denied. Please see the Appeals and Complaints section of your Benefit Handbook for a description of the appeal process under the plan. You must use the appeal process before you can use the reconsideration process described below.

If you disagree with an appeal decision concerning HPHC's coverage of services, you may request reconsideration of the appeal by an HPHC review committee.

Requests for reconsideration should be sent to the following address:

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

Telephone: (888) 333-4742

FAX: (617) 509-3085

You must request such review within 15 days of the date of HPHC's letter denying the appeal. You, or your representative, may participate in the committee's meeting via telephone conference call to discuss the appeal, or you may request that the committee review the appeal based upon the documents and records in the appeal file. You, or your representative, are also welcome to provide HPHC with any additional documents or records concerning your appeal prior to the meeting. The HPHC review committee will provide you with a written decision after the reconsideration of your appeal.

HPHC's reconsideration process is voluntary and optional. You may request reconsideration by HPHC before or after seeking any other dispute resolution process described in the Appeals and Complaints section of the Benefit Handbook.

Reconsideration by an HPHC review committee will not affect your rights to any other benefits. You may have an authorized representative file a request for reconsideration and participate in the review committee meeting on your behalf. On reconsideration, the HPHC review committee will make an impartial evaluation of your appeal based on the review criteria in the Benefit Handbook without deference to any prior decisions made on the claim.

HPHC will not assert that you have failed to exhaust administrative remedies because you have chosen not to seek reconsideration of an appeal that has been denied under the appeal process. HPHC also agrees that any statute of limitations or defense based on timeliness is tolled during the time period in which a request for reconsideration is pending.

No fees or costs will be charged by HPHC for reconsidering an appeal decision.

Independent External Review for Nongrandfathered Health Plans

If the Plan is NOT grandfathered under the Patient Protection and Affordable Care Act (the Affordable Care Act) (see above), then, for most types of claims, you are entitled to request an independent, external review of an appeal decision. If the Plan is nongrandfathered, you may contact the Plan Administrator for more information about the external review process.

STATEMENT OF ERISA RIGHTS:

As a participant in the Plan you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan, with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain upon written request to the Plan Administrator, copies of all Plan documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report where the Plan Administrator is required by law to furnish a participant with a copy of this summary annual report.

Continuation Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review your summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order for a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Schedule of Benefits

THE HPHC INSURANCE COMPANY PPO PLAN MASSACHUSETTS

This Schedule of Benefits summarizes your benefits under The HPHC Insurance Company PPO Plan (the Plan) and states the Member Cost Sharing amounts that you must pay for Covered Benefits. However, it is only a summary of your benefits. Please see your Benefit Handbook and Prescription Drug Brochure (if you have the Plan's outpatient pharmacy coverage) for detailed information on benefits covered by the Plan and the terms and conditions of coverage.

There are two levels of coverage - In-Network and Out-of-Network

In-Network coverage applies when you use a Plan Provider for Covered Benefits. When using Plan Providers, coverage is based on the contracted rate between HPHC and the Provider.

Out-of-Network coverage applies when you use a Non-Plan Provider for Covered Benefits. When using Non-Plan Providers, the Plan pays only a percentage of the cost of the care you receive up to the Allowed Amount for the service. In most cases, this will be higher than the HPHC contracted rate. If a Non-Plan Provider charges any amount in excess of the Allowed Amount, you are responsible for the excess amount. Please refer to section I.E.6., titled "Member Cost Sharing" in your Benefit Handbook for additional information about Out-of-Network Charges in excess of the Allowed Amount.

In a Medical Emergency you should go to the nearest emergency facility or call 911 or other local emergency access number. Your emergency room Member Cost Sharing, including your Deductible if applicable, is listed in the tables below.

Member Responsibility for Notification and Prior Approval

Members must contact HPHC for coverage of a number of services. These are listed below.

Mental Health Care (Including the Treatment of Substance Abuse Disorders). Prior Approval must be obtained before receiving certain mental health services from Non-Plan Providers. This requirement also applies to treatment of substance abuse disorders. Please refer to our internet site, www.harvardpilgrim.org, or contact the Member Services Department at **1-888-333-4742** for a list of services. To obtain Prior Approval for mental health or substance abuse services, please call the Behavioral Health Access Center at **1-888-777-4742**.

Medical Services. Members are required to notify HPHC before the start of any planned inpatient admission to a Non-Plan Medical Facility. Members are also required to obtain Prior Approval from HPHC for certain services. Before you receive services from a Non-Plan Provider, please refer to our Internet site, www.harvardpilgrim.org, or contact the Member Services Department at **1-888-333-4742** for a list of Out-of-Network services that require Prior Approval.

If you do not provide Notification or obtain Prior Approval when required, you will be responsible for paying the Penalty amount stated in this Schedule of Benefits in addition to any applicable Member Cost Sharing. No coverage will be provided if HPHC determines that the service is not Medically Necessary, and you will be responsible for the entire cost of the service.

Emergency Care. You do not need to contact HPHC before receiving care in a Medical Emergency. In the event of an emergency hospital admission to a Non-Plan Provider, you must notify HPHC within 48 hours of the admission, unless notification is not possible because of your condition. If notice is given to HPHC by an attending emergency physician, no further notification

is required. However, if notification is not received when the Member's condition permits it, the Member is responsible for the Penalty amount stated in this Schedule of Benefits. Please call **1-800-708-4414** to notify us of an emergency admission to a Non-Plan facility.

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**.

COPAYMENTS

A Copayment is a dollar amount that is payable by the Member for certain covered services. The Copayment is due at the time services are rendered or when billed by the provider. Different Copayments apply depending on the type of service, the specialty of the provider and the location of service. Your identification card contains the Copayment amounts that apply to the Plan's most frequently used services.

COINSURANCE

Coinsurance is a percentage of the cost for certain covered services that is payable by the Member. Please see the tables below for the Coinsurance amounts that apply to your plan.

COVERED BENEFITS

Your Covered Benefits are administered on a calendar year basis.

General Cost Sharing Features:	Member Cost Sharing:
In-Network Coinsurance and Copayments	
	See Covered Benefits below
Out-of-Network Coinsurance and Copayments	
	See Covered Benefits below
In-Network Deductible	
	None
Out-of-Network Deductible	
	\$250 per Member per calendar year \$500 per family per calendar year
In-Network Out-of-Pocket Maximum	
Includes all In-Network Member Cost Sharing except: – Prescription drugs	\$1,250 per Member per calendar year \$2,500 per family per calendar year

THE HPHC INSURANCE COMPANY PPO PLAN - MASSACHUSETTS

General Cost Sharing Features:		Member Cost Sharing:
Out-of-Network Out-of-Pocket Maximum		
Includes all Out-of-Network Member Cost Sharing except: – Prescription drugs – Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers.		\$1,250 per Member per calendar year \$2,500 per family per calendar year
Out-of-Network Penalty Payment		
– Does not count toward the Deductible or Out-of-Pocket Maximum.		\$500
Deductible Rollover		
– Your Plan has a Deductible Rollover that applies to any Deductible amount that is incurred for services during the last 3 months of the calendar year and is applied toward the Deductible requirement for the next calendar year.		

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Ambulance Transport		
– Emergency ambulance transport	No charge	Same as In-Network
– Non-emergency ambulance transport	No charge	Same as In-Network
Autism Spectrum Disorders Treatment		
Applied Behavior Analysis	\$20 Copayment per visit	Deductible, then 20% Coinsurance
Chemotherapy and Radiation Therapy – Other than Inpatient		
– Outpatient hospital or other facility	No charge	Deductible, then 20% Coinsurance
– Physician office visit	\$20 Copayment per visit	Deductible, then 20% Coinsurance
Dental Services		
Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.		

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Dental Services (Continued)		
– Emergency Dental Care Please Note: services must be received within 3 days of injury	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided in a dentist’s office, see “Physician and Other Professional Office Visits.” For services provided in a hospital emergency room, see “Emergency Room Care.”	
– Extraction of teeth impacted in bone	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided in a dentist’s office, see “Physician and Other Professional Office Visits.”	
– Pediatric dental care for children (up to the age of 13) – limited to 2 preventive dental exams per calendar year, only the following services are included: – cleaning – fluoride treatment – teaching plaque control – x-rays	No charge	Deductible, then 20% Coinsurance
Dialysis		
– Dialysis services	\$20 Copayment per visit	Deductible, then 20% Coinsurance
– Installation of home equipment is covered up to \$300 in a Member's lifetime.	No charge	Deductible, then 20% Coinsurance
Durable Medical Equipment		
– Durable Medical Equipment	20% Coinsurance	Deductible, then 20% Coinsurance
– Blood Glucose Monitors, Infusion Devices and Insulin Pumps (including supplies)	No charge	No charge
– Oxygen and Respiratory Equipment	No charge	Deductible, then 20% Coinsurance
Early Intervention Services		
	No charge	No charge
Emergency Admission		
	No charge	Same as In-Network
Emergency Room Care		
	\$100 Copayment per visit This Copayment is waived if admitted to the hospital directly from the emergency room.	Same as In-Network
Home Health Care		
	No charge	Deductible, then 20% Coinsurance

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Hospice – Outpatient Services		
	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see “Physician and Other Professional Office Visits.” For inpatient hospital care, see “Hospital – Inpatient Services.”	
Hospital – Inpatient Services		
– Acute Hospital Care	No charge	Deductible, then 20% Coinsurance
– Inpatient Maternity Care	No charge	Deductible, then 20% Coinsurance
– Inpatient Routine Nursery Care, including prophylactic medication to prevent gonorrhea	No charge	Deductible, then 20% Coinsurance
– Inpatient Rehabilitation – Limited to 60 days per calendar year	No charge	Deductible, then 20% Coinsurance
– Skilled Nursing Facility – Limited to 100 days per calendar year	No charge	Deductible, then 20% Coinsurance
Hypodermic Syringes and Needles		
	Subject to the applicable pharmacy Member Cost Sharing in your Outpatient Prescription Drug Schedule of Benefits and listed on your ID Card. If your Plan does not include coverage for outpatient prescription drugs, then coverage is subject to the lower of the pharmacy’s retail price or a Copayment of \$5 for Tier 1 drugs or supplies, \$10 for Tier 2 drugs or supplies and \$25 for Tier 3 drugs or supplies. All Copayments are based on a 30 day supply.	
	For information on the different drug tiers, please visit our website at www.harvardpilgrim.org/members and select “ pharmacy/drug tier look up ” or contact our Member Services Department at 1-888-333-4742 .	
Infertility Services and Treatments (see the Benefit Handbook for details)		
	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see “Physician and Other Professional Office Visits.” For inpatient hospital care, see “Hospital – Inpatient Services.”	
Laboratory and Radiology Services		
Laboratory and x-rays	No charge	Deductible, then 20% Coinsurance
Advanced radiology – CT scans – PET scans – MRI – MRA – Nuclear medicine services	\$75 Copayment per procedure Note: A maximum of two Copayments apply per Member per calendar year for all high end radiology scans	Deductible, then 20% Coinsurance
Please Note: No In-Network Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services Notice at: www.harvardpilgrim.org		

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Low Protein Foods		
– Limited to \$5,000 per calendar year	No charge	No charge
Maternity Care - Outpatient		
Routine outpatient prenatal and postpartum care	No charge	Deductible, then 20% Coinsurance
<p>Please Note: Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, for services provided by another physician or specialist, see “Physician and Other Professional Office Visits” for your applicable Member Cost Sharing. Please see your Benefit Handbook for more information on maternity care.</p>		
Medical Formulas		
	No charge	No charge
Mental Health Care (Including the Treatment of Substance Abuse Disorders)		
Inpatient Mental Health Care Services	No charge	Deductible, then 20% Coinsurance
Intermediate Mental Health Care Services – Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization – Intensive outpatient programs, partial hospitalization and day treatment programs	No charge	Deductible, then 20% Coinsurance
Outpatient Mental Health Care Services	Group therapy – \$10 Copayment per visit Individual therapy – \$20 Copayment per visit	Group therapy – Deductible, then 20% Coinsurance Individual therapy – Deductible, then 20% Coinsurance
– Detoxification	\$20 Copayment per visit	Deductible, then 20% Coinsurance
– Medication management	\$20 Copayment per visit	Deductible, then 20% Coinsurance
– Psychological testing and neuropsychological assessment	\$20 Copayment per visit	Deductible, then 20% Coinsurance
Ostomy Supplies		
	20% Coinsurance	Deductible, then 20% Coinsurance
Physician and Other Professional Office Visits (This includes all covered Providers unless otherwise listed in this Schedule of Benefits.)		
– Routine examinations for preventive care, including immunizations	No charge	Deductible, then 20% Coinsurance
– Consultations, evaluations and sickness and injury care	\$20 Copayment per visit	Deductible, then 20% Coinsurance
– Administration of allergy injections	\$5 Copayment per visit	Deductible, then 20% Coinsurance

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Preventive Services and Tests		
<p>Preventive care services, including all FDA approved contraceptive devices. Under the federal health care reform law, many preventive services and tests are covered with no Member Cost Sharing.</p> <p>For a list of covered preventive services, please see the Preventive Services Notice on our website at: www.harvardpilgrim.org. You may also get a copy of the Preventive Services Notice by calling the Member Services Department at 1-888-333-4742.</p>	No charge	Deductible, then 20% Coinsurance
<p>Under federal law the list of preventive services and tests covered above may change periodically based on the recommendations of the following agencies:</p> <ol style="list-style-type: none"> Grade "A" and "B" recommendations of the United States Preventive Services Task Force; With respect to immunizations, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and With respect to services for women, infants, children and adolescents, the Health Resources and Services Administration. <p>Information on the recommendations of these agencies may be found on the web site of the U.S. Department of Health and Human Services at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1.</p> <p>Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with changes in the recommendations of the agencies listed above. You can find a list of the current recommendations for preventive care on Harvard Pilgrim's web site at www.harvardpilgrim.org.</p>		
Prosthetic Devices		
	20% Coinsurance	Deductible, then 20% Coinsurance
Rehabilitation Therapy - Outpatient		
– Cardiac Rehabilitation	\$20 Copayment per visit	Deductible, then 20% Coinsurance
– Pulmonary rehabilitation therapy	\$20 Copayment per visit	Deductible, then 20% Coinsurance
– Speech-Language and Hearing Services	\$20 Copayment per visit	Deductible, then 20% Coinsurance
– Occupational therapy – limited to 30 visits per calendar year – Physical therapy – limited to 30 visits per calendar year	\$20 Copayment per visit	Deductible, then 20% Coinsurance

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
– Colonoscopy, endoscopy and sigmoidoscopy	Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see “Surgery– Outpatient.” For services provided in a physician’s office, see “Physician and Other Professional Office Visits.” For inpatient hospital care, see “Hospital – Inpatient Services.”	
Please Note: No In-Network Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services Notice at: www.harvardpilgrim.org .		
Spinal Manipulative Therapy (including care by a chiropractor)		
– Limited to 20 visits per calendar year	\$20 Copayment per visit	Deductible, then 20% Coinsurance
Surgery – Outpatient		
	No charge	Deductible, then 20% Coinsurance
Vision Services		
– Routine eye examinations – limited to 1 exam per calendar year	\$20 Copayment per visit	Deductible, then 20% Coinsurance
– Vision hardware for special conditions	No charge	Deductible, then 20% Coinsurance
Wigs and Scalp Hair Protheses as required by law		
– Limited to \$350 per calendar year (see the Benefit Handbook for details)	20% Coinsurance	Deductible, then 20% Coinsurance



Benefit Handbook

THE HARVARD PILGRIM PPO PLAN *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 PPO Plan *for Self-Insured Members* (the Plan) offered by HPHC Insurance Company, Inc. 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, Inc. (Harvard Pilgrim or HPHC) administers the plan's benefits on behalf of your Plan Sponsor.

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

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

To use the Plan effectively, you will want to review this Handbook and the Schedule of Benefits, which describe your In-Network, and Out-of-Network benefits. This Plan has been designed to offer you the flexibility of obtaining Covered Benefits through the Plan's network of Plan Providers or the Non-Plan Provider of your choice. Benefits are covered both In-Network and Out-of-Network. However, in most cases, your In-Network benefits provide you with a higher level of coverage. In addition, when you use In-Network benefits you will never be responsible for charges in excess of the Allowed Amount for the service.

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

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

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

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

As a Member, you can take advantage of a wide range of helpful online tools and resources. For instance, **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, 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 at **1-888-333-4742** if you have any questions. Member Services staff are available to help you with questions about the following:

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

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

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.

HPHC Insurance Company, Inc.
Member Services Department
1600 Crown Colony Drive
Quincy, MA 02169
1-888-333-4742
www.harvardpilgrim.org

Clinical Review Criteria. HPHC uses clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of 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 للعناية الصحية (Harvard Pilgrim) هارفارد بيلجريم ، وذلك للحصول على 1-888-333-4742 على الرقم إجابات لاستفساراتهم. ويقدم البرنامج خدمات ترجمة مجانية بأكثر من 120 لغة.

[Portuguese]

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

[French]

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

[Greek]

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

[Haitian Creole]

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

[Italian]

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

[Traditional Chinese]

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

[Lao]

ສະມາຊິກ ທັງ ສາຍ ທີ່ ບາດ ພາສາ ຈິ່ງ ຕິດ ອໍ່ ເປັນຕົ້ນ ສາມາດ ຕິດ ຕໍ່ ກັບ ພະນັກ ບໍລິຫານ ສາ ອຳ ຂອງ ໂຄງ ການ ລັກສາ ສູນພາຍ Harvard Pilgrim ໄດ້ ໂດຍ ໂທ ໂທ ຫາ 1-888-333-4742 ເພື່ອ ອໍ່ ຊາຍ ອຳ ກອບ ຂອງ ອຳ ການ ຕ່າງໆ ຂອງ ເປັນ. ໂຄງ ການ ນີ້ ອໍ່ ສະບັບ ບໍລິຫານ ພາສາ ໃນ ສາຍ ກວ່າ 120 ພາສາ ໂດຍ ອໍ່ ອິດ ອຳ ບໍລິຫານ ໂຄງ ຈິ່ງ ສິມ.

[Cambodian]

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

Non-English speaking Member's 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 PPO Plan *for Self-Insured Members* (the Plan). The Plan provides you with two levels of benefits known as In-Network coverage and Out-of-Network coverage. You receive In-Network coverage when you obtain Covered Benefits from Providers participating in the Plan. These Providers are referred to as “Plan Providers.” Plan Providers have agreed to accept our payment plus any Member Cost Sharing as payment in full.

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

You receive Out-of-Network coverage when you obtain Covered Benefits from Non-Plan Providers. The Plan does not have agreements or contracts with these Providers. We pay a percentage of the cost of care you receive from Non-Plan Providers, up to the Allowed Amount for the service. If a Non-Plan Provider charges any amount in excess of the Allowed Amount, you are responsible for the excess amount. Your In-Network and Out-of-Network coverage is described further below.

A. HOW TO USE THIS BENEFIT HANDBOOK

1. Why This Benefit Handbook Is Important

This Benefit Handbook, the Schedule of Benefits, and the Prescription Drug Brochure (if your Plan includes outpatient pharmacy coverage) make up the agreement stating the terms of the Plan. If you have any questions about Dependent eligibility, we recommend that you see your Employer 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:

- How to obtain benefits with the lowest out-of-pocket expense
- Covered Benefits
- Exclusions

- The requirements for In-Network and Out-of-Network coverage

You can view your Benefit Handbook, Schedule of Benefits, Prescription Drug Brochure (if your Plan includes 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

In order to be eligible for In-Network coverage under the Plan, all services, except care in a Medical Emergency, must be received from Plan Providers. These are the physicians, Hospitals and other medical professionals who are under contract to care for Plan Members. You can find Plan Providers by using the Provider Directory.

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

The online Provider Directory enables you to search for Providers by name, gender, specialty, hospital affiliations, languages spoken and office locations. You can also obtain information about whether a Provider

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is accepting new patients. Since it is frequently updated, the information in the online directory will be more current than a 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: The physicians and other medical professionals in the Plan's provider network participate through contractual arrangements that can be terminated either by a Provider or by us. 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.

C. MEMBER OBLIGATIONS

1. Show Your Identification Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the Provider may not bill 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.

2. Share Costs

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

- Copayments
- Coinsurance
- Deductibles

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

3. Obtain Prior Approval

You are required to notify us or obtain Prior Approval before receiving certain Covered Benefits from a Non-Plan Provider. For In-Network medical benefits a Plan Provider will do this for you. Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for more information on these requirements.

To provide notification or obtain Prior Approval for Out-of-Network medical services you should call: **1-800-708-4414**.

To provide notification or obtain Prior Approval for Out-of-Network mental health and drug and alcohol rehabilitation services you should call the Behavioral Health Access Center at **1-888-777-4742**.

You do not need to provide advance notification or obtain Prior Approval if services are needed in a Medical Emergency.

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

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

D. HOW TO OBTAIN CARE

IMPORTANT POINTS TO REMEMBER

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

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

1. How Your In-Network Benefits Work

In-Network benefits are available when you receive Covered Benefits from a Plan Provider. Your Member

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Cost Sharing is generally lower for In-Network benefits. In-Network coverage applies to Plan Providers in Massachusetts, Maine, New Hampshire, Rhode Island, Vermont, Connecticut and a large number of Providers in HPHC's affiliated national network around the country. Since we pay Plan Providers directly, you do not have to file a claim when you use your In-Network benefits.

Plan Providers are under contract to provide Covered Benefits to Members of the Plan. They are listed in the Plan Provider Directory. Although changes in Providers are relatively rare, Plan Providers may leave the network for a variety of reasons. Members should consult the Plan's on-line Provider Directory to verify a Provider's status as a Plan Provider. (You may view the on-line Provider Directory at www.harvardpilgrim.org.) A Member may also contact HPHC's Member Services Department at **1-888-333-4742** for information on Plan Providers. Members are responsible for advising Providers of their membership in the Plan by showing them their identification card before receiving services.

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

2. How Your Out-of-Network Benefits Work

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

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

To request Prior Approval, please call:

- **1-800-708-4414** for Medical Services
- **1-888-777-4742** for Mental Health and Drug and Alcohol Rehabilitation Services

Payments to Plan Providers are usually based on a contracted rate between us and the Plan Provider.

Since we have no contract with Non-Plan Providers, there is no limit on what such Providers can charge. You are responsible for any amount charged by a Non-Plan Provider in excess of the Allowed Amount for the service.

3. Selecting a Plan Provider

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

If you have 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 or substance abuse 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.

Please Note: The physicians and other medical professionals in the Plan's provider network participate through contractual arrangements that can be terminated either by a Provider or by us. In addition, a Provider may leave the network because of retirement, relocation or other reasons. This means that we cannot guarantee that the physician you choose will continue to participate in the network for the duration of your membership.

4. Centers of Excellence

Certain specialized services are only covered at the In-Network benefit level 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.

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In order to receive In-Network benefits for the following service in Massachusetts, Maine, New Hampshire or Rhode Island, you must obtain care at a Plan Provider that has been designated as a Center of Excellence:

- Weight loss surgery (bariatric surgery)

Important Notice: If you choose to receive treatment for the above service at a facility other than a contracted Center of Excellence, coverage will be at the Out-of-Network benefit level. A list of Centers of Excellence for Massachusetts, Maine, New Hampshire and Rhode Island may be found in the Provider Directory. The Provider Directory is available online at www.harvardpilgrim.org or by calling our Member Services Department at 1-888-333-4742.

If you are receiving care outside of Massachusetts, Maine, New Hampshire or Rhode Island, please check your provider directory for a list of participating hospitals.

We may revise the list of services that must be received from a Center of Excellence upon 30 days' notice to Members. Services or procedures may be added to the list when we identify services in which significant improvements in the quality of care may be obtained through the use of selected Providers. Services or procedures may be removed from the list if we determine that significant advantages in quality of care will no longer be obtained through the use of a specialized panel of Providers.

5. Covered Benefits from Our Affiliated National Network of Providers

HPHC offers a comprehensive network of Plan Providers located in Massachusetts, New Hampshire, Rhode Island, Vermont, Connecticut and Maine. In addition, HPHC's national provider network allows Members to obtain In-Network benefits outside of those states. As of the issuance of this Handbook, the national network includes nearly 450,000 physicians and over 4,000 hospitals. To locate one of these Providers, log onto the Plan's online directory at www.harvardpilgrim.org or call Member Services at 1-888-333-4742.

6. How to get Care After Hours

Either your doctor or a covering Provider is available to direct your care 24-hours a day. Talk to your doctor to find out what arrangements are available for care after normal business hours. Some doctors may have covering physicians after hours and others may have extended office/clinic hours. In a Medical Emergency,

you should go to the nearest emergency facility or call 911 or other local emergency number.

7. Medical Emergency Services

In a Medical Emergency, including an emergency mental health condition, you should go to the nearest emergency facility or call 911 or other local emergency number. Your emergency room Member Cost Sharing is listed in your Schedule of Benefits. Please remember that if you are hospitalized, you must call the Plan at **1-888-333-4742** within 48 hours or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to the Plan or PCP by an attending emergency physician no further notice is required. If notification is not received when the Member's condition permits, the Member is responsible for the Penalty Payment.

E. MEMBER COST SHARING

Below are descriptions of Member Cost Sharing that may apply to your Plan. Member Cost Sharing under your Plan may apply to services received In-Network, Out-of-Network or both. See your Schedule of Benefits for Member Cost Sharing details that are specific to your Plan.

1. Copayment

A Copayment is a fixed dollar amount payable for certain Covered Benefits. If the Covered Benefit you are receiving is subject to a Copayment, the Copayment is payable at the time of the visit or when billed by the Provider. Copayment amounts are specified in your Schedule of Benefits.

2. Deductible

A Deductible is a specific dollar amount that is payable by the Member for Covered Benefits received each calendar year before any benefits subject to the Deductible are payable by the Plan. Deductible amounts are incurred on the date of service. You may have different Deductibles that apply to different Covered Benefits under your Plan. If a Deductible applies to your plan, it will be stated in the Schedule of Benefits.

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

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- a. If a Member of a covered family meets an individual Deductible, then services for that Member that are subject to that Deductible are covered by the Plan for the remainder of the calendar year.
- b. If any number of Members in a covered family collectively meet the family Deductible, then all Members of the covered family receive coverage for services subject to that Deductible for the remainder of the calendar year.

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

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

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

3. Coinsurance

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

4. Out-of-Pocket Maximum

Your coverage may include an Out-of-Pocket Maximum. An Out-of-Pocket Maximum is the

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

Certain expenses do not apply to the Out-of-Pocket Maximum. Please see your Schedule of Benefits for Member Cost Sharing amounts that do not apply to the Out-of-Pocket maximum. In addition, Penalty amounts and charges above the Allowed Amount never apply to the Out-of-Pocket maximum.

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

- a. If a Member of a covered family meets an individual Out-of-Pocket Maximum, then that Member has no additional Member Cost Sharing for the remainder of the calendar year.
- b. If any number of Members in a covered family collectively meet the family Out-of-Pocket Maximum, then all Members of the covered family have no additional Member Cost Sharing for the remainder of the calendar year.

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

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

On occasion, a Non-Plan Provider may charge amounts in excess of the Allowed Amount. In those instances, you will be financially responsible for the difference between what the Provider charges and the amount of the Allowed Amount payable by the Plan. This means that you will be responsible for

paying the full amount above the Allowed Amount. Amounts charged by a Non-Plan Provider in excess of the Allowed Amount do not count toward the Out-of-Pocket Maximum. You may contact the Member Services Department at **1-888-333-4742** or at **1-800-637-8257** for TTY service if you have questions about the maximum Allowed Amount that may be permitted by HPHC for a service.

6. Penalty

The amount that a Member is responsible to pay for certain Out-of-Network services when notification or Prior Approval has not been received before obtaining the services. The Penalty charge is in addition to any Member Cost Sharing amounts. Penalty charges do not count towards any Out-of-Pocket Maximum. Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for a detailed explanation of the Prior Approval program.

7. Combined Payment Levels

Under some circumstances you may receive services from both a Plan Provider and a Non-Plan Provider when obtaining care. When this occurs, your entitlement to In-Network or Out-of-Network coverage always depends upon the participation status of the individual service Provider. For example, you may receive treatment in a Plan Provider's office and receive associated blood work from a non-plan laboratory. Since the payment level is dependent upon the participation status of the Provider, the Plan Provider would be paid at the In-Network coverage level and the laboratory would be paid at the Out-of-Network coverage level.

The benefit payment level that is applied to a hospital admission depends on the participation status of both the admitting physician and the hospital. If a Plan Provider admits you to a participating hospital, both the hospital and physician are paid at the In-Network coverage level. If an Out-of-Network physician admits you to a participating hospital, the hospital's charges are paid at the In-Network coverage level but the physician's charges are paid at the Out-of-Network coverage level. Likewise if a Plan Provider admits you to a non-plan hospital, the hospital's charges are paid at the Out-of-Network coverage level but the physician's charges are paid at the In-Network coverage level. All Out-of-Network payments are limited to the Allowed Amount.

F. NOTIFICATION AND PRIOR APPROVAL

Members are required to notify HPHC before the start of any planned inpatient admission to a Non-Plan Medical Facility. A "Non-Plan Medical Facility" is any inpatient medical Provider that is not under contract with us to provide care to members. Members are also required to obtain Prior Approval from HPHC before receiving certain services. This section explains when notification and Prior Approval are required and the procedures to follow to meet those requirements.

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

1. Notification of Planned Inpatient Admissions

You must notify HPHC in advance of any planned inpatient admission to a Non-Plan Medical Facility. This requirement applies to admissions to all types of inpatient medical facilities, including hospitals, Skilled Nursing Facilities (SNFs) and rehabilitation hospitals. (For Non-Plan inpatient mental health and drug and alcohol rehabilitation services, please follow the Prior Approval process explained in the next section.)

To provide notification, you should contact HPHC at **1-800-708-4414** at least five (5) business days in advance of the admission. You do not need to provide advance notification to HPHC if you are hospitalized in a Medical Emergency. In the event of a Medical Emergency admission, you or your physician must notify HPHC within 48 hours or as soon as possible.

If either the hospital or admitting physician is a Non-Plan Provider, you are responsible for notifying HPHC. As noted above, Providers may notify HPHC on your behalf.

2. When Prior Approval is Required

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

1) For Mental Health and Drug and Alcohol Rehabilitation Services

Prior Approval must be obtained before receiving certain mental health services (including substance abuse treatment) from a Non-Plan Provider. To obtain Prior Approval for mental health or substance abuse services you should call the Behavioral Health Access Center at **1-888-777-4742**. Please refer to HPHC's Internet site at **www.harvardpilgrim.org**, or

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call Member Services for updates and revisions to the following list:

- **Inpatient Care** – Inpatient care includes all mental health care (including substance treatment) requiring the patient to spend the night at a facility. As noted above, Prior Approval is not required for care needed in a Medical Emergency.

- **Outpatient Care** – Prior approval must be obtained for the following outpatient mental health services (including substance abuse treatment):

1. Intensive Outpatient Program

Treatment – Treatment programs at an outpatient clinic or other facility generally lasting three or more hours a day on two or more days a week.

2. Partial Hospitalization and Day Treatment Programs

3. Extended Outpatient Treatment Visits – Outpatient visits of more than 50 minutes duration with or without medication management. Also included is any treatment routinely involving more than one outpatient visit in a day.

4. Outpatient Electro-Convulsive Treatment (ECT)

5. Psychological Testing and Neuropsychological Assessment

6. Applied Behavioral Analysis (ABA) for the treatment of Autism

Please Note: You may also contact the Behavioral Health Access Center at **1-888-777-4742** for assistance in obtaining covered mental health services (including substance abuse treatment), even if prior approval is not required for the service you require.

2) For Medical Services.

You must obtain Prior Approval in advance of receiving any of the medical services listed below from a Non-Plan Provider. To obtain Prior Approval for medical services you or your Provider should call: **1-800-708-4414**. Please refer to HPHC's Internet site at **www.harvardpilgrim.org**, or call Member Services for updates and revisions to the following list:

- **Cosmetic, reconstructive and restorative procedures** – All covered

services, including, but not limited to, blepharoplasty, breast reduction mammoplasty, gynecomastia surgery, panniculectomy, ptosis repair, rhinoplasty, and scar revision. (Please note that the Plan provides very limited coverage for Cosmetic Services. Please see "Reconstructive Surgery" in section *III. Covered Benefits* for details.)

- **Dental and Oral Surgery** – All covered services, including surgical treatment of temporomandibular joint dysfunction (TMD). (Please note that the Plan provides very limited coverage for Dental Care. Please see "Dental Services" in section *III. Covered Benefits* for details.)
- **Durable Medical Equipment** – Continuous glucose monitoring systems only.
- **Formulas and enteral nutrition** – Outpatient services only.
- **Home health care** – Includes home infusion (including treatment of Lyme Disease) and home hospice care.
- **Immune Globulin (IVIg)**
- **Infertility Services** – All services for the treatment of infertility.
- **Non—Emergency Air Ambulance Transportation** – Emergency air ambulance transportation is immediate transportation by air ambulance that is arranged by police, fire or other emergency rescue officials during a Medical Emergency. Emergency air ambulance services do not require Prior Approval. You must obtain Prior Approval for coverage of any other air ambulance transportation.
- **Occupational therapy** – Outpatient services only.
- **Physical therapy** – Outpatient services only.
- **Pulmonary rehabilitation** – Outpatient services only
- **Radiology – Advanced Radiology**- Computerized axial tomography (CAT and CT and CTA scans); Magnetic resonance imaging (MRI and MRA scans); Nuclear cardiac studies; and Positron emission tomography (PET scans).

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- **Skilled Nursing Facility (SNF) and rehabilitation hospital care** – Includes all admissions to Skilled Nursing Facilities (SNFs) and inpatient rehabilitation facilities.
- **Speech and language therapy** – Outpatient services only
- **Surgery (both inpatient and outpatient)** – Prior Approval is required for the following surgical procedures: bariatric surgery (weight loss surgery), breast reduction and reconstructive surgery, including breast implant removal and gynecomastia; septoplasty; surgical treatment of obstructive sleep apnea, including uvulopalatopharyngoplasty (UPPP); and treatment of varicose veins.

Please refer to HPHC's Internet site, www.harvardpilgrim.org, for updates and revisions to the above lists.

3. How to Obtain Prior Approval

To seek Prior Approval for medical services received from a Non-Plan Provider, you should call: **1-800-708-4414**. To seek Prior Approval for mental health and substance abuse services received from a Non-Plan Provider, you should call **1-888-777-4742**.

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

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

For inpatient admission to a Non-Plan Provider the following additional information must be given:

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

4. The Effect of Notification and Prior Approval on Coverage

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

If you do not provide notification or obtain Prior Approval when required, you will receive coverage for services later determined to be Medically Necessary, but you will be responsible for paying the Penalty amount stated in the Schedule of Benefits in addition to any applicable Member Cost Sharing.

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

Neither notification nor Prior Approval entitle you to any benefits not otherwise payable under this Benefit Handbook or the Schedule of Benefits.

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

5. What Notification and Prior Approval Do

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

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

If the Prior Approval program conducts a medical review of a service, you and your attending physician will be notified of HPHC's decision to approve or not to approve the care proposed. All decisions to deny a medical service will be reviewed by a physician (or, in the case of mental health and drug and alcohol rehabilitation services, a qualified clinician) in accordance with written clinical criteria. The relevant criteria will be made available to Providers and Members upon request.

If the Prior Approval program denies a coverage request, it will send you a written notice that

explains the decision, your Provider's right to obtain reconsideration of the decision, and your appeal rights.

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

1. 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 In-Network coverage for services delivered by the disenrolled Provider, under the terms of this Handbook and your Schedule of Benefits, for the period up to, and including, your first postpartum visit.

2. 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 In-Network coverage for services delivered by the disenrolled Provider, under the terms of this Handbook and the Schedule of Benefits, until the Member's death.

3. New Membership

If you are a new Member, we will provide In-Network coverage for services delivered by a physician or nurse practitioner 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 or nurse practitioner is a Non-Plan Provider, and
- The physician or nurse practitioner is providing you with an ongoing course of treatment.

4. 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 (or, in the case of a new member, our applicable rate) 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 obtaining prior authorization and providing Covered Benefits pursuant to a treatment plan, if any, approved by us.

H. CLINICAL REVIEW CRITERIA

HPHC uses clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of 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**.

I. PROVIDER FEES FOR SPECIAL SERVICES (CONCIERGE SERVICES)

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

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

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

The Allowed Amount for Out-of-Network benefits depends upon where you receive Out-of-Network services as explained below:

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

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

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

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

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

When a rate is not published by CMS for the service and no industry standard methodology applies to the service, or the provider does not submit sufficient information

on the claim to pay it under CMS published rates or an industry standard methodology, the Allowed Amount will be 50% of the provider's billed charge, 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 CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.

Anniversary Date The date agreed to by HPHC and your Plan Sponsor upon which the yearly benefit changes normally become effective. This Benefit Handbook, Schedule of Benefits, Prescription Drug Brochure 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 us, 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 certain 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 stated in your Schedule of Benefits.

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

Centers of Excellence Certain specialized services are only covered as In-Network services in Massachusetts, Maine, New Hampshire or Rhode Island 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 are in addition to any Deductible and any applicable Copayment. Coinsurance amounts applicable to your Plan are stated in your Schedule of Benefits.

✓ FOR EXAMPLE: If the Coinsurance for a service is 20%, you pay 20% of the Allowed Amount while we pay the remaining 80%. (In the case of Out-of-Network services, we only pay up to the Allowed Amount.)

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.

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 calendar year before any benefits subject to the Deductible are payable by the Plan. If a family Deductible applies, it is met when any combination of Members in a covered family incur expenses for services to which the Deductible applies in a calendar 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 you to apply any Deductible amount incurred for Covered Benefits during the last three (3) months of a calendar year toward the Deductible for the next calendar year. To be eligible for a Deductible Rollover, a Member must have had continuous coverage with us through the same Plan Sponsor at the time the prior calendar year charges were incurred. If your Plan has a Deductible Rollover it will be stated in your Schedule of Benefits.

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

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

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

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

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HPHC Insurance Company, Inc. (HPHC) Harvard Pilgrim Health Care 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.

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

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 HPHC.

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.

Please remember that if you are hospitalized, you must call HPHC within 48 hours or as soon as you can. If the notice of hospitalization is given to HPHC by an attending emergency physician, no further notice is required.

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.

Non-Plan Provider A Provider not under contract with HPHC or its

affiliates to provide care to Members. Payments for services received from Non-Plan Providers are limited to the Allowed Amount. When care is received from a Non-Plan Provider, Member's are responsible for the applicable Deductible and Coinsurance plus any amounts in excess of the Allowed Amount. The Deductible and Coinsurance amounts are described in your Schedule of Benefits.

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

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 calendar 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. In addition, Penalty amounts and charges above the Allowed Amount never apply to the 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: Penalty payments and charges above the Allowed Amount never apply to the Out-of-Pocket Maximum.

 **FOR EXAMPLE:** If your Plan has an individual Out-of-Pocket Maximum of \$1,000, this is the most Member Cost Sharing you would pay in a calendar 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.

Penalty The amount a Member is responsible to pay for certain Out-of-Network services when

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notification has not been given or Prior Approval has not been received when required. The Penalty charge is in addition to any Member Cost Sharing amounts. Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for a detailed explanation of the Prior Approval program. A Penalty amount does not apply to an Out-of-Pocket Maximum, if any.

Physical Functional Impairment

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

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

Plan This package of health care benefits known as The Harvard Pilgrim PPO 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 who are under contract to provide In-Network services to Plan Members, and have agreed to charge Members only the applicable Copayments, Coinsurance and Deductible amounts for Covered Benefits. Plan Providers are listed in the Provider Directory.

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

Prior Approval or Prior Approval Program A program to (1) verify that certain covered services are and

continue to be, Medically Necessary and provided in an appropriate and cost-effective manner or (2) to arrange for the payment of benefits. Prior Approval is required for certain Out-of-Network benefits. Before you receive services from a Non-Plan Provider, please refer to our Internet site, www.harvardpilgrim.org or contact the Member Services Department at **1-888-333-4742** for the complete listing of Out-of-Network services that require Prior Approval. To seek Prior Approval for medical services you should call: **1-800-708-4414**. To seek Prior Approval for mental health and drug and alcohol rehabilitation services you should call **1-888-777-4742**.

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

Prior Carrier Credit A credit given for the first calendar 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 may be applied to the Deductible or the Out-of-Pocket Maximum of this Plan if the following requirements were met: a) You were enrolled in your Plan Sponsor's prior plan on the termination date of coverage; and b) Your coverage became effective with us on the same day as the Plan Sponsor's plan.

Provider A Provider is defined as: a hospital or facility that is licensed to provide inpatient medical, surgical, or rehabilitative services; a Skilled Nursing Facility; and medical professionals including but not limited to: physicians, psychologists, psychiatrists, podiatrists, nurse practitioners, physician's assistants, psychiatric social workers, licensed nurse mental health clinical specialist, psychotherapists, psychologists, licensed independent clinical social workers, licensed mental health counselors, physicians with recognized expertise in specialty pediatrics (including mental health care), nurse midwives, nurse anesthetists,

chiropractors, optometrists, speech-language pathologists and audiologists, and early intervention specialists who are credentialed and certified by the Massachusetts Department of Public Health. Dentists may also be Providers when providing services under this Plan. (Please note that coverage for dental services is very limited.) Plan Providers are listed in the Provider Directory.

Provider Directory A directory that identifies Plan Providers. We may revise the Provider Directory from time to time without notice to Members. The most current listing of Plan Providers is available on line at 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 and any applicable riders.

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

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or Deductible you must pay and any limitations on coverage.

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 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 describes the benefits available under the Plan. Not all benefits listed in this Handbook may apply to you. Please see your Schedule of Benefits for your specific Covered Benefits. If your Plan includes outpatient pharmacy coverage, that coverage is described in your Prescription Drug Brochure.

Some benefits have limits on the amount of coverage provided in a calendar year. If a Covered Benefit has a benefit limit, your In-Network or Out-of-Network benefits are combined and count toward your benefit limit. For example, if the Covered Benefit is limited to ten visits per calendar year and you receive nine visits In-Network and one visit Out-of-Network, then you have reached your benefit limit. That benefit will not be covered again until the next calendar year.

Member Cost Sharing information and any applicable benefit limitations that apply to your Plan are stated in your Schedule of Benefits. Benefits are administered on a calendar year basis.

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

Basic Requirements for Coverage

To be covered by the Plan, a product or service must meet each of the following requirements. It must be:

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

Prior Approval or Notification Required: When you use your Out-of-Network benefits, some services require Prior Approval by the Plan. Before you receive services from a Non-Plan Provider, please refer to our Internet site, www.harvardpilgrim.org or contact the Member Services Department at **1-888-333-4742** for the complete listing of Out-of-Network services that require Prior Approval. Please see section I.F. *NOTIFICATION AND PRIOR APPROVAL* for information on the Prior Approval Program.

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>

Benefit	Description
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 Provider.</p> <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p>
3 . Autism Spectrum Disorders Treatment	
	<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 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>
4 . Cardiac Rehabilitation Therapy	
	<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>

Benefit	Description
<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>
<p>6 . Clinical Trials for the Treatment of Cancer or Other Life-Threatening Diseases</p>	<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>
<p>7 . Dental Services</p>	<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</i>. <i>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>

Benefit	Description
Dental Services (Continued)	
	<p>Preventive Dental Care for Children:</p> <p>The Plan covers two preventive dental exams per calendar year for children under the age limit stated in the Schedule of Benefits. Only the following services are covered:</p> <ul style="list-style-type: none"> • Cleaning • Fluoride treatment • Teaching plaque control • X-rays <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p>
8 . Diabetes Services and Supplies	
	<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. Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care. 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 Provider and present it at a participating pharmacy. You can find participating pharmacies online at www.harvardpilgrim.org click Pharmacy Program or by calling the Member Services Department at 1-888-333-4742.</p>

Benefit	Description
Diabetes Services and Supplies (Continued)	
	<p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p>
9 . Dialysis	
	<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>Prior Approval or Notification Required: You must notify HPHC in advance of any planned inpatient admission to a Non-Plan Medical Facility. Also, Prior Approval is required for any services provided in the home. If you use a Plan Provider, he or she will notify HPHC of your inpatient admission or seek Prior Approval for you. The Prior Approval process is initiated by calling: 1-800-708-4414. Please see section <i>I.F. NOTIFICATION AND PRIOR APPROVAL</i> for more information.</p>
10 . Drug Coverage	
	<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>

Benefit	Description
<p>Drug Coverage (Continued)</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> <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 Provider. The Plan may rent or buy the equipment you need. 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

Benefit	Description
Durable Medical Equipment (DME) (Continued)	
	<p>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>
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 get your care from a Plan Provider for coverage to be at the In-Network benefit payment level. • If you are hospitalized, you must call 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 the Plan 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 stated 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 on a short term intermittent basis. To be eligible for home health care, your Provider must determine that skilled nursing care or physical therapy is an essential part of active treatment. There must also be a defined medical goal that your 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 time limits apply to all services combined.</p> <p>Prior Approval or Notification Required: You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: 1-800-708-4414. Please see the section titled, "Prior Approval" for more information.</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 calendar year. Inpatient care is also covered in an acute hospital or extended care facility when it is Medically Necessary to control pain and manage acute and severe clinical problems that cannot be managed in a home setting. Covered Benefits include:</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>Prior Approval or Notification Required: You must obtain Prior Approval for home hospice care. If you use a Plan Provider, he or she will seek Prior Approval for you. The Prior Approval process is initiated by calling: 1-800-708-4414. Please see section <i>I.F. NOTIFICATION AND PRIOR APPROVAL</i> for more information.</p>
<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>Please Note: In Massachusetts, Maine, New Hampshire and Rhode Island there are certain specialized services that must be received from designated Plan Providers, referred to as “Centers of Excellence” to receive In-Network coverage. Please see section <i>I.D.4. Centers of Excellence</i> for further information.</p>

Benefit	Description
Hospital – Inpatient Services (Continued)	
	<p>Prior Approval or Notification Required: You must notify HPHC in advance of any planned inpatient admission to a Non-Plan Medical Facility. This requirement applies to admissions to all types of inpatient medical facilities, including hospitals, Skilled Nursing Facilities (SNFs) and rehabilitation hospitals. Please see section <i>I.F. NOTIFICATION AND PRIOR APPROVAL</i> for more information.</p>
20 . House Calls	
	The Plan covers house calls.
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 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)

Benefit	Description
Infertility Services and Treatment (Continued)	
	<ul style="list-style-type: none"> • 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) • 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> <p>Prior Approval or Notification Required: You must obtain Prior Approval for all services for the treatment of infertility. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: 1-800-708-4414. Please see section <i>I.F. NOTIFICATION AND PRIOR APPROVAL</i> for more information.</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 as required by law including: hereditary and metabolic screening at birth; tuberculin tests; lead screenings; hematocrit, hemoglobin or other appropriate blood tests, human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish bone marrow transplant donor suitability, and urinalysis. • 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 <p>Prior Approval or Notification Required: You must obtain Prior Approval for computerized axial tomography (CAT and CT and CTA scans); Magnetic resonance imaging (MRI and MRA scans); Nuclear cardiac studies; and Positron emission tomography (PET scans). If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling:</p>

Benefit	Description
Laboratory and Radiology Services (Continued)	
	1-800-708-4414. Please see section <i>I.F. NOTIFICATION AND PRIOR APPROVAL</i> for more information.
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 acids up to the limit stated in your Schedule of Benefits.</p> <p>Please Note: Not all Plans cover this benefit. Please see 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. • 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 <i>VII.D. ADDING A DEPENDENT</i> for more enrollment information. • Routine outpatient postpartum care for the mother, including lactation consultations, up to six weeks after delivery <p>Prior Approval or Notification Required: You must notify HPHC in advance of any planned inpatient admission to a Non-Plan Medical Facility. This requirement applies to admissions to all types of inpatient medical facilities, including hospitals, Skilled Nursing Facilities (SNFs) and rehabilitation hospitals. Please see section <i>I.F. NOTIFICATION AND PRIOR APPROVAL</i> for more information.</p>
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. <p>Prior Approval or Notification Required: You must obtain Prior Approval for outpatient formulas and enteral nutrition. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: 1-800-708-4414. Please see section <i>I.F. NOTIFICATION AND PRIOR APPROVAL</i> for more information.</p> <p>Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits.</p>

Benefit	Description
<p>28 . Mental Health Care (Including the Treatment of Substance Abuse Disorders)</p>	<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 Out-of-Network coverage of certain mental health care (including the treatment of substance abuse disorders), you must obtain Prior Approval from the Behavioral Health Access Center by calling 1-888-777-4742. The mental health and substance abuse treatment services for which Prior Approval is required are as follows:</p> <ul style="list-style-type: none"> • Inpatient Care – Inpatient care includes all mental health care (including substance treatment) requiring the patient to spend the night at a facility. As noted above, Prior Approval is not required for care needed in a Medical Emergency. • Outpatient Care – Prior approval must be obtained for the following outpatient mental health services (including substance abuse treatment): <ol style="list-style-type: none"> 1. Intensive Outpatient Program Treatment – Treatment programs at an outpatient clinic or other facility generally lasting three or more hours a day on two or more days a week. 2. Partial Hospitalization and Day Treatment Programs 3. Extended Outpatient Treatment Visits – Outpatient visits of more than 50 minutes duration with or without medication management. Also included is any treatment routinely involving more than one outpatient visit in a day. 4. Outpatient Electro-Convulsive Treatment (ECT) 5. Psychological Testing and Neuropsychological Assessment 6. Applied Behavioral Analysis (ABA) for the treatment of Autism <p>Even when Prior Approval is not required, mental health care may be arranged through the Behavioral Health Access Center by calling 1-888-777-4742. (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 Provider, and arranging the services you require.</p> <p>In a Medical Emergency you should go to the nearest emergency facility or call 911 or your local emergency number.</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</p>

Benefit	Description
	<p>Mental Health Care (Including the Treatment of Substance Abuse Disorders) (Continued)</p> <p>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 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 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.

Benefit	Description
<p>29 . Ostomy Supplies</p>	<p>The Plan covers ostomy supplies up to the Benefit Limit stated 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
<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 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 calendar year are covered for a child from birth to age one. • At least three visits per calendar year are covered for a child from age one to age two. • At least one visit per calendar 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>

Benefit	Description
<p>31 . Prosthetic Devices</p>	<p>The Plan covers prosthetic devices as described below. 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.</p> <p>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 <p>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"> • Prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient; • Reconstruction of the breast on which the mastectomy was performed; and • Surgery and reconstruction of the other breast to produce a symmetrical appearance. <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;

Benefit	Description
Reconstructive Surgery (Continued)	
	<ul style="list-style-type: none"> • 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> <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> <p>Prior Approval or Notification Required: You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: 1-800-708-4414. Please see section <i>I.F. NOTIFICATION AND PRIOR APPROVAL</i> for more information.</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 stated in the Schedule of Benefits.</p> <p>Prior Approval or Notification Required: You must notify HPHC in advance of any planned inpatient admission to a Non-Plan Medical Facility. This requirement applies to admissions to all types of inpatient medical facilities, including hospitals, Skilled Nursing Facilities (SNFs) and rehabilitation hospitals. Please see section <i>I.F. NOTIFICATION AND PRIOR APPROVAL</i> for more information.</p>

Benefit	Description
<p>34 . Rehabilitation Therapy – Outpatient</p>	<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 stated in the Schedule of Benefits. Services are covered only:</p> <ul style="list-style-type: none"> • If, in the opinion of your Provider, there is likely to be significant improvement in your condition within the period of time benefits are covered; and • When needed to improve your ability to perform Activities of Daily Living. <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>Prior Approval or Notification Required: You must obtain Prior Approval for coverage of outpatient physical, occupational, pulmonary rehabilitation and speech therapy. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: 1-800-708-4414. Please see section <i>I.F. NOTIFICATION AND PRIOR APPROVAL</i> for more information.</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>
<p>35 . Scopic Procedures – Outpatient Diagnostic</p>	<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
<p>36 . Skilled Nursing Facility Care</p>	<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 stated in the Schedule of Benefits.</p> <p>Prior Approval or Notification Required: You must notify HPHC in advance of any planned inpatient admission to a Non-Plan Medical Facility. This requirement applies to admissions to all types of inpatient medical facilities, including hospitals, Skilled Nursing Facilities (SNFs) and rehabilitation hospitals. Please see section <i>I.F. NOTIFICATION AND PRIOR APPROVAL</i> for more information.</p>

Benefit	Description
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> <p>Prior Approval or Notification Required: You must obtain Prior Approval for coverage of outpatient physical, occupational, pulmonary rehabilitation and speech therapy. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: 1-800-708-4414. Please see section <i>I.F. NOTIFICATION AND PRIOR APPROVAL</i> for more information.</p>
38 . Spinal Manipulative Therapy (including care by a chiropractor)	
	<p>The Plan covers musculoskeletal adjustment or manipulation up to the Benefit Limit stated 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>Please Note: In Massachusetts, Maine, New Hampshire and Rhode Island there are certain specialized services that must be received from designated Plan Providers, referred to as "Centers of Excellence" to receive In-Network coverage. Please see section <i>I.D.4. Centers of Excellence</i> for further information.</p> <p>Prior Approval or Notification Required: You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: 1-800-708-4414. Please see section <i>I.F. NOTIFICATION AND PRIOR APPROVAL</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 stated 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> <p>Prior Approval or Notification Required: You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: 1-800-708-4414. Please see section <i>I.F. NOTIFICATION AND PRIOR APPROVAL</i> for more information.</p>

Benefit	Description
<p>41 . Vision Services</p>	<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 calendar year. The replacement of lenses, due to a change in the Member's condition, is limited to 3 per affected eye per calendar year. • Post cataract surgery with an intraocular lens implant (pseudophakes). Coverage is limited to \$140 per surgery toward the purchase of eyeglass frames and lenses. The replacement of lenses due to a change in the Member's prescription of .50 diopters or more within 90 days of the surgery is also covered up to a limit of \$140. • Post cataract surgery without lens implant (aphakes). One pair of eyeglass lenses or contact lenses is covered per calendar year. Coverage up to \$50 per calendar year is also provided for the purchase of eyeglass frames. The replacement of lenses due to a change in the Member's condition is also covered. Replacement of lenses due to wear, damage, or loss, is limited to 3 per affected eye per calendar year. • Post retinal detachment surgery. For a Member who wore eyeglasses or contact lenses prior to retinal detachment surgery, the Plan covers the full cost of one lens per affected eye up to one calendar year after the date of surgery. For Members who have not previously worn eyeglasses or contact lenses, the Plan covers 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>
<p>42 . Voluntary Sterilization</p>	<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>
<p>43 . Voluntary Termination of Pregnancy</p>	<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>
<p>44 . Wigs and Scalp Hair Protheses</p>	<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 stated 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"> 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"> 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). 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"> Planned home births.
7 . Mental Health Care	
	<ol style="list-style-type: none"> Biofeedback. 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. Methadone maintenance. Sensory integrative praxis tests. 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. 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. 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. 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 received in Massachusetts, Maine, New Hampshire or Rhode Island is listed as requiring that it be provided at a Center of Excellence, no In-Network coverage will be provided under this Handbook if that service is received in Massachusetts, Maine, New Hampshire or Rhode Island from a Provider that has not been designated as a Center of Excellence. Please see <i>Handbook</i> section "Centers of Excellence" 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 which were provided after the date on which your membership ends. 2. Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit under this Handbook. 3. Charges for missed appointments. 4. Concierge service fees. (See <i>Handbook</i> section “<i>Provider Fees For Special Services</i>” for more information.) 5. Inpatient charges after your hospital discharge. 6. Provider's charge to file a claim or to transcribe or copy your medical records. 7. Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
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 <i>bHandbook</i> section “<i>Covered Benefits</i>”, <i>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 III. Covered Benefits of this Handbook for details. 4. All food or nutritional supplements except those covered under the benefits for (1) low protein foods and (2) medical formulas, if available under your Plan. 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.

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Exclusion	Description
All Other Exclusions (Continued)	<ol style="list-style-type: none"> 9. Services that are not Medically Necessary. 10. Taxes or governmental assessments on services or supplies. 11. Transportation other than by ambulance. 12. The following products and services: <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. Reimbursement and Claims Procedures

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

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

Proof of loss is administered under this Handbook by filing a claim on HPHC claims forms. Such forms may be obtained from a Member's Plan Sponsor or by calling HPHC Member Services Department at **1-888-333-4742**.

Standard health care industry claim forms, known as the CMS 1500 and the UB04 will also be accepted. Such forms are also available at most hospitals and physician's offices. In order to be paid by HPHC, all claims must be filed in writing or electronically. (Providers should contact HPHC for instructions concerning electronic filing.). Claims for services must be submitted to the following addresses:

Claims for Mental Health Care:

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

Pharmacy Claims:

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

All Other Claims:

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

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

B. INFORMATION NEEDED FOR CLAIMS PROCESSING

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 (if reimbursement is sought)

Important Notice: We may need more information for some claims. If you have any questions about claims, please call our Member Services Department at **1-888-333-4742**.

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 at **1-888-333-4742**.

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

The following information must be on the Prescription Claim Form:

- The Member's name and Plan ID number
- The name of the drug or medical supply

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- 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. If a service is provided by a Non-Plan Provider, you are responsible for any amount in excess of the Allowed Amount.

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

F. NOTICE OF CLAIM

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

G. MISCELLANEOUS CLAIMS PROVISIONS

Benefits will be paid to the Member who received the services for which a claim is made unless such Member is a minor. In such case, benefits will be paid to the parent or custodian with whom the child resides. The Member may authorize the Plan to pay benefits directly to the health care Provider whose charge is the basis for the claim.

VI. 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 VI.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 VI.B.3. *The Expedited Appeal Process* for the expedited review procedure.)

You must file your appeal within 180 days after you receive notice that a claim has been denied. Please be as specific as possible in your appeal request. We need all the important details in order to make a fair

decision, including pertinent medical records and itemized bills.

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.

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 necessary 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 VI.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 to 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 VI.B.3. *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 a complaint 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.

VII. 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 for Dependents and effective dates of coverage.

A. ELIGIBILITY

1. 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 payment for coverage.

2. Dependent Eligibility

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

B. 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 *VII.G. SPECIAL ENROLLMENT RIGHTS* for additional rights upon adoption of a child.

C. 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.

D. 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.

E. NEWBORN COVERAGE

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

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

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

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

If you are hospitalized at an Out-of-Network hospital, you must notify HPHC by calling **1-800-708-4414** for medical services. For all mental health and drug and alcohol rehabilitation services please call **1-888-777-4742**. Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for more information.

G. 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,

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

Special enrollment rights may also apply to persons who lose coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for state premium assistance under Medicaid or CHIP. 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 within 60 days after Medicaid or CHIP coverage ends. An employee or Dependent who becomes eligible for group health plan premium assistance under Medicaid or CHIP may be able to enroll in this Plan if enrollment is requested within 60 days after the employee or Dependent is determined to be eligible for such premium assistance.

VIII. Termination and Transfer to Other Coverage

Important Notice: HPHC may not have current information concerning membership status. Plan Sponsors may notify HPHC of enrollment changes retroactively. As a result, the information we have 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.

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.

IX. 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 this Handbook, Schedule of Benefits, and Prescription Drug Brochure 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. 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.

X. Plan Provisions and Responsibilities

A. LIMITATION ON LEGAL ACTIONS

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

B. ACCESS TO INFORMATION

You agree that, except where restricted by law, HPHC and the Plan Sponsor may have access to (1) all health records and medical data from health care Providers providing services covered under this Handbook and (2) information concerning health coverage or claims from all providers of motor vehicle insurance, medical payment policies, 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 the 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.

C. 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: 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 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.

D. 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 VI. *Appeals and Complaints*.

E. MODIFICATION OF THIS HANDBOOK

This Benefit Handbook, Schedule of Benefits, Prescription Drug Brochure (if applicable) and 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

F. HPHC'S RELATIONSHIP WITH PLAN PROVIDERS

HPHC's relationship with Plan Providers is governed by separate agreements. They are independent contractors. Such Providers may not modify this Handbook or Schedule of Benefits, Prescription Drug Brochure, 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 its arrangements with service Providers, including the addition or removal of Providers, without notice to Members.

G. 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 HPHC cannot provide or arrange services due to a major disaster, it is not responsible for the costs or outcome of this inability.

H. EVALUATION OF NEW TECHNOLOGY

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

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

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

I. 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.

THE HARVARD PILGRIM PPO PLAN FOR SELF-INSURED MEMBERS - MASSACHUSETTS

If requested by your Plan Sponsor, HPHC will send you a Certificate of Creditable Coverage upon termination of . 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.

J. 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 Approval) of selected products or services. Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for further information on HPHC's Prior Approval requirements, including procedures for which Prior Approval is required. Prior Approval determinations will be made within 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 hospitals and extended care 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, 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. 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 *VI. Appeals and Complaints*. Your right to appeal does not depend on whether or not your Provider sought reconsideration.

K. 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.

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.

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

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

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

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

M. PROCESS TO DEVELOP 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.

XI. 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.

HPHC Insurance Company, Inc.
1600 Crown Colony Drive
Quincy, MA 02169
1-800-333-4742
www.harvardpilgrim.org

Four-Tier

Prescription Drug Brochure

This brochure is a legal document that explains the prescription drug benefits provided by HPHC Insurance Company, Inc. (HPHC) to Members with plans that include outpatient pharmacy coverage.

PRESCRIPTION DRUG COVERAGE

Prescription medications can play an important role in keeping you healthy. Your coverage includes an outpatient prescription drug benefit to help make paying for these medications more affordable. This benefit covers most outpatient prescription drugs and some non-prescription drugs and medical supplies.

In this brochure, you'll find information about:

- Our four-tier prescription drug benefit
- Your Member Cost Sharing
- Covered and non-covered drugs
- Where to buy your prescriptions
- Our Mail Service Prescription Drug Program
- Drug coverage policies

You will find words in this brochure that have special meanings. When we use one of those words, we start it with a capital letter. Capitalized terms that are not defined in this brochure are defined in the Glossary in your Benefit Handbook.

FOUR-TIER PRESCRIPTION DRUG BENEFIT

We place all covered drugs into one of four levels or “tiers.” Each tier has its own Member Cost Sharing, which is listed on your identification (ID) card. The four tiers are described below.

Tier 1:

Tier 1 is made up of lower cost generic drugs that have been selected by Harvard Pilgrim. These drugs contain the same active ingredients as their brand-name counterparts. You pay the lowest Copayment or Coinsurance amount for Tier 1 drugs.

Tier 2:

Tier 2 is primarily made up of higher-cost generic drugs. These drugs contain the same active ingredients as their brand-name counterparts. Tier 2 may also include brand-name drugs that we have determined to be more effective, less costly or to have fewer side effects than similar medications.

Tier 3:

Tier 3 is primarily made up of brand name drugs for which generic equivalents are not available. These drugs have been selected based on review of the relative safety, effectiveness and cost of the many brand name drugs on the market. Tier 3 may also include generic drugs that we have determined to be more costly than their brand name alternatives.

Tier 4:

Tier 4 is made up of drugs that we have not included in Tiers 1- 3. You pay the highest Member Cost Sharing for Tier 4 drugs.

Please see your ID card for your applicable Member Cost Sharing amounts.

Getting a Copy of the Drug List

You can get a copy of the Four-Tier Prescription Drug List online at www.harvardpilgrim.org by *clicking Pharmacy Program* or by calling the Member Services Department at **1-888-333-4742**.

MEMBER COST SHARING

This section describes how we administer the different types of Member Cost Sharing under your outpatient prescription drug benefit.

Similar to your medical coverage, Members are required to share the cost of the benefits provided under the Plan. Your Member Cost Sharing may include a combination of Copayments, Coinsurance or a Deductible. For the Member Cost Sharing amounts that apply to your Plan, please see your ID card.

Discount Rate

In this brochure, we refer to the term “Discount Rate.” The Discount Rate is a discount price for prescription drugs that has been negotiated with participating pharmacies. The Discount Rate is the basis for calculating your Member Cost Sharing.

Note: The Discount Rate is not a fixed discount. It may be modified as market conditions change.

How the Discount Rate Benefits Members

The Discount Rate is usually lower than the retail price pharmacies charge for drugs. If a participating pharmacy’s retail price is less than the Discount Rate, your Member Cost Sharing is always based on the lower amount.

Note: Our cost for covered drugs is generally lower than the Discount Rate.

Copayments

Some plans provide prescription drug coverage with Copayments. Copayments are fixed dollar amounts you must pay for covered medications. Copayments are paid to the pharmacy at the time of purchase. Different Copayment amounts usually apply to each of the four drug tiers. Your Copayment amounts are listed on your ID card.

What You Pay

Copayments are calculated in two ways, depending on whether you use a participating or non-participating pharmacy:

Participating Pharmacy

If you buy your prescriptions at a participating pharmacy, you pay the lower of the Copayment, the Discount Rate, or the pharmacy’s retail price for the drug.

Non-Participating Pharmacy

If you buy your prescriptions at a non-participating pharmacy, the Discount Rate does not apply. You pay the lower of the Copayment or the pharmacy’s retail price for the drug.

Please see “Buying Prescriptions” for more information on participating and non-participating pharmacies.

What the Copayment Covers

Each Copayment covers up to a 30-day supply for each prescription or refill, except where limited by us. If your physician prescribes less than a 30-day supply of a medication, each Copayment covers the amount prescribed. We may limit the quantity of a drug available per 30-day period or per Copayment.

Coinsurance

Some plans provide prescription drug coverage with Coinsurance. With Coinsurance, you pay percentage payments for a drug, instead of fixed dollar amounts. If your coverage requires the payment of Coinsurance, the applicable Coinsurance percentages are listed on your ID card.

What You Pay

Coinsurance is calculated in two ways, depending on whether you use a participating or non-participating pharmacy.

Participating Pharmacy
If you buy your prescriptions at a participating pharmacy, your Coinsurance payment is calculated using the lower of the Discount Rate or the pharmacy’s retail price for the drug.
Non-Participating Pharmacy
If you buy your prescriptions at a non-participating pharmacy, the Discount Rate does not apply. Your Coinsurance payment is calculated using the pharmacy’s retail price for the drug.

The Coinsurance percentage is multiplied by the Discount Rate or the pharmacy’s retail price, as applicable, to arrive at your out-of-pocket Coinsurance payment. Coinsurance is calculated the day the pharmacy fills the prescription and the Coinsurance is paid to the pharmacy at the time of purchase.

 **FOR EXAMPLE:** If the participating pharmacy’s retail price is \$150 but the Discount Rate is \$100, your Coinsurance amount is based on the Discount Rate of \$100. If your Coinsurance is 20%, your Member Cost Sharing will be \$20.

Some Plans include a minimum or maximum Coinsurance amount, or both. If your Plan includes a per prescription minimum Coinsurance amount, you always pay at least that minimum, unless the Discount Rate or the pharmacy’s retail price for the drug is less than the minimum. In that case, at a participating pharmacy you pay the lower of (1) the minimum Coinsurance amount, (2) the Discount Rate or (3) the pharmacy’s retail price for the drug. At a non-participating pharmacy you pay the lower of (1) the minimum Coinsurance amount or (2) the pharmacy’s retail price for the drug. If your Plan includes a per prescription maximum amount, your per prescription Coinsurance payment is limited to that maximum.

Please see “Buying Prescriptions” for more information on participating and non-participating pharmacies.

Deductibles

Your Plan may include a Deductible.

A Deductible is a specific dollar amount that you pay each calendar year for certain covered services before any coverage is available for those services. If a Deductible applies to your coverage, you must first pay the Deductible amount for the purchase of prescription drugs before any coverage for drugs begins for the calendar year.

Please see your ID card to see if a Deductible applies to your Plan.

What You Pay

Participating Pharmacy
When you use a participating pharmacy, you pay the lower of the Discount Rate or the pharmacy’s retail price for prescriptions until the Deductible is met.
Non-Participating Pharmacy
When you use a non-participating pharmacy, the Discount Rate does not apply. You pay the pharmacy’s retail price for prescriptions until the Deductible is met.

If the Discount Rate or retail price for a prescription, as applicable, exceeds the balance remaining on the Deductible for the calendar year, you are required to pay the balance of the Deductible and the applicable Copayment. If Coinsurance applies, you are required to pay the applicable Coinsurance percentage on any amount exceeding the Deductible. You are never obligated to pay any combination of Copayments,

FOUR-TIER PRESCRIPTION DRUG BROCHURE - MASSACHUSETTS

Coinsurance or Deductible amounts that exceed the lower of the Discount Rate or the pharmacy's retail price for the drug.

The Deductible amount is applied the day the pharmacy fills the prescription and is paid to the pharmacy at the time of purchase.

Where the Deductible Applies

The Deductible may apply to drugs in any Tier. Please see your ID card for the amount of your Deductible and the tiers to which it applies. Once you have met your Deductible for the calendar year, drugs are covered for the rest of the calendar year, subject to the applicable Copayment or Coinsurance.

 FOR EXAMPLE: If your Plan has a \$100 Deductible and you have a claim with a discount rate of \$200, you will be responsible for the first \$100 to satisfy your Deductible requirement before we begin to pay benefits.

Your Deductible may not apply to certain medications used for preventive care. These medications have been selected by the Plan because they are often used to lower the risk of illness. In some cases these medications are prescribed for people who have developed risk factors for an illness that has not yet manifested itself. In others it may be to prevent the recurrence of an illness from which the patient has recovered. Please see your ID card to determine if you have this coverage. Your ID card will include the words "Preventive Drug Benefit" if you have this coverage.

The preventive medications described above are separate from the preventive care services, including drugs, listed in your Schedule of Benefits, for which no Member Cost Sharing applies.

If your Plan exempts preventive drugs from the Deductible and your health care provider prescribes one of the designated preventive medications, the Deductible will not apply to that prescription. However, you will be required to pay the applicable Copayment or Coinsurance amount for the drug. Since no deductible applies to preventive medications, expenses you incur for such drugs do not apply to your In-Network Deductible.

The Plan may change the listing of designated preventive medications from time to time. For a current list of designated preventive medications, please visit our web site at www.harvardpilgrim.org.

Out-of-Pocket Maximum

Your Plan may provide prescription drug coverage with an Out-of-Pocket Maximum. Your Out-of-Pocket Maximum may apply to both medical and prescription Member Cost Sharing. The Out-of-Pocket Maximum is the total amount you are required to pay in Member Cost Sharing. Please refer to your ID card to see if an Out-of-Pocket Maximum applies to your Plan.

Participating pharmacies will not charge you Member Cost Sharing once you have reached your Out-of-Pocket Maximum.

WHAT IS COVERED

Your prescription drug benefit covers all Medically Necessary drugs that require a prescription by law, except drugs we exclude or limit. Your benefit also covers the non-prescription items, listed below. All covered drugs are subject to the applicable Member Cost Sharing. Please check your ID card for the Member Cost Sharing amounts that apply to your drug coverage.

Your Plan covers the following prescription and non-prescription items:

FOUR-TIER PRESCRIPTION DRUG BROCHURE - MASSACHUSETTS

Covered Prescription Drugs	Covered Non-Prescription Items
<ul style="list-style-type: none"> • FDA approved prescription drugs prescribed by a physician • Needles and syringes needed to administer covered drugs • FDA approved contraceptive drugs and devices • Prenatal vitamins • FDA approved hormone replacement therapy (HRT) • Off-label uses of FDA approved drugs, including drugs for the treatment of cancer and HIV/AIDS • Compounded prescriptions are covered if: (1) all of the active ingredients in the compound are FDA approved prescription drugs; <u>and</u> (2) either the patient is under the age of 18 <u>or</u> HPHC has given prior approval for coverage of the compound. • Oral fluoride (only for children up to age 5) • Folic acid (only for women planning or capable of pregnancy) 	<ul style="list-style-type: none"> • Insulin • Oral agents for controlling blood sugar • Lancets • Blood glucose testing strips • Urine diabetic testing strips • Ketone diabetic testing strips

Please Note: No Member Cost Sharing applies to certain preventive care services, including FDA approved contraceptive drugs and devices, oral fluoride for children up to age five, and folic acid for women planning or capable of pregnancy. Please go to www.harvardpilgrim.org to see a complete list of covered preventive services.

*Certain religious employers may exclude coverage for contraceptive drugs and devices. Please see the Exclusions section of your Benefit Handbook to determine whether these items are excluded under your Plan.

BUYING PRESCRIPTIONS

Participating Pharmacies

It's easier and often less expensive to fill prescriptions at a participating pharmacy whenever possible. If you use a participating pharmacy, you only have to show your ID card and pay the applicable Member Cost Sharing amount. If you do not use a participating pharmacy, you must pay the retail price for the medication and submit a claim for reimbursement.

There are over 60,000 participating pharmacies in the United States, including:

<ul style="list-style-type: none"> • CVS/pharmacy • Kmart Pharmacy • Rite Aid • Stop & Shop 	<ul style="list-style-type: none"> • Target Pharmacy • Walgreens • Walmart • Many independent drug stores
---	---

You can get more information on participating pharmacies online at www.harvardpilgrim.org by *clicking Pharmacy Program* or by calling our Member Services Department at **1-888-333-4742**.

The Specialty Pharmacy Program

We have designated pharmacies that you must use to obtain certain specialty medications. These include drugs for the treatment of infertility, hepatitis C, osteoarthritis, multiple sclerosis, rheumatoid arthritis and certain hereditary diseases. A list of the drugs that must be purchased from the specialty pharmacies may be obtained on our website at www.harvardpilgrim.org (*click Pharmacy Program*, then *click* either **Infertility Pharmacy Program** or **Specialty Pharmacy Program**). This information is also available by calling our Member Services Department at **1-888-333-4742**.

Our specialty pharmacies have expertise in the delivery of the drugs they provide. They maintain these medications in stock at all times and can deliver them by overnight mail with the medical supplies necessary for their use. In an emergency, same day delivery can also be provided. The specialty pharmacies will give you instructions for the administration of the drugs they provide. Additional drugs may be added to the specialty pharmacy program from time to time.

Your Member Cost Sharing at the specialty pharmacies is the same as at other participating pharmacies. Please see your ID card for the Member Cost Sharing that applies to you. The specialty pharmacies are not part of the Mail Order Prescription Drug Program, to which different Member Cost Sharing rules may apply.

Non-Participating Pharmacies

If you fill a prescription for a covered drug at a non-participating pharmacy, you must pay the retail price for the drug, and submit a claim for reimbursement. The reimbursement procedures for pharmacy items are explained in your Benefit Handbook. Reimbursement for drugs purchased at non-participating pharmacies will be paid minus your applicable Member Cost Sharing. Payment will be limited to the Allowed Amount for the drug.

In the case of HMO coverage plans, no benefits are provided for prescriptions obtained at a non-participating pharmacy, except in the event of unforeseen illness or injury.

Mail Service Prescription Drug Program

We provide a Mail Service Prescription Drug Program for Members who prefer the convenience of receiving their prescriptions through the mail. You may purchase up to a 90-day supply of maintenance medications through the Mail Service Program. In addition to saving a trip to the pharmacy, some plans provide lower Member Cost Sharing amounts for drugs purchased through the Mail Service program.

Although most maintenance medications are available from the Mail Service Program, we may exclude drugs from the program for clinical reasons or to prevent potential waste. In addition, drugs included in the Specialty Pharmacy Program, discussed above, are not available through the Mail Service Program.

Please see your ID card for your Mail Service Member Cost Sharing. The Mail Service Member Cost Sharing amounts listed on your ID card apply only to the Mail Service Program.

For more information about the Plan's Mail Service Prescription Drug Program, please call **1-877-347-3216 (TTY 1-877-517-9301)**.

WHAT IS NOT COVERED OR HAS LIMITED COVERAGE

There are a number of prescription drugs that are not covered, are subject to quantity limits or require prior authorization.

We cover only drugs that are Medically Necessary for preventive care or for treating illness, injury, or pregnancy. Drugs that are not covered include, but are not limited to, drugs primarily used for cosmetic purposes and weight loss.

We also limit the coverage of specific drugs for reasons of cost and to assure their safe and effective use. Limitations may be placed on the quantity of certain drugs we cover.

FOUR-TIER PRESCRIPTION DRUG BROCHURE - MASSACHUSETTS

We may require prior authorization to evaluate whether certain drugs are Medically Necessary. Prior authorization is based on clinical criteria and may include: (1) an evaluation of whether a drug is clinically appropriate for the medical condition for which it has been prescribed; or (2) whether "step therapy" will be required. Drugs subject to step therapy are only covered if a Member has either tried another drug to treat a specific condition or obtained prior authorization to be exempted from that requirement. Members or their practitioners may obtain a copy of our clinical review criteria for a drug for which coverage is requested by calling **1-888-888-4742 ext. 31786**.

Drugs that are excluded from coverage, subject to quantity limits, or require prior authorization are listed in the Four-Tier Prescription Drug List. You may view this list online at www.harvardpilgrim.org by *clicking Pharmacy Program* or you may request a copy of this list by calling the Member Services Department at **1-888-333-4742**.

Exclusions from Coverage

No coverage is provided under this prescription drug brochure for the following:

- Drugs that are not Medically Necessary for preventive care or for treating illness, injury or pregnancy.
- Drugs that we specifically exclude, including, but not limited to, drugs primarily used for cosmetic purposes and weight loss.
- Drugs in excess of coverage limitations imposed by the Plan. (Limitations may be placed on the quantity of a drug covered; the medical conditions for which a drug may be prescribed; and/or whether another drug must be tried first.)
- Non-prescription items, other than those specifically listed under "What is Covered."
- Drugs that have not been approved by the FDA.
- Drugs prescribed as part of a course of treatment that we do not cover.
- Drugs provided to you anywhere other than an outpatient pharmacy. (See your Benefit Handbook for an explanation of the limited coverage available for medications received from physicians and other non-pharmacy providers.)
- Drugs that must be obtained through the Specialty Pharmacy Program if not purchased from one of the program's specially designated pharmacies.
- In the case of HMO coverage plans, no benefits are provided for medications prescribed by providers who are not authorized to do so by us or for prescriptions obtained at a non-participating pharmacy, except in the event of unforeseen illness or injury.
- Any sales tax or governmental assessment on pharmacy items.
- Compounded prescriptions unless: (1) all of the active ingredients in the compound are FDA approved prescription drugs; and (2) either the patient is under the age of 18 or HPHC has given prior approval for coverage of the compound.

Prior Approval and Exception Policy

We may require prior authorization for coverage of certain drugs. We may add to the list of drugs for which prior authorization is required or for which coverage is excluded or limited at any time. Medical providers may request an exception on behalf of a Member for coverage of any drug that is excluded or limited. Exceptions may be granted only for clinical reasons. Providers may request such an exception by calling the Pharmacy Services Department at **1-888-888-4742 ext. 39014**. Providers may also use this number to request prior approval for a compounded drug. We will act on any such request within two working days of receiving the clinical rationale for the request.

We will not grant individual exceptions to waive or reduce the Copayment and Coinsurance amounts for a particular drug. However, medical providers may submit a request to us to review or reconsider coverage of a drug.

ABOUT YOUR DRUG BENEFIT

Pharmacy and Therapeutics Committee

Our Pharmacy and Therapeutics (P & T) Committee is an advisory group comprised of our clinical staff and of physician specialists, independent physicians, and pharmacy specialists that work together to promote clinically sound, cost effective pharmaceutical care.

The P&T Committee makes recommendations for tier placement of drugs, and limitations on drug coverage, as well as providing guidance on clinical criteria.

Tier Changes

We regularly review and update the Four-Tier Drug List as new drugs or drug information becomes available. As a result, the tier placement of covered drugs may change at any time. In the event that a drug has been reassigned to a higher tier, we will send notice to Members who have received coverage for the drug and product during the 100-day period prior to the notice date. Such notice will be sent 60 days before the tier change takes effect. You can get an updated Four-Tier Drug List online at www.harvardpilgrim.org by *clicking Pharmacy Program* or by calling the Member Services Department at **1-888-333-4742**.

Deletions from Coverage

On occasion we may discontinue coverage of a drug or other product covered under this Brochure. In such event, we will send notice to Members who have received coverage for the drug or product during the 12-month period prior to the date of discontinuation. Such notice will be sent at least 60 days before discontinuing coverage for the drug or product unless the FDA has determined the drug or product to be unsafe.

Important Notice

In the event of a Medical Emergency, seek immediate care. You may call **911** or your local emergency number. Please see your Benefit Handbook and Schedules of Benefits for information on your emergency coverage.

HPHC Insurance Company, Inc.
1600 Crown Colony Drive
Quincy, MA 02169
1-800-333-4742
www.harvardpilgrim.org

Call Us!

¡Llámenos! Ligue para nós! Chiamateci!

Rele nou! Hã y gọi cho chúng tôi!

សូមទូរស័ព្ទមកយើង! Zadzwoń do nas!

Позвоните нам! 歡迎來電! 請來電!

Member Services is Here For You

Do you have questions about your benefits or membership? We would like to help you! Please call our Member Services Department at the toll-free number on the back of your ID card, weekdays between 8:00 a.m. and 5:30 p.m., and until 7:30 p.m. on Monday and Wednesday evenings. We will be happy to answer your questions about membership or benefits. If you are deaf or hard-of-hearing, please call 1-800-637-8257 for TTY service.

El Departamento de Atención al Cliente se complacerá en servirle

¿Tiene alguna pregunta acerca de los beneficios o derechos de afiliado? Nos complacería ayudarle. Para ello, comuníquese en forma gratuita con el Departamento de Atención al Cliente al número de teléfono ubicado en el dorso de su tarjeta, los lunes y miércoles de 8:00 a.m. a 7:30 p.m., y los martes, jueves y viernes de 8:00 a.m. a 5:30 p.m. Si usted es sordo o tiene problemas de audición, por favor llame al 1-800-637-8257 para servicio de TTY.

O Departamento de Atendimento aos Membros está ao seu dispor

Você tem perguntas sobre seus benefícios ou sobre seu plano de saúde? Gostaríamos de ajudá-lo! Ligue para o Departamento de Atendimento aos Membros pelo número gratuito que consta no verso do seu cartão, às terças, quintas e sextas-feiras entre 8h00 e 17h30 e às segundas e quartas-feira entre 8h00 e 19h30. Teremos o maior prazer em esclarecer todas as suas dúvidas acerca dos seus benefícios ou sua participação no plano. Se você é deficiente auditivo ou escuta mal ligue para 1-800-673-8257, para serviço TTY.

Il Servizio per soci è qui per assistervi

Avete domande inerenti ai benefici e sull'iscrizione? Saremo lieti di aiutarvi! Chiamate il Servizio soci al numero verde scritto sul retro della vostra ID card (carta personale), tutti i giorni feriali dalle 8.00 alle 17.30 e fino alle 19.30 il lunedì e il mercoledì pomeriggio. Saremo lieti di rispondere alle vostre domande inerenti ai benefici e sull'iscrizione. Se siete non udenti o avete problemi di udito, chiamate il numero 1-800-637-8257 per usufruire del servizio TTY.

Member Services la pou Ede W

Èske w gen kesyon konsènan benefis ou oswa adezyon manm ou? Nou ta renmen ede w! Tanpri rele Member Services Department nan nimewo gratis ki padèye kat ID w la, jou lasemenn ant 8:00 a.m. ak 5:30 p.m., epi jiska 7:30 p.m. jou Lendi ak Mèkredi. N ap kontan pou reponn kesyon ou genyen konsènan adezyon manm ou oswa benefis ou. Si w se yon moun ki soud oswa si w gen pwoblèm pou w tande, tanpri rele nan 1-800-637-8257 pou sèvis TTY.

Ban Dịch Vụ Hội Viên Sẵn Sàng Giúp Cho Quý Vị

Quý vị có thắc mắc nào về các quyền lợi và tình trạng hội viên của mình hay không? Chúng tôi muốn được giúp quý vị! Xin gọi cho Ban Dịch Vụ Hội Viên của chúng tôi tại số điện thoại miễn phí có ghi phía sau thẻ ID của quý vị, vào ngày thường từ 8 giờ sáng đến 5 giờ 30 chiều, và cho đến 7 giờ 30 tối thứ Hai và thứ Tư. Chúng tôi hân hạnh được trả lời cho các thắc mắc về tình trạng hội viên hoặc các quyền lợi của quý vị. Nếu quý vị bị điếc hoặc lãng tai, xin gọi số 1-800-637-8257 để có dịch vụ dành cho người khiếm thính (TTY).

ការិយាល័យបំរើសមាជិកមាននៅទីនេះសំរាប់ជួយលោកអ្នក

តើលោកអ្នកមានសំណួរអំពីផលប្រយោជន៍ដែលលោកអ្នកត្រូវទទួល ឬអំពីសមាជិកភាព? យើងមានបំណងចង់ជួយលោកអ្នក! សូមទូរស័ព្ទ មកការិយាល័យសេវាសមាជិករបស់យើង តាមលេខទូរស័ព្ទឥតបង់ថ្លៃដែលមាននៅខាងខ្នងនៃប័ណ្ណ ID របស់អ្នក ថ្ងៃធ្វើការរវាងម៉ោង 8 ព្រឹក និងម៉ោង 5:30 ល្ងាច និងរហូតដល់ ម៉ោង 7:30 យប់នៅថ្ងៃ ច័ន្ទ និងថ្ងៃពុធ ។ យើងមានសេចក្តីរីករាយនឹងធ្វើការសម្របសម្រួលទាំងឡាយដែលលោកអ្នកមានទាក់ទង អំពីសមាជិកភាព និងផលប្រយោជន៍ ។ បើសិនជា អ្នកជាមនុស្សច្រំ ឬច្រំត្រចៀក សូមទូរស័ព្ទមកលេខ 1-800-637-8257 សំរាប់សេវា TTY ។

Serwis dostępny dla członków

Czy masz pytania dotyczące naszych świadczeń lub członkostwa? Chcielibyśmy Tobie pomóc! Zadzwoń do naszego Wydziału obsługi członków na bezpłatny numer znajdujący się na odwrocie legitymacji członkowskiej. Godziny obsługi, to: od 8 rano do 7:30 wieczorem w poniedziałki i środy oraz od 8 rano do 5:30 po południu we wtorki, czwartki i piątki. Będzie nam miło odpowiedzieć na Twoje pytania dotyczące naszych świadczeń lub członkostwa. Jeżeli jesteś osobą niesłyszącą lub niedosłyszącą, zadzwoń na numer 1-800-637-8257 w celu połączenia się z usługą TTY (telefoniczny serwis dla niesłyszących i niedosłyszących).

Отдел обслуживания к Вашим услугам

Если у Вас есть вопросы о льготах или членстве, мы готовы помочь Вам! Пожалуйста, позвоните в наш Отдел обслуживания по бесплатному телефону, указанному на обороте вашего членского удостоверения, в будние дни с 8:00 утра до 5:30 вечера, а в понедельник и среду до 7:30 вечера. Мы будем рады ответить на Ваши вопросы по поводу членства и предоставляемых льгот. Если вы страдаете глухотой или нарушением слуха, пожалуйста, воспользуйтесь специальным сервисом TTY, позвонив по телефону 1-800-637-8257.

會員服務樂於效勞

您對會員福利或權益有沒有任何疑問？我們竭誠為您提供協助。請於星期一至星期三上午八時至下午七時半，星期二、四及五上午八時至下午五時半，致電會員ID卡背面的免費長途電話聯絡我們的會員服務部。我們樂意為您解答任何有關福利或會員權益的問題。如果您是聽障人士，請致電1-800-637-8257使用TTY電傳打字機服務。

为您提供会员服务

您是否对自己的福利或会员权益有疑问？我们愿意助您一臂之力！请拨打会员卡背面的免费电话与我们的会员服务部门联系。我们的上班时间为每周一至周五的上午8点到下午5点半，其中周一、周三延长到下午7点半。我们乐意为您解答有关福利或会员权益的问题。如果您有听力障碍，请拨打 1-800-637-8257 获取电传打字机终端 (TTY) 服务。



Preventive Care: Services Covered Under the Affordable Care Act

This is to provide you with a list of preventive care services covered in accordance with the federal Affordable Care Act. These services are covered by all health plans offered by Harvard Pilgrim and its affiliates, except “grandfathered” plans.¹ When you obtain these services from an In-Network Plan Provider, they are covered free of charge; there is no Member Cost Sharing required. However, if your plan offers Out-of-Network benefits, you will usually have to pay Member Cost Sharing if you receive preventive care from a Non-Plan Provider.

The list on the following pages includes only the services and tests required under the Affordable Care Act. Your plan may cover additional preventive services purchased by an employer or required to be provided under state law. Please see your Benefit Handbook and Schedule of Benefits for these services.

What is Preventive Care?

Preventive care is care you receive when you're healthy and symptom-free, such as routine check-ups, screenings and immunizations.

Diagnosis and treatment are different from preventive care. They involve testing or treatment for a symptom or health issue you already have, such as an existing illness or injury. When a doctor takes steps to diagnose or treat your health condition, you will be responsible for Member Cost Sharing as stated in your plan.

To learn more, view the preventive care presentation in our member Learning Center, available at www.harvardpilgrim.org/learningcenter.

¹ Harvard Pilgrim includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England, Harvard Pilgrim Health Care of Connecticut and HPHC Insurance Company. If you have a Grandfathered Plan there will be a notice to that effect in your Schedule of Benefits.

Preventive Care Services

The preventive services and tests listed below are covered with no Member Cost Sharing when received from a Plan Provider.

Adults and Children

- Routine physical examinations
- Alcohol misuse screening and counseling (primary care visits only, beginning at age 11)
- Cholesterol screening
- Depression screening (adults, children ages 12-18, primary care visits only)
- Diet behavioral counseling (included as part of annual visit and intensive counseling by primary care clinicians or by nutritionists and dieticians)
- Hemoglobin A1c
- Hepatitis B testing
- Hepatitis C testing (for members born between 1945 through 1965)
- Immunizations, including flu shots (flu shots at age 19 and above at a doctor's office or pharmacy; under age 19 at a doctor's office)
- Obesity screening and counseling (adults and children, in primary care settings)
- Sexually transmitted diseases (STDs) – screenings and counseling (adolescents, adults and pregnant women)
- Tobacco use screening and counseling, including smoking cessation counseling and FDA-approved nicotine replacement therapy (primary care visits only)
- Total cholesterol tests

Adults Only

- Aspirin for the prevention of heart disease when prescribed by a health care provider
- Blood pressure screening (adults without known hypertension)
- Colorectal cancer screening, including colonoscopy, sigmoidoscopy and fecal occult blood test
- Diabetes screenings
- HIV screening and counseling
- Vitamin D supplements for the prevention of falls when prescribed by a health care provider to community-dwelling members beginning at age 65

Women Only

- BRCA 1 or 2 genetic counseling, evaluation and testing for women with a family history associated with increased risk of mutation
- Breast cancer chemoprevention (counseling only for women at high risk for breast cancer and low risk for adverse effects of chemoprevention)
- Breast cancer screening, including mammograms and counseling for genetic susceptibility screening
- Breastfeeding primary care interventions (applicable to pregnant women and new mothers), including electric and manual breast pumps, lactation classes and support at prenatal and post-partum visits, and newborn visits

- Cervical cancer screening, including pap smears
- Comprehensive lactation support, counseling, and costs of renting breastfeeding equipment
- Contraceptive methods approved by the FDA², sterilization procedures and contraceptive patient education and counseling (contraceptives covered with no member cost sharing include generics and brand name drugs with no generic alternative, including emergency contraceptives.)
- Folic acid supplements (women planning or capable of pregnancy only)
- Gestational diabetes screening
- HPV (human papillomavirus) testing
- Interpersonal and domestic violence counseling and screenings
- Iron deficiency anemia (pregnant women at prenatal visits)
- Microalbuminuria test (pregnant women)
- Osteoporosis screening (screening to begin at age 50 for women at increased risk)
- Ovarian cancer susceptibility screening
- Over the counter contraceptive items such as sponges and spermicides, when prescribed by a health care provider
- Rh (D) incompatibility, screening (pregnant women)
- Routine OB/GYN examinations
- Routine outpatient prenatal and postpartum visits

Men Only

- Abdominal aortic aneurysm screening (for males 65-75 one time only, if ever smoked)

Children Only

- Autism screening (for children at 18 and 24 months of age; primary care settings)
- Behavioral assessments (children of all ages; developmental surveillance, in primary care settings)
- Congenital hypothyroidism (screening for newborns only)
- Dental caries prevention – oral fluoride (for children to age 5 only) Note: Coverage for fluoride is only provided if your plan includes outpatient pharmacy coverage
- Dyslipidemia screening (for children at high risk for higher lipid levels)
- Hearing screening (screening for newborn only, primary care settings)
- Iron deficiency prevention (primary care counseling for children ages 6 to 12 months only)
- Lead screening (children at risk)
- Phenylketonuria screening (newborns before 7days old)
- Sickle cell disease, screening (screening at birth and first newborn visit)
- Tuberculosis skin testing
- Vision screening (children to age 5 only)

² Plans provided by certain religious employers may be exempt from covering contraceptive services. Please see your Schedule of Benefits.

Under federal law the list of preventive services and tests covered under this benefit may change periodically based on the recommendations of the following agencies:

- a. Grade “A” and “B” recommendations of the United States Preventive Services Task Force;
- b. With respect to immunizations, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- c. With respect to services for woman, infants, children and adolescents, the Health Resources and Services Administration

Information on the recommendations of these agencies may be found on the web site of the US Department of Health and Human Services at:

<https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1>

Harvard Pilgrim will add or delete services from this list of preventive services and tests in accordance with changes in the recommendations of the agencies listed above. You can find a list of the current recommendations for preventive care on Harvard Pilgrim’s web site at www.harvardpilgrim.org.

Routine Preventive Care Recommendations*

Use these recommendations as a guide in scheduling routine care appointments for your family. Your doctor can make more specific recommendations based on your own health risks, health status and lifestyle.

Pediatric	0–1 Year (Infancy)	1–4 Years (Early Childhood)	5–10 Years (Middle Childhood)	11–17 Years (Adolescence)
HEALTH MAINTENANCE VISIT				
Includes history and physical exam; age-appropriate developmental assessment and anticipatory guidance; behavioral health assessment; and immunizations	Ages 1 to 2 weeks and 1, 2, 4, 6, 9 and 12 months; assess breast-feeding babies between ages 3 and 5 days	Ages 15, 18 and 24 months and 3 and 4 years	Annually	
ROUTINE LABS				
Anemia	Once between ages 9 and 12 months	Conduct assessment including dietary iron sufficiency at clinician discretion		Annually at clinician discretion
Blood Pressure	Selective screening from 0 to 3 years. At every routine visit starting at 3 years			
Cholesterol	Not routine	Older than age 2 at least once with family history of premature cardiovascular disease or other known risk factors		
Lead	Initial screening between ages 9 and 12 months	Annually at ages 2 and 3 years. Again at age 4 years if at high risk.	At entry into kindergarten if never screened	Not routine
Body Mass Index (BMI)	Screen annually for healthy growth and weight; screen annually for eating disorders starting in middle childhood.			
SENSORY SCREENING				
Hearing	Assess newborn before discharge or by age 1 month. Subjective assessment at all other routine checkups.	Objective hearing screening at ages 4, 5, 6, 8 and 10 years. Conduct audiological monitoring every six months until age 3 if there is a language delay or hearing loss. Subjective assessment at all other routine checkups.		
Vision/Eye Care	Assess newborn before discharge. Evaluation by age 6 months.	Visual acuity test at ages 3, 4, 5, 6, 8, 10, 12, 15 and 17 years. Screen for strabismus between 3 and 5 years.		
INFECTIOUS DISEASE SCREENING				
Sexually Transmitted Infections (Chlamydia, Gonorrhea, HPV and Syphilis)	Not routine		Counsel regarding schedule of HPV vaccine	Chlamydia and gonorrhea: All sexually active patients annually. HPV: Counsel regarding schedule of HPV vaccine. Syphilis: If at risk.
Hepatitis C	Not routine	After age 12 months for those with hepatitis C-infected mothers	Not routine	Periodic for those at high risk
Human Immunodeficiency Virus (HIV)	Not routine			Patients with risk factors and those age 13 or older
Tuberculosis (TB)	Tuberculin skin testing of all patients at high risk			

*Adapted from guidelines developed through Massachusetts Health Quality Partners, Inc. (MHQP). More information at www.mhqp.org.

**Adapted from the U.S. Centers for Disease Control and Prevention 2011 Child and Adolescent Immunization Guidelines. More information at www.cdc.gov.

Note: Ask your clinician if your child is at high risk for any of the conditions mentioned in these guidelines. This chart lists only routinely recommended vaccines; talk with your clinician about your child's risk for other diseases.

Pediatric

0–1 Year
(Infancy)

1–4 Years
(Early Childhood)

5–10 Years
(Middle Childhood)

11–17 Years
(Adolescence)

CANCER SCREENING

Pelvic Exam/Pap Test (Girls)	Not routine	At 3 years after first sexual intercourse, or by age 21 years. Every one to three years thereafter based on risk factors.
Testicular Exam (Boys)	Not routine	Clinical testicular exam and self-exam counseling annually beginning at age 15
Clinical Breast Exam (Girls)	Not routine	

GENERAL COUNSELING

All parents and patients should be periodically screened and counseled as appropriate regarding infant sleep positioning, alcohol/substance abuse, autism, bullying, tobacco, diet/nutrition, physical activity, weight management and eating disorders, safety/injury and violence prevention, motor vehicle injury prevention, family violence/abuse, media exposure, behavioral health, sleep habits, oral care, sun safety and sexual behavior.

Pediatric

0–1 Year
(Infancy)

1–4 Years
(Early Childhood)

5–10 Years
(Middle Childhood)

11–17 Years
(Adolescence)

IMMUNIZATIONS**

Hepatitis B	Three doses at birth and at ages 1 to 2 months and 6 to 18 months	Not routine
Diphtheria, Tetanus, Acellular Pertussis (DTaP and Tdap) and Tetanus, Diphtheria	Five doses of DTaP at ages 2, 4 and 6 months, 15 to 18 months and 4 to 6 years	One dose of Tdap ages 11 to 12 years; one dose for ages 13 to 18 years if not previously vaccinated with Tdap
<i>Haemophilus Influenzae</i> Type B (Hib)	Four doses at ages 2, 4 and 6 months and 12 to 15 months	Not recommended for ages 5 years and older
Inactivated Polio (IPV)	Four doses at ages 2 and 4 months, 6 to 18 months and 4 to 6 years	Not routine
Measles-Mumps-Rubella (MMR)	Two doses at ages 12 to 15 months and 4 to 6 years	Not routine
Pneumococcal Conjugate Vaccine (PCV)	Four doses at ages 2, 4 and 6 months and 12 to 15 months. For ages 2 to 5 years, administer PCV to those incompletely vaccinated.	Not recommended. High-risk children should receive PCV according to guidelines.
Pneumococcal Polysaccharide (PPV)	Not routine	For high-risk children age 2 or older only
Varicella (Chickenpox)	Two doses at ages 12 to 15 months and 4 to 6 years.	Not routine
Hepatitis A	Not routine	Two doses at ages 12 to 23 months. Second dose six months after the first. At clinician discretion based on risk
Influenza	Annually for healthy children ages 6 months to 18 years.	
HPV (Human Papillomavirus)	Not routine	Three doses for ages 11 to 12 years. Second dose two months after the first dose, third dose six months after the first dose.
Meningococcal Conjugate (MCV4) and Meningococcal Polysaccharide (MPSV4): MCV4 is preferred; MPSV4 is acceptable.	Not routine	One dose for children ages 2 to 10 at elevated risk One dose at ages 11 to 12; one dose for between ages 13 to 18 if not previously vaccinated; one dose for those at elevated risk and as needed for school/college entry requirements

Routine Preventive Care Recommendations*

Use these recommendations as a guide in scheduling routine care appointments for your family. Your doctor can make more specific recommendations based on your own health risks, health status and lifestyle.

Adult	18–29 Years	30–39 Years	40–49 Years	50–64 Years	65+ Years
HEALTH MAINTENANCE VISIT					
Including history; physical exam; preventive screenings and counseling; and administration of appropriate immunizations	Annually for ages 18 to 21. Every one to three years depending on risk factors for ages 22 to 49.			Annually	
CANCER SCREENING					
Breast Cancer	Starting at age 20, clinical breast exam. Counseling on benefits and limitations of self-exam. Mammography or other imaging for patients at high risk.		Clinical breast exam and self-exam counseling. Mammography or other imaging at clinician/patient discretion.		Clinical breast exam and self-exam counseling. Discretionary imaging through age 74. 75+ based on health status.
Cervical Cancer (Pap Test and Pelvic Exam)	Pelvic exam and Pap test every one to three years depending on risk factors. Initiate Pap test and pelvic exam within three years after first sexual intercourse or by age 21.				Every one to three years at clinician discretion
Colorectal Cancer	Not routine except for patients at high risk			Colonoscopy at age 50 and then every 10 years, <i>OR</i> annual fecal occult blood test (FOBT) plus sigmoidoscopy every five years, <i>OR</i> double-contrast barium enema every five years, <i>OR</i> annual FOBT. Screening after age 75 at clinician/patient discretion.	
Testicular and Prostate Cancer (Men)	Clinical testicular exam and self-exam counseling. Prostate cancer screening not routine.			Digital rectal exam. Offer PSA screening at physician/patient discretion.	
Skin Cancer	Periodic total skin exams at clinician discretion based on risk factors.				
OTHER RECOMMENDED SCREENINGS					
Hypertension	At every acute/nonacute medical encounter and at least once every two years				
Cholesterol	Screen if not previously tested. Screen every five years with fasting lipoprotein profile (total, LDL and HDL cholesterol and triglycerides).				
Diabetes (Type 2)	Every three years beginning at age 45. More often and starting earlier for those with risk factors.				
Body Mass Index (BMI)	Screen for obesity, eating disorders, body image and dieting patterns.				
INFECTIOUS DISEASE SCREENINGS					
Sexually Transmitted Diseases — Chlamydia, Gonorrhea, Syphilis and HPV	Chlamydia and gonorrhea: Sexually active patients younger than age 25. Annually for patients ages 25 and older if at risk. Syphilis: Annually for patients at risk. HPV: For ages 26 and younger, if not previously vaccinated, counsel regarding HPV vaccine schedule.				
Human Immunodeficiency Virus (HIV)	Routine/annual testing of all patients at increased risk. Starting at age 13, CDC recommends universal screening.				
Hepatitis C	Periodic testing of all patients at high risk				
Tuberculosis (TB)	Tuberculin skin testing for all patients at high risk				

Adult	18–29 Years	30–39 Years	40–49 Years	50–64 Years	65+ Years
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SENSORY SCREENING					
Eye Exam for Glaucoma	At least once for patients with no risk factors. Every three to five years for patients at high risk.		Every two to four years		Every one to two years
GENERAL COUNSELING					
Periodic screening and counseling as appropriate regarding: depression/suicide, alcohol/substance abuse, tobacco, diet/nutrition, obesity and eating disorders, preconception counseling, physical activity, infectious diseases/STIs, safety/injury and violence prevention, family violence/abuse, skin cancer, menopause, osteoporosis, hearing and vision assessment, counseling on use of aspirin for the prevention of cardiovascular disease and dementia/cognitive impairment.					

Adult	18–29 Years	30–39 Years	40–49 Years	50–64 Years	65+ Years
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IMMUNIZATIONS**					
Tetanus, Diphtheria, Pertussis (Td/Tdap)	For adults not previously vaccinated with Td: one dose of Tdap, followed by two doses of Td. Td booster every 10 years. For adults who have not previously received a dose of Tdap, Tdap should replace a single dose of Td.				Three doses of Td if not previously immunized. Td booster every 10 years.
Measles-Mumps-Rubella (MMR)	One or more doses if born after 1956 and no documentation of vaccination and no laboratory evidence of immunity to MMR			Additional doses based on risk factors and health history	
Varicella (Chickenpox)	Two doses (four to eight weeks apart) if not previously immunized and no history of chickenpox or shingles, or if at high risk				
Influenza	Annually for all ages				
Pneumococcal (Polysaccharide)	One dose if at high risk and not previously immunized. Revaccinate once after five years for persons with chronic renal or nephrotic syndrome, asplenia, sickle cell disease or immunosuppressive disorders.				One dose after age 65, even if vaccinated before age 65
Hepatitis B	Three doses if at high risk and not previously immunized				
Hepatitis A	Two doses if at high risk and not previously immunized				
Herpes zoster	Not routine			Single dose for all adults ages 60 and older	
Human papillomavirus (HPV) (Women)	Three doses for females ages 26 and younger	Not routine			
Meningococcal (Polysaccharide) MPSV4	Adults younger than age 56: MCV4 preferred, MPSV4 acceptable			Adults older than age 55: MPSV4 is the only licensed product for this age group.	
Meningococcal Conjugate MCV4	One dose for adults at elevated risk due to school-based, working, medical or travel conditions				

* Adapted from guidelines developed through Massachusetts Health Quality Partners, Inc. (MHQP). More information at www.mhqp.org.
 ** Adapted from the U.S. Centers for Disease Control and Prevention 2011 Adult Immunization Guidelines. More information at www.cdc.gov.

Note: Ask your clinician if you are at high risk for any of the conditions mentioned in these guidelines. This chart lists only routinely recommended vaccines; talk with your clinician about your risk for other diseases.

More ways to shape up and save!

Harvard Pilgrim's discounts help you and your family on the many paths to wellness.

\$150 health and fitness club reimbursement

- Receive up to \$150 if you're an eligible member of Harvard Pilgrim and a qualified health and fitness club member for four months in a calendar year¹

Nutrition

- DASH for Health[®] Online Nutrition Program
- Diet.com—savings on membership fees
- iDiet in-person and online programs
- Jenny Craig[®]—free 30-day trial program and savings on a Premium Success program²
- Weight Watchers[®]—registration fee waived at all North America locations (savings vary at locally owned locations)

Eye and ear

- Free eyewear program from Visionworks (formerly called Cambridge Eye Doctors and Vision World) at participating locations in MA, NH and RI³

- Additional eyewear savings at many popular eyewear locations, including Visionworks, JC Penney[®] Optical, LensCrafters[®], Pearle Vision[®], Sears Optical and Target Optical
- Laser vision correction procedures at participating providers
- Hearing aids by Flynn Associates—up to \$200 off per hearing aid, free quarterly cleanings and adjustments, and more
- Savings on hearing aids and hearing services at HearPO—with more than 2,300 locations nationwide—plus one year of follow-up services included with purchase
- Speech-Language and Hearing Associates of Greater Boston, PC—save up to \$200 on each hearing aid purchase

Turn over for more program discounts ▶▶

▶ For more details on these programs, visit www.harvardpilgrim.org/savings. If you don't have Internet access, call our Member Services department at **(888) 333-4742**. For TTY service, call **(800) 637-8257**.

¹ \$150 maximum reimbursement per Harvard Pilgrim policy in a calendar year (individual or family contract). Restrictions apply, and reimbursement is not available to all members. Visit www.harvardpilgrim.org/savings or call for details. (For tax information, consult with your employer.)

² Food and, if applicable, shipping not included. Offer applies to initial membership fee only and is valid at participating U.S., Canada and Puerto Rico centres and through Jenny Craig At Home. (Jenny Craig At Home[®] also offers a six-month Premium Success program subject to a 20% discount.)

³ You must have an eye exam and choose eyeglasses during the same visit. Additional restrictions apply. Visit www.harvardpilgrim.org/savings or call for details.

These savings programs are not insurance products. Rather, they are discounts for programs and services designed to help keep members healthy and active. All programs subject to change without advance notice.

Per the Patient Protection and Affordable Care Act, as of January 1, 2014, some small group and individual plans include coverage for fitness and weight loss program reimbursement, and some prescription eyewear. Please see your *Benefit Handbook*, *Schedule of Benefits* or applicable Rider for details.

Complementary and alternative medicine

- Save 10-30% on services from an extensive network of fitness centers, spas and practitioners, including acupuncture, chiropractic⁴, yoga, holistic and naturopathic medicine, pain management, Chinese herbal medicine and more
- Save on massage therapy services at Massage Envy
- Mindful magazine—25% off subscription
- Mindfulness based stress reduction program
- RESPeRATE blood pressure machine rebate offer

Fitness

- Discounts at select fitness clubs in MA, NH and ME
- Brand-name athletic footwear at Marathon Sports and Northampton Running Company (MA), and Runner's Alley (NH)
- Appalachian Mountain Club membership
- Boston Ski & Sports Club membership
- Genavix Wellness Network offers savings on their “90 Day Commit to Get Fit” program and Comprehensive Wellness Assessment
- Exercise Equipment at Workout Fitness Store (ME)

Safety and comfort care

- In Control Crash Prevention Program 15% discount
- My Notification Service 50% discount
- The Original Healing Threads™ by Spirited Sisters, Inc.
- Support Plus™ foot, leg and comfort care products
- Personal Emergency Response System (PERS)—savings on products
- Sense-Able Autism Spectrum Disorder—savings on all products
- MedMinder electronic pill dispensers—discount on membership fee

New parent support

- Safe Beginnings home and child safety products
- The Happiest Baby™— 40% off CDs and DVDs

Eldercare

- No-cost telephone assessment and family consultation, plus \$500 off lifetime flat fee of services for SeniorAssist
- \$100 credit toward charges for services at participating Home Instead Senior Care offices, plus a free home safety inspection at the start-up of services
- Save on subscriptions (plus an extra month FREE) to My Vigorous Mind, a web-based wellness software program offering brain exercise programs to help improve attention, memory processing speed and reasoning
- CareScout® Eldercare Advocacy Program

More wellness discounts

- www.Care.com for assistance in finding a caregiver for children, aging parents, your pets and even your home
- Take 18% off QuitSmart®, a proven effective program to quit smoking
- Save \$300 on the purchase of a hot tub or spa at New England Spas
- Organic vegetable garden installation and support by Green City Growers for Eastern Massachusetts members
- Up to 83% off magazine subscriptions—more than 40 healthy reads available
- And even more!

▶ For more details on these programs, visit www.harvardpilgrim.org/savings. If you don't have Internet access, call our Member Services department at **(888) 333-4742**. For TTY service, call (800) 637-8257.

⁴ Does not replace or supplement coverage under your Harvard Pilgrim medical benefits plan. Some plans include chiropractic coverage, in which case the provider networks and benefits differ. Consult your Benefit Handbook or call Member Services for details.

Be well, save money and use your plan with www.harvardpilgrim.org

Our Web site for members is designed to make it easy for you to get information and do the things you need to do to make the most of your Harvard Pilgrim plan.

That includes learning about:

- + Ways to improve your overall health and well-being
- + Special programs and tips to help you save money along the way
- + Tools and resources to help you manage your plan benefits

Be well

Learn about important topics affecting your health

- Access preventive care guidelines
- See educational resources on condition and disease management, including cholesterol, blood pressure, asthma, ADHD, depression, diabetes, cancer and heart health
- Take a health quiz
- Look up health topics from A to Z
- Check out our health and wellness publications for members
- Search online resources via our Web library

Health improvement

- Learn about treatment options and how to prepare for a procedure 
- Participate in our Healthy Pregnancy program using interactive tools
- Take a Health Questionnaire and learn your wellness score 
- Visit www.harvardpilgrim.org/wellness for well-being support based on where you are in life

About **HPHConnect** for members

HPHConnect is a secure online member account that helps you manage your personal health through a wide variety of tools and resources.

Save money

Save on products and services to help you keep fit and healthy

- See the newest additions to our Your Member Savings program, which features special savings on health-related products and services including eyewear, fitness reimbursement,* nutrition, alternative complementary medicine, safety products, eldercare and much more

Save on medications**

- Learn how to save with generic prescriptions
- Order mail service prescriptions 

Use your plan

Providers and services

- Find participating physicians
- See physician hospital affiliations and profiles
- Choose or change your primary care physician 
- Compare hospital safety and quality 
- Find typical costs for tests and procedures

Your prescriptions**

- Look up your medications by tier or retail price
- Find a pharmacy
- Check your prescription drug records 

Your benefits and records

- Check your benefit and eligibility details 
- Check the status of your claims and authorizations 
- Track your health history (including allergies, illnesses/conditions, procedures and family history) and share information with providers using your Harvard Pilgrim Personal Health Record 
- Order an ID card 
- Update your contact info 
- Learn about new member programs
- Find out about benefit changes

We're also available by phone

Contact Member Services at (888) 333-4742. If you are deaf or hard-of-hearing, please call (800) 637-8257 for TTY service.

* \$150 maximum reimbursement per Harvard Pilgrim policy in a calendar year (individual or family policy). Restrictions apply; reimbursement is not available to all members. Visit www.harvardpilgrim.org/savings or call us for details. (For tax information, consult with your employer.)

** If your employer offers prescription drug coverage through Harvard Pilgrim.

Your Harvard Pilgrim Health Care Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.

The privacy of your information is important. Harvard Pilgrim may collect, use and disclose financial and medical information about you when doing business with you or with others.

Harvard Pilgrim Health Care, Inc. and its affiliates and subsidiaries, including Harvard Pilgrim Health Care of New England and HPHC Insurance Company take the protection of your personal privacy seriously. We do this in accordance with Harvard Pilgrim's privacy policies and applicable state and federal laws for all of our benefit designs. Harvard Pilgrim also requires its business partners who administer health care coverage to you on our behalf to protect your information in accordance with applicable state and federal laws.

We may make a change to this notice and our privacy practices at any time, as long as the change is consistent with our current privacy policies and state and federal law. If we make an important change to our policies, we will notify you by mail or electronically as permitted by applicable law. We will also post the revised notice on our web site, www.hphc.org. For members enrolled in a student health plan offered by HPHC insurance company and administered by UnitedHealthcare Student Resources, you may also access the revised notice at www.uhcsr.com.

This notice is effective 7/1/2013 and supersedes the revision dated September 1, 2004.

WHAT IS PERSONAL AND HEALTH INFORMATION?

Personal and Health Information (referred to as 'information' elsewhere in this notice) includes protected health information (PHI) and individually identifiable information like your name and social security number. PHI is health information related to your physical or behavioral health condition used in providing health care to you or for payment for health care services. We protect all forms of information including electronic, written and verbal information.

TO WHOM WILL HARVARD PILGRIM DISCLOSE MY INFORMATION?

Harvard Pilgrim may disclose information to:

- Our Business Associates and Business Partners:
 - Harvard Pilgrim may contract with other organizations to provide services on our behalf. In these cases, Harvard Pilgrim will enter into an agreement with the organization explicitly

outlining the requirements associated with the protection, use and disclosure of your information.

- Your Family and Others:
 - When you are unavailable to communicate, such as during an emergency
 - When you have previously indicated an individual is your personal representative
 - When the information is clearly relevant to their authorized involvement with your health care or payment for health care. For example, we may confirm a claim has been received or paid if an individual has prior knowledge of the claim.
 - When sharing co-payment, coinsurance and deductible information with subscribers for dependents in order to facilitate management of health costs and Internal Revenue Service verification.
 - When sharing a minor's information with

parents who have custodial rights when that information is not further restricted by pertinent state or federal law. Information related to any care a minor may seek and receive without parental consent remains confidential unless the minor authorizes disclosure.

- Your Providers and Others Involved in Your Care:
 - Harvard Pilgrim may share information with those involved in your care for quality initiatives, safety concerns and coordination of care. Examples include state-mandated quality improvement initiatives, results of laboratory tests not otherwise restricted by law, and clinical reminders sent to your primary care provider.
 - Your employer-sponsored health benefit plan administrator
 - When sharing data used for enrollment and Plan renewal with your Plan Sponsor (your employer and/or their representatives, if you are enrolled through an employer)
 - When providing detailed claims and other health plan information to your Plan Sponsor after receiving appropriate certifications that the Plan Sponsor agrees to protect your privacy and the information will not be used for employment decisions. For example, supporting an employer's efforts to design and develop a wellness program for employees by sharing results of screening tests offered for evaluating common medical conditions and responses to health status questionnaires employees may elect to complete and submit.

HOW WILL HARVARD PILGRIM USE AND DISCLOSE MY INFORMATION?

In order to provide coverage for treatment and to pay for those services, we need to use and disclose your information in several different ways. Harvard Pilgrim maintains and enforces company policies governing the use and disclosure of information. Our staff is trained to handle your information appropriately and to only use information required for their roles. The following are examples of the types of uses and information disclosures we are permitted to make without your authorization:

FOR PAYMENT

Harvard Pilgrim will use and disclose your information to administer your health benefits. This may involve the determination of eligibility, claims payment, utilization review activities, medical necessity review, coordination of benefits, appeals and external review requests. Examples include:

- Paying claims that were submitted to us by physicians and hospitals
- Transmitting information to a third party to facilitate administration of a Flexible Spending Account, a Health Savings Account, a Health Reimbursement Account or a dental benefits plan.

FOR HEALTH CARE OPERATIONS

Harvard Pilgrim may use and disclose your information for operational purposes, such as care management, customer service, coordination of care or quality improvement. Examples include:

- Assessing the quality of care and outcomes for our members
- Learning how to improve our services through the use of internal and external surveys
- Reviewing and credentialing our affiliated physicians and institutions
- Evaluating the performance of our staff, such as reviewing our customer service representatives' phone conversations with you
- Seeking accreditation by independent organizations, such as the National Committee for Quality Assurance
- Engaging in wellness programs, preventive health, early detection, disease management, health risk assessment participation initiatives, case management and coordination of care programs, including sending preventive health service reminders
- Using information for underwriting, establishing premium rates and determining cost sharing amounts, as well as administration of reinsurance policies. (Harvard Pilgrim will not use or disclose any genetic information it might otherwise receive for underwriting purposes.)
- Facilitating transition of care from and to other

insurers, health plans or third party administrators

- Other general administrative activities, including data and information systems management, risk management, auditing and detection of unlawful conduct

FOR TREATMENT

Harvard Pilgrim may disclose your information to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers) in connection with your treatment. Examples include:

- Quality improvement and cost containment wellness programs, preventive health initiatives, early detection programs, safety initiatives and disease management programs. For example, Harvard Pilgrim may disclose information to physicians involved in your care. This includes a list of medications you've received using your Harvard Pilgrim coverage (this will alert your treating physicians about any medications prescribed for you by other providers and will help minimize potential adverse drug interactions).
- To administer quality-based cost effective care models. For example, if you receive your treatment through a "Medical Home," a setting in which team-based care is led by your physician, Harvard Pilgrim may share information with the Medical Home providers about the services you receive elsewhere to assure effective and high quality care is coordinated.
- Harvard Pilgrim may receive your test results from labs you use, from your providers or directly from you. These results may be used to develop tools to improve your overall health, and may be shared with providers involved in your care.

FOR OTHER PERMITTED PURPOSES

Harvard Pilgrim may use or disclose your information for the following permitted purposes:

- To provide data for **health services research** to improve the health of our members and the community. Harvard Pilgrim may use your health information for research purposes when our Human Subjects Committee has reviewed

the research proposal and approved the research based on established protocols to ensure your privacy.

- To comply with laws and regulations related to **Workers' Compensation**.
- For **public health activities** such as assisting public health authorities with disease prevention or disease control. This can include data collection by state government-mandated or -sponsored consortiums or public health authorities.
- For **health oversight activities** data may be submitted to a government agency authorized to oversee the health care system or government programs, or to its contractors. Examples include the U.S. Department of Health and Human Services (HHS), a state insurance department or the U.S. Department of Labor for activities authorized by law, such as audits, examinations, investigations, inspections and licensure activity.
- In response to a **court order** or an administrative tribunal and, in certain cases, in response to a subpoena, discovery request or other lawful process.
- To funeral directors or coroners so they can carry out their lawful duties. Harvard Pilgrim may also disclose information **about a decedent** to the executor, administrator or other person with authority to act on behalf of the decedent's estate.
- To **organ procurement** organizations to facilitate cadaveric organ, eye or tissue donation/transplantation, only after your prior authorization.

OTHER REQUIRED USES AND DISCLOSURES

Harvard Pilgrim may use and disclose information about you as required by law. Examples of such situations include:

- To **report** information related to victims of **abuse, neglect or domestic violence**
- To prevent serious **threat to your health or safety**, or that of another person
- To authorized federal officials for **national**

security purposes. In addition, under certain conditions, we may disclose your information if you are or were a member of the Armed Forces, for those activities deemed necessary by appropriate military authorities.

- For **inmates**, to a correctional institution or a law enforcement official having lawful custody, if the provision of such information is necessary to provide you with health care, protect your health and safety, and that of others, or maintain the safety and security of the correctional institution.

WILL HARVARD PILGRIM USE OR DISCLOSE MY INFORMATION IN WAYS NOT DESCRIBED IN THIS NOTICE?

Other than the uses previously listed, your information will only be used or disclosed with your written authorization. You may revoke such an authorization at any time in writing, except to the extent we have already taken an action based on a previously executed authorization.

To authorize us to use or disclose any of your information to a person or organization for reasons other than those described in this notice, please complete an authorization form located www.HarvardPilgrim.org/Members. You should send the completed form to:

**Harvard Pilgrim Health Care
Customer Service Department
1600 Crown Colony Drive
Quincy MA 02169**

For members enrolled in a student health plan offered by HPHC Insurance Company and administered by UnitedHealthcare Student Resources, the form is located at www.uhcsr.com, and the completed form should be sent to:

**UnitedHealthcare StudentResources
PO Box 809025
Dallas, TX 75380-9025**

Harvard Pilgrim will neither use nor sell your information to offer you services or products unrelated to your health care coverage or your health status, without your authorization.

WHAT RIGHTS DO I HAVE REGARDING MY INFORMATION?

Access and receive copies of your information

You have the right to receive a copy of your information, once you provide us with specific information to fulfill your request. We reserve the right to charge a reasonable fee for the cost of producing and mailing copies of such information.

Amend your information

If you believe your information is incorrect or incomplete, you have the right to ask us to amend it. In certain cases, we may deny your request and provide you with a written explanation. For example, we may deny a request if we did not create the information, as is often the case for medical information that was generated by a provider, or if we believe the current information is correct.

Confidential communications

Harvard Pilgrim recognizes you have the right to receive communications regarding your information in a manner and at a location that you feel is safe from unauthorized use or disclosure. To support this commitment, Harvard Pilgrim will permit you to request your information by alternative means or at alternative locations. We will attempt to accommodate reasonable requests.

Accounting of disclosures

You have the right to request an accounting of those instances in which we or our business associates have disclosed your information for purposes other than treatment, payment or health care operations, or other permitted or required purposes. Harvard Pilgrim will require specific information needed to fulfill your request. If you request an accounting more than once in a 12-month period, we may charge you a reasonable fee.

Restrictions

You have the right to ask us to place restrictions on the way we are permitted to use or disclose your information. We are not, however, required by law to agree to these requested restrictions. If we do agree to a restriction, we will abide by the restriction unless it is related to an emergency.

Notice of Privacy Practice

You have the right to receive a paper copy of the Notice of Privacy Practices upon request at any time.

Rights under state law

You may be entitled to additional rights under state law. Harvard Pilgrim pays careful attention to protecting your information as required by these state laws.

Right to be notified of a breach

You have the right to be notified of a breach of your unsecured information.

How do I exercise my rights?

You can exercise all of your privacy rights by contacting our Customer Service Department. We may require a written request be completed and submitted to:

**Harvard Pilgrim Health Care
Customer Service Department
1600 Crown Colony Drive
Quincy, MA 02169**

To request a form, call (888) 333-4742 or go to www.HarvardPilgrim.org/Members for more information.

For members enrolled in a student health plan offered by HPHC Insurance Company and administered by UnitedHealthcare Student Resources, the form is located at www.uhcsr.com, and the completed form should be sent to:

**UnitedHealthcare StudentResources
PO Box 809025
Dallas, TX 75380-9025**

What do I do if I feel my rights have been violated?

If you believe your privacy rights have been violated, you may file a written complaint with:

**Privacy Officer
Harvard Pilgrim Health Care
93 Worcester Street
Wellesley, MA 02481**

Or, you may call this office at (617) 509-3258.

You may also notify the Secretary of the Department of Health and Human Services (HHS). Send your complaint to:

**Medical Privacy, Complaint Division
Office for Civil Rights (OCR)
U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201.**

You may also call OCR's Voice Hotline at (800) 368-1019 or you can find more information at www.hhs.gov/ocr.

Harvard Pilgrim will not take retaliatory action against you if you file a complaint about our privacy practices with either OCR or Harvard Pilgrim.

Non-English speaking members may also call Harvard Pilgrim's Customer Service Department at (888) 333-4742 to have their questions answered. Harvard Pilgrim offers free language interpretation services in more than 200 languages.

Deaf and hard-of-hearing members who have access to a Teletypewriter (TTY) may communicate directly with the Customer Service Department by calling our TTY machine at 1-800-637-8257.

Non-English speaking members may also call Harvard Pilgrim’s Member Services Department at **1-888-333-4742** to have their questions answered. Harvard Pilgrim offers free language interpretation services in more than 200 languages.

[Spanish]

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

[Russian]

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

[Arabic]

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

[Portuguese]

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

[French]

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

[Greek]

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

[Haitian Creole]

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

[Italian]

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

[Traditional Chinese]

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

[Lao]

ສະມາຊິກ ທັງ ຫລາຍ ທີ່ ຢາກ ພາສາ ອັງກິດ ບໍ່ ບັນກໍ ສາມາດ ຕິດ ຕໍ່ ກັບ ຜະນນາ ບໍລິການ ອຸກ ຄ້າ ຂອງ ໂຄງ ການ ຮັກສາ ສຸຂະພາບ Harvard Pilgrim ໄດ້ ໂດຍ ໂທ ໄປ ຫາ 1-888-333-4742 ເພື່ອ ຂໍ ຊາບ ຄຳ ຕອບ ຂອງ ຄຳ ຖາມ ຕ່າງໆ ຂອງ ຕົນ. ໂຄງ ການ ນີ້ ຂໍ ສະນີ ບໍລິການ ໝູ່ ພາສາ ໃນ ຫລາຍ ກວ່າ 120 ພາສາ ໂດຍ ສິດ ຄຳ ບໍລິການ ໂຄງ ທັງ ສິ້ມ.

[Cambodian]

សមាជិកដែលមិនចេះនិយាយភាសាអង់គ្លេស ក៏អាចទូរស័ព្ទទៅការិយាល័យផ្នែកសេវាបំរើសមាជិកនៃ ផែនការសុខភាព **Harvard Pilgrim Health Care** លេខ **1-888-333-4742** ដើម្បីឲ្យគេភ្លើយសំនួរចំពោះជំនួញ។ ផែនការសុខភាពនេះមានផ្តល់ជូនសេវាបកប្រែភាសាដោយ ឥតគិតថ្លៃ រហូតដល់ 120 ភាសា ។

The HPHC Insurance Company PPO
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2014 — 12/31/2014

Coverage for: Individual + Family | **Plan Type:** PPO


This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or [plan](#) document at www.harvardpilgrim.org or by calling 1-888-333-4742.

Important Questions	Answers	Why this matters:
What is the overall deductible?	Out-of-Network: \$250 per member per calendar year/ \$500 per family per calendar year The deductible applies to benefits cited in the chart starting on Page 3 , for other benefits see your Plan document.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. In-Network: \$1,250 per member per calendar year/ \$2,500 per family per calendar year Out-of-Network: \$1,250 per member per calendar year / \$2,500 per family per calendar year	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Please see your Schedule of Benefits for out-of-pocket maximum exclusions for your plan.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Important Questions	Answers	Why this matters:
Does this plan use a network of providers?	Yes. For a list of preferred providers , see www.harvardpilgrim.org or call 1-888-333-4742.	If you use an in- network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in- network doctor or hospital may use an out-of- network provider for some services. Plans use the term in- network , preferred, or participating for providers in their network . See the chart starting on page 3 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan .
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services .

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

	<ul style="list-style-type: none"> • Co-payments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service. • Co-insurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is \$1,000, your co-insurance payment of 20% would be \$200. This may change if you haven't met your deductible. • The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.) • This plan may encourage you to use participating providers by charging you lower deductibles, co-payments and co-insurance amounts.
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Common Medical Event	Services You May Need	Participating Provider	Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 Copayment per visit	Deductible, then 20% Coinsurance	None
	Specialist visit	\$20 Copayment per visit	Deductible, then 20% Coinsurance	None
	Other practitioner office visit	\$20 Copayment per visit	Deductible, then 20% Coinsurance	Cost sharing may vary for certain practitioners.
	Preventive care/screening/immunization	No charge	Deductible, then 20% Coinsurance	None
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Deductible, then 20% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	\$75 Copayment per procedure	Deductible, then 20% Coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.harvardpilgrim.org .	Most generic drugs	Retail Pharmacy Tier 1: \$5 Copayment Mail Order Pharmacy Tier 1: \$10 Copayment Retail Pharmacy Tier 2: \$20 Copayment Mail Order Pharmacy Tier 2: \$40 Copayment		– Retail Pharmacy – limited to 30 day supply per refill – Mail Order Pharmacy – limited to 90 day supply per refill
	Preferred brand drugs	Retail Pharmacy Tier 3: \$30 Copayment Mail Order Pharmacy Tier 3: \$60 Copayment		Same as above.
	Non-preferred brand drugs	Retail Pharmacy Tier 4: \$50 Copayment Mail Order Pharmacy Tier 4: \$150 Copayment		Some generic drugs are in this tier. Same as above.
	Specialty drugs	All drugs are covered in Retail Pharmacy and Mail Order Pharmacy Tiers 1 — 4		Must be obtained through a Specialty Pharmacy.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Common Medical Event	Services You May Need	Participating Provider	Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Deductible, then 20% Coinsurance	None
	Physician/surgeon fees	No charge	Deductible, then 20% Coinsurance	None
If you need immediate medical attention	Emergency Room Services	\$100 Copayment per visit This Copayment is waived if admitted to the hospital directly from the emergency room.	Same As Participating Provider	None
	Emergency Medical Transportation	No charge	Same As Participating Provider	None
	Urgent Care	\$20 Copayment per visit	Deductible, then 20% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Deductible, then 20% Coinsurance	None
	Physician/surgeon fee	No charge	Deductible, then 20% Coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Group Therapy: \$10 Copayment per visit Individual Therapy: \$20 Copayment per visit	Deductible, then 20% Coinsurance	None
	Mental/Behavioral health inpatient services	No charge	Deductible, then 20% Coinsurance	None
	Substance use disorder outpatient services	Group Therapy: \$10 Copayment per visit Individual Therapy: \$20 Copayment per visit	Deductible, then 20% Coinsurance	None
	Substance use disorder inpatient services	No charge	Deductible, then 20% Coinsurance	None
If you are pregnant	Prenatal and postnatal care	No charge	Deductible, then 20% Coinsurance	None
	Delivery and all inpatient services	No charge	Deductible, then 20% Coinsurance	None

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Common Medical Event	Services You May Need	Participating Provider	Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	Deductible, then 20% Coinsurance	None
	Rehabilitation services (Inpatient)	No charge	Deductible, then 20% Coinsurance	– Limited to 60 days per calendar year
	Habilitation services (Outpatient)	\$20 Copayment per visit	Deductible, then 20% Coinsurance	– Physical Therapy – limited to 30 visits per calendar year – Occupational Therapy – limited to 30 visits per calendar year
	Skilled nursing care	No charge	Deductible, then 20% Coinsurance	– Limited to 100 days per calendar year
	Durable medical equipment	20% Coinsurance	Deductible, then 20% Coinsurance	– Wigs – limited to \$350 per calendar year
	Hospice services	No charge	Deductible, then 20% Coinsurance	If inpatient services are required, please see “If you have a hospital stay”.
If your child needs dental or eye care	Eye exam	\$20 Copayment per visit	Deductible, then 20% Coinsurance	– Limited to 1 exam per calendar year You may have other coverage under a Vision Rider.
	Glasses	Not covered	Not covered	You may have other coverage under a Vision Rider.
	Dental check-up – Up to the age of 13	No charge	Deductible, then 20% Coinsurance	– Limited to 2 exams per calendar year You may have other coverage under a Dental Rider.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Hearing Aids
- Long-Term (Custodial) Care
- Most Cosmetic Surgery
- Most Dental Care (Adult)
- Private-duty nursing
- Routine foot care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic Care
- Infertility Treatments
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

Your Rights to Continue Coverage:

Individual health insurance -

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at **1-800-333-4742**. You may also contact your state insurance department at:

Group health coverage -

If you lose coverage under the **plan**, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the **plan**. Other limitations on your rights to continue coverage may also apply.

OR

For more information on your rights to continue coverage, contact the **plan** at **1-800-333-4742**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or **www.cciio.cms.gov**

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your **plan**, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

HPHC Member Appeals-Member Services Department
HPHC Insurance Company, Inc.
1600 Crown Colony Drive
Quincy, MA 02169
Telephone: 1-888-333-4742
Fax: 1-617-509-3085

Department of Labor's Employee Benefits Security Administration
1-866-444-3272
www.dol.gov/ebsa/healthreform

Health Care for All
30 Winter Street, Suite 1004
Boston, MA 02108
1-800-272-4232
http://www.hcfama.org/helpline

Para obtener asistencia en Español, llame al 1-888-333-4742.

如果需要中文的帮助, 请拨打这个号码 1-888-333-4742.

De assistência em Português, por favor ligue 1-888-333-4742.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

About these Coverage Examples:

These examples show how this **plan** might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different **plans**.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this **plan**. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: **\$7,540**
- Plan pays: **\$7,380**
- Patient pays: **\$160**

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Co-pays	\$10
Co-insurance	\$0
Limits or exclusions	\$150
Total	\$160

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: **\$5,400**
- Plan pays: **\$3,920**
- Patient pays: **\$1,480**

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Co-pays	\$1,400
Co-insurance	\$0
Limits or exclusions	\$80
Total	\$1,480

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health **plan**.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any **member** covered under this **plan**.
- **Out-of-pocket** expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

X No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

X No. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health **plan** allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other **plans**, you'll find the same Coverage Examples. When you compare **plans**, check the "Patient Pays" box in each example. The smaller that number, the more coverage the **plan** provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in **out-of-pocket** costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay **out-of-pocket** expenses.