THE HARVARD PILGRIM BEST BUY HSA HMO FOR SELF-INSURED MEMBERS

MASSACHUSETTS

This bene□t 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 hi□ity oh

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Welcome to The Harvard Pilgrim Best Buy HSA HMO for Self-Insured Members for Self-Insured Members (the Plan) and thank you for choosing us to help meet your health care needs. Your benefits are provided by your Plan Sponsor, generally an employer or union. Harvard Pilgrim Health Care (Harvard Pilgrim or HPHC) administers the plan's benefits on behalf of your Plan Sponsor.

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

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

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

You must choose a Primary Care Provider (PCP) for yourself and each of your family members when you enroll in the Plan.

When you enroll, the Plan provides the covered health care services described in this Handbook, the Schedule of Benefits, the Prescription Drug Brochure (if your Plan includes our outpatient pharmacy coverage) and any riders. These services must be provided or arranged by your PCP, except as described in section *I.D.1. Your PCP Manages Your Health Care*.

As a Member, you can take advantage of a wide rangepharmacyPCP

The cost transparency tool allows you to compare cost and quality on many types of health care services including surgical procedures and office visits. The cost transparency tool provides estimated costs only. Your Member Cost Sharing may be different.

To access information, tools and resources online, visit . . and select the Member Login button (first time users must create an account and then log in). To access the cost transparency tool once you're logged in, click on the "Tools and Resources" link from your personalized Member dashboard and look for the Estimate My Cost link.

You may call the Member Services Department at **888 333 474** if you have any questions. Member Services staff is also available to help you with questions about the following:

- Selecting a PCP
- Your Benefit Handbook
- Your benefits
- Your enrollment
- Your claims
- Pharmacy management dTfL.''fiK""wudTu

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

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not knowingly select, who provided services to you while you were receiving covered services from a Plan Provider or facility. If you receive a Surprise Bill, you are only responsible for the applicable Member Cost Sharing that would apply if the covered service was provided by a Plan Provider, unless you had a reasonable opportunity to choose to have the service performed by a Plan Provider.

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

4. Flex Providers
Some Plans may include Flex Providers. A Flex Provider is a Plan Provider that provides certain outpatient services with lower Member Cost Sharing. When you receive certain Covered Benefits from a Flex Provider you will pay a lower Member Cost Sharing amount than if you received the same Covered Benefit from a provider that is not a Flex Provider.

FOR EXAMPLE: An example OK

If you are hospitalized, you must call HPvDy

1. Copayment
A Copayment is a □xed dollar amount that you must pay for certain Covered Bene□ts. Copayments are due at the time of service or when billed by the provider.

Your Plan may have other Copayment amounts. For more information about Copayments under your Plan, including your speci□c Copayment requirements, please refer to your Schedule of Bene□ts.

2. Deductible
A Deductible is a speci□c dollar amount that is payable by a Member for Covered Bene□ts received each Plan Year or Calendar Year before any bene□ts 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 Bene□ts under your Plan. Your Deductible is listed in your Schedule of Bene□ts.

Your Plan will have one of the following types of Deductibles:

Individual Deductible. An individual Deductible will apply when you have Individual Coverage. Once you have met the individual Deductible amount, you will have no additional Deductible Member Cost Sharing for Covered Bene□ts for the remainder of the Plan Year or Calendar Year. An individual Deductible may also apply if you have Family Coverage that includes a family Deductible with an embedded individual Deductible. Please see additional information on Family Coverage Deductible below.

Family Deductible. A family Deductible will apply when you have Family Coverage.

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

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

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

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

An embedded individual Deductible may not be less than the applicable minimum family Deductible required for a High Deductible Health Plan.

Please see your Schedule of Bene□ts to determine which Deductible applies to your Plan. Once a Deductible is met, coverage by the Plan is subject to any other Member Cost Sharing that may apply.

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

3. Coinsurance
After the appropriate Deductible amount is met, you may be responsible for paying a Coinsurance amount, which is a percentage of the Allowed Amount or the Recognized Amount, if applicable. When using Plan Providers, the Allowed Amount is based on the contracted rate between HPHC and the provider. Coinsurance amounts are listed in your Schedule of Bene□ts.

4. Out-of-Pocket Maximum
Your coverage includes an Out-of-Pocket Maximum. An Out-of-Pocket Maximum is the total amount of Copayments, Deductible or Coinsurance payments for which a Member or a family is responsible in a Plan Year or 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 the Plan will pay 100% of the AllowedPaRx0WEFA•ATdp[MeOEMrO]T"pts

or Calendar Year. Once a family Out-of-Pocket Maximum has been m

undergoing a course of institutional or inpatient care, or has scheduled nonelective surgery including any related postoperative care.

The term “serious and complex condition” is an acute illness that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or ia

I. BUNDLED PAYMENT ARRANGEMENTS

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

J. CARE MANAGEMENT PROGRAMS

The Plan provides care management programs for Members with certain illnesses and injuries. These programs are designed to encourage the use

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.

Acute Treatment

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education; or any other discipline deemed acceptable by the Plan.

Limited Network A network of providers that is smaller than the Harvard Pilgrim's full provider network. This provider network includes, but is not limited to physicians, hospitals, and other health care facilities that are under contract with us to provide services to Members.

Medical Drugs A prescription drug that is administered to you either (1) in a doctor's of□ce or other outpatient medical facility, or (2) at home while you are recei

Cost Sharing may include Copayments, Coinsurance and Deductibles. Please refer to your Schedule of Bene□ts for the speci□c Member Cost Sharing that applies to your Plan.

There may be two types of of□ce visit cost sharing that apply to your Plan: a lower cost sharing known as "Level 1" and a higher cost sharing known as "Level 2."

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

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

Out-of-Network Rate With respect to a Surprise Bill, the total amount paid by the Plan to a Non-Plan Provider for Covered Bene□ts under section 2799A-1 and 2799A-2 of the Public Service Act and their implementing regulations for: (1) Emergency Medical Services, (2) non-emergency ancillary services, (3) non-emergency, non-ancillary services, and (4) air ambulance services. The amount is based on: (1) Applicable state law, (2) an All Payer Model Agreement if adopted, (3) the initial payment made by us or the amount subsequently agreed to by the Non-Plan Provider and us, or□v v

from time to time without notice to Members. The most current listing of Plan Providers is available on **www.harvardpilgrim.org**.

Recognized Amount With respect to a Surprise Bill, the amount on which a Copayment, Coinsurance or Deductible is based for Medical Emergency Services and certain non-emergency Covered Bene□ts when provided by Non-Plan Providers. The amount under sectio

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This section contains detailed information on the bene□ts covered

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3 . Autism

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7 . Dental Services	
	Important Notice: The Plan does not provide dental insurance. It covers only the limited Dental Care described below. No other Dental Care is covered. **Cleft Palate:** For coverage of orthodontic and dental care related to the treatment of cleft lip or cleft palate for children up to the age of 18, please see section *III. Covered Benefits*, *Reconstructive Surgery,* for information on this benefit. **Emergency Dental Care:** The Plan covers emergency Dental Care needed due to an injury to sound, natural teeth. All services, except for suture removal, must be received within three days of injury. Only the following services are covered: • Extraction of the teeth damaged in the injury when needed to avoid infection • Reimplantation and stabilization of dislodged teeth • Repositioning and stabilization of partly dislodged teeth • Suturing and suture removal • Medication received from the provider **Extraction of Teeth Impacted in Bone:** The Plan may cover extraction of teeth impacted in bone. If covered under your Plan, only the following services are covered: • Extraction of teeth impacted in bone • Pre-operative and post-operative care, immediately following the procedure • Anesthesia • Bitewing x-rays **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. **Preventive Dental Care for Children:** The Plan may cover two preventive dental exams per Plan Year or Calendar Year for children under the age limit listed in the Schedule of Benefits. If covered under your Plan, only the following services are covered: • Cleaning • Fluoride treatment • Teaching plaque control • X-rays **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.

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8 . Diabetes Services and Supplies	
	Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care: The Plan covers outpatient self-management education and training for the treatment of diabetes, including medical nutrition therapy services, used to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes. Services must be provided on an individual basis and be provided by a Plan Provider. Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care. The following items are also covered: **Diabetes Equipment:** • Blood glucose monitors • Continuous glucose monitors • Dosage gauges • Injectors • Insulin pumps (including supplies) and infusion devices • Lancet devices • Therapeutic molded shoes and inserts • Visual magnifying aids • Voice synthesizers **Outpatient Pharmacy Supplies:** • Blood glucose strips • Certain blood glucose monitors • Certain insulin pumps (including supplies) and infusion devices • Flash glucose monitors (including supplies) • Insulin, insulin and syringes • Lancets • Oral agents for controlling blood sugar • Urine and ketone test strips For coverage of pharmacy items listed above, you must get a prescription from your Plan Provider and present it at a participating pharmacy. You can find participating pharmacies by logging into at . . or by calling the Member Services Department at **1-888-333-4742**. **Please Note:** Not all Plans provide coverage for outpatient prescription drugs, including pharmacy supplies, through Harvard Pilgrim Health Care. If your Plan provides coverage for outpatient prescription drugs through Harvard Pilgrim Health Care, please refer to your prescription drug brochure for additional information.

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9 . Dialysis	The Plan covers dialysis on an inpatient, outpatient or at home

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Drug Coverage (Continued)

No coverage is provided under this Benefit Handbook for (1) drugs that have not been approved by the United States Food and Drug Administration; (2) drugs the Plan excludes or limits, including, but not limited to, drugs for cosmetic purposes; and (3) any drug that is obtained at an outpatient pharmacy except (a) covered diabetes supplies and (b) syringes and needles, as explained above.

2) Outpatient Prescription Drug Coverage

In addition to the coverage provided under this Benefit Handbook, you may also have the Plan's outpatient prescription drug rider. That rider provides coverage for most prescription drugs purchased at an outpatient pharmacy.

If the Plan includes outpatient prescription drug coverage, your Member Cost Sharing for prescription drugs will be listed on your jdCdTdLbdrug(TjLw"gSjdCdTdLbLboxTdl

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12 . Early Intervention Services	
	The Plan may cover early intervention services provided for Members until three years of age. Covered Benefits include: • Nursing care • Physical, speech, and occupational therapy • Psychological counseling • Screening and assessment of the need for services **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.
13 . Emergency Room Care	
	If you have a Medical Emergency, you are covered for care in a hospital emergency room. Please remember the following: • If you need follow-up care after you are treated in an emergency room, you must call your PCP. Your PCP will provide or arrange for the care you need. • If you are hospitalized, you must call HPHC at **1-888-333-4742** within 48 hours or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to HPHC or PCP by an attending emergency physician no further notice is required.
14 . Family Planning Services	
	The Plan covers family planning services, including the following: • Contraceptive monitoring • Family planning consultation • Pregnancy testing • Genetic counseling • FDA approved birth control drugs, implants or devices.* • Professional services relating to the injection of birth control drugs and the insertion or removal of birth control implants or devices. *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 Plan Sponsor to determine if you are covered under a Grandfathered plan that limits this coverage. **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 Plan Sponsor to see if this exclusion applies to your Plan.

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15 . Fertility Services

This fertility benefit applies to members who do not meet the definition of infertility described further in this handbook under the *Infertility Services and Treatment* benefit. This benefit is meant to support inclusive family expansion for people across sexual orientation and gender identity spectra, including those without coparenting partners. Fertility services may be considered Medically Necessary without a diagnosis of infertility.

The Plan may cover fertility services when determined to be Medically Necessary. Only the following fertility services are covered:

- Intrauterine Insemination (IUI)
- Donor sperm
- Donor egg procedures, including related egg and inseminated egg procurement, processing and cryopreservation up to a maximum of 24 months.
- In-Vitro Fertilization (IVF)
- Reciprocal In-Vitro Fertilization (IVF)
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Gender Affirming Services (Continued)	
	Please Note: Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.
17 . Hearing Aids	

The Plan may cover 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.

If a Covered Benefit, 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 Member 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.

Covered Benefits include the following:

- One hearing aid per hearing impaired ear every 36 months.

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ThePlancoversacutehospitalcareincluding,butnotlimitedto,thefollowing

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21 . House Calls	
	The Plan covers house calls.
22 . Human Organ Transplant Services	
	The Plan covers human organ transplants, including bone marrow transplants for a Member with metastasized breast cancer in accordance with the criteria of the Massachusetts Department of Public Health. The Plan covers the following services when the recipient is a Member of the Plan: • Care for the recipient • Donor search costs through established organ donor registries • Donor costs that are not covered by the donor's health plan If a Member is a donor for a recipient who is not a Member, then the Plan will cover the donor costs for the Member, when they are not covered by the recipient's health plan.
23 . Hypodermic Syringes and Needles	
	The Plan covers hypodermic syringes and needles to the extent Medically Necessary. You must get a prescription from your PCP or Plan Provider and present it at a participating pharmacy for coverage. Hypodermic syringes and needles are subject to the applicable pharmacy Member Cost Sharing listed on your outpatient prescription drug flyer and Summary of Benefits and Coverage. 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. You can get more information on participating pharmacies and the drug tiers by logging into at . . or by calling the Member Services Department at **1-888-333-4742**.
24 . Infertility Services and Treatment	
	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: • Consultation • Evaluation • Laboratory tests When a Member meets Medical Necessity Guidelines, the Plan may cover infertility treatment. If covered under your Plan, only the following infertility treatments are included: • Therapeutic artificial insemination (AI), including related sperm procurement and banking • Donor egg procedures, including related egg and inseminated egg procurement, processing and banking • Donor oocyte (DO/IVF) • Donor embryo/frozen embryo transfer (DO/FET) • Frozen embryo transfer (FET)

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Infertility Services and Treatment (Continued)	
	• Assisted hatching • Gamete intrafallopian transfer (GIFT) • Intra-cytoplasmic sperm injection (ICSI) • Intra-uterine insemination (IUI) • In-vitro fertilization and embryo transfer (IVF), including preimplantation genetic testing (PGT) **:** PGT will apply genetic testing cost sharing as listed in your Schedule of Benefits. • Zygote intrafallopian transfer (ZIFT) • Miscrosurgical epididiymal 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, sperm, and embryos with storage up to 24 months per Member per lifetime **Important Notice:** We use evidence based clinical criteria to evaluate whether the use of infertility treatment is Medically Necessary. Infertility treatments evolve and new treatments may be developed. If you are planning to receive infertility treatment we recommend that you review the current Medical Necessity Guidelines online at **.** **.** . To obtain a copy, please call the Member Services Department at **1-888-333-4742**. **Please Note:** Not all Plans cover infertility treatment. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.
25 . Laboratory, Radiology and Other Diagnostic Services	
	The Plan covers laboratory and radiology services (including Advanced Radiology), and other diagnostic services on an outpatient basis. The term "Advanced Radiology" means CT scans, PET Scans, MRI and MRA, and nuclear medicine services. Coverage includes: • The facility charge and the charge for supplies and equipment • The charges of anesthesiologists, pathologists and radiologists In addition, the Plan covers the following: • 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, oKqlgall

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Mental Health and Substance Use Disorder Treatment (Continued)

Necessity for mental health and substance use disorder treatment will be made in consultation with a Licensed Mental Health Professional.

Minimum Requirements for Covered Providers

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 and substance use disorder treatment facility. A facility that is also licensed as an educational or recreational institution will not meet this requirement unless the predominate purpose of the facility is the provision of mental health and substance use disorder treatment.

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 certified social worker; a licensed psychiatric nurse mental health clinical specialist; a licensed psychiatric mental health nurse practitioner; a licensed physician assistant who practices in the area

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Mental Health and Substance Use Disorder Treatment (Continued)

Benefits

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.

Covered mental health services include the following:

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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 and substance use disorder treatment:

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30 . Observation Services	
	The Plan covers observation services including short term treatment, assessment and reassessment for up to 48 hours in an acute care facility (i.e. hospital). Observation services determine if a Member needs to be admitted for additional treatment or if the Member is able to be discharged from the hospital.
31 . Ostomy Supplies	
	The Plan covers ostomy supplies up to the Benefit Limit listed in the Schedule of Benefits. Only the following supplies are covered: • Irrigation sleeves, bags and catheters • Pouches, face plates and belts • Skin barriers
32 . Palliative Care	
	The Plan covers palliative care in conjunction with inpatient, home health care, hospice and physician services. Member Cost Sharing for palliative care is included in the cost sharing associated with these services. Palliative care is a medical specialty that supports improved quality of life for Members with chronic or serious illness. Care is focused on providing relief from symptoms and the stress of illness. Palliative care can be provided at any stage of illness, along with treatment for your condition while remaining under the care of your regular provider. This care is offered alongside curative or other treatments you may be receiving. Palliative care may include physician services, nursing care, home health care, pain and symptom management, medication management, rehabilitation therapies (occupational, physical, speech and pulmonary), behavioral health services and durable medical equipment.
33 . Physician and Other Professional Office Visits	
	Physician services, including services of all covered medical professionals, can be obtained on an outpatient basis in a physician's office or a hospital. These services may include: • Routine physical examinations, including routine gynecological examination and annual cytological screenings • Follow-up care provided by an obstetrician or gynecologist for obstetrical or gynecological conditions identified during maternity care or an annual gynecological visit • Psychiatric collaborative care in which a primary care team provides structured behavioral health care management to a Member. A primary care team includes a [illegible]

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Physician and Other Professional Office Visits (Continued)

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Reconstructive Surgery (Continued)	
	Benefits are also provided for post mastectomy care, including coverage for: • Prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient; • Reconstruction of the breast on which the mastectomy was performed; and • Surgery and reconstruction of the other breast to produce a symmetrical appearance. Coverage may also be provided for the treatment of cleft lip and cleft palate for children up to the age of 18, including coverage for: • Medical, dental, oral, and facial surgery, including surgery performed by oral and plastic surgeons, and surgical management and follow-up care related to such surgery; • Orthodontic treatment; • Preventative and restorative dentistry to ensure good health and adequate dental structures to support orthodontic treatment or prosthetic management therapy; • Speech therapy; • Audiology services; and • Nutrition services. **Please Note:** Not all Plans cover this benefit. Please contact your Human Resources Department to confirm whether coverage is provided and under what circumstances. Benefits include coverage for procedures that must be done in stages, as long as you are an active Member. Membership must be effective on all dates on which services are provided. There is no coverage for Cosmetic Services or surgery except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, (3) post-mastectomy care as described above, and (4) gender affirming procedures and related services (if a covered benefit). **Important Notice:** We use Medical Necessity Guidelines to evaluate whether different types of reconstructive and restorative procedures are Medically Necessary. If you are planning to receive such treatment, you may review the current Medical Necessity Guidelines online at . . . To obtain a copy, please call the Member Services Department at **1-888-333-4742.**
36 . Rehabilitation Hospital Care	
	The Plan covers care in a facility licensed to provide rehabilitative care on an inpatient basis. Coverage is provided when you need daily Rehabilitation Services that must be provided in an inpatient setting. Rehabilitation Services include cardiac rehabilitation therapy, physical therapy, pulmonary rehabilitation therapy, occupational therapy and speech therapy. The Benefit Limit is listed in the Schedule of Benefits.

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43 . Telemedicine Virtual Visit Services

The Plan covers Medically Necessary telemedicine virtual visit services for the purpose of evaluation, diagnosis, consultation, monitoring, or treatment of a Member's

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Urgent Care Services (Continued)	
	separate from the hospital. These urgent care centers are owned and operated by the hospital and are considered a department of the hospital. They are staffed by doctors, nurse practitioners, and physician assistants and provide treatment for illnesses and injuries that require urgent attention but are not life threatening. Because the services provided are considered outpatient hospital services, only the hospitals are listed in the Provider Directory. These services may require higher Member Cost Sharing than urgent care services received at independent urgent care centers. **Please Note:** Hospital urgent care center services are treated differently than similar services received in a hospital emergency room. For information on services received in a hospital emergency room, please see the Emergency Room Care benefit above, and in your Schedule of Benefits. Please refer to your Schedule of Benefits for the Member Cost Sharing applicable to each type of Urgent Care service. Coverage for Urgent Care is provided for services that are required to prevent deterioration to your health resulting from an unforeseen sickness or injury. Covered Benefits include but are not limited to the following: • Care for minor cuts, burns, rashes or abrasions, including suturing • Treatment for minor illnesses and infections, including earaches • Treatment for minor sprains or strains You do not need to obtain a Referral from your PCP to be covered for Urgent Care. Whenever possible, you should contact your PCP prior to obtaining Urgent Care. Your PCP may be able to provide the services you require at a lower out-of-pocket cost. In addition, your PCP is responsible for coordinating your health care services and should know about the services you receive. **Important Notice:** Urgent Care is not emergency care. You should call 911 or go directly to a hospital emergency room if you suspect you are having a Medical Emergency. These include heart attack or suspected heart attack, shock, major blood loss, or loss of consciousness. Please see section *I.D.6. Medical Emergency Services* for more information.
46 . Vision Services	
	Routine Eye: The Plan may cover routine eye examinations. **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. **Vision Hardware for Special Conditions:** The Plan provides coverage for contact lenses or eyeglasses needed for the following conditions: • Keratoconus. One pair of contact lenses is covered per Plan Year or Calendar Year. The replacement of lenses, due to a change in the Member's condition, is limited to 3 per affected eye per Plan Year or Calendar Year. • Post cataract surgery with an intraocular lens implant (pseudophakes). Coverage is limited to $140 per surgery toward the purchase of eyeglass frames and lenses. The replacement of lenses due to a change in the Member's prescription of .50 diopters or more within 90 days of the surgery is also covered up to a limit of $140.

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Vision Services (Continued)	
	• Post cataract surgery without lens implant (aphakes). One pair of eyeglass lenses or contact lenses is covered per Plan Year or Calendar Year. Coverage up to $50 per Plan Year or Calendar Year is also provided for the purchase of eyeglass frames. The replacement of lenses due to a change in the Member's condition is also covered. Replacement of lenses due to wear, damage, or loss, is limited to 3 per affected eye per Plan Year or Calendar Year. • Post retinal detachment surgery. For a Member who wore eyeglasses or contact lenses prior to retinal detachment surgery, the Plan covers the full cost of one lens per affected eye up to one Plan Year or Calendar Year after the date of surgery. For Members who have not previously worn eyeglasses or contact lenses, the Plan covers either (1) a pair of eyeglass lenses and up to $50 toward the purchase of the frames, or (2) a pair of contact lenses.
47 . Voluntary Sterilization	
	The Plan may cover voluntary sterilization, including tubal ligation and vasectomy. **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.
48 . Voluntary Termination of Pregnancy	
	The Plan may cover voluntary termination of pregnancy and related services provided in conjunction with the covered termination procedure: 1) pre-pregnancy termination evaluation and examination; 2) pre-operative counseling; 3) ultrasounds; 4) laboratory services, including pregnancy testing, blood type, and Rh factor; 5) Rh (D) immune globulin (human); 6) anesthesia (general or local); 7) post-pregnancy termination care; 8) follow-up care; and 9) advice on contraception or referral to family planning services. Care related to a pregnancy or miscarriage is not covered under this benefit. **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.
49 . Wigs and Scalp Hair Prostheses	
	The Plan may cover wigs and scalp hair prostheses when needed for hair loss suffered as a result of the treatment for any form of cancer or leukemia or for a certain pathologic condition such as alopecia areata, alopecia totalis, alopecia medicamentosa or permanent loss of scalp hair due to injury up to the Benefit Limit listed in the Schedule of Benefits. **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.

4. Experimental, Unproven, or Investigational Services		
		1. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.
5. Foot Care		
		1. Foot orthotics, except for the treatment of severe diabetic foot disease or systemic circulatory disease. 2. Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members diagnosed with diabetes or systemic circulatory disease.
6. Maternity Services		
		1. Delivery outside the Service Area after the 37th week of pregnancy, or after you have been told that you are at risk for early delivery. 2. Services provided by a doula. 3. Planned home births. 4. Routine pre-natal and post-partum care when you are traveling outside the Service Area.
7. Mental Health and Substance Use Disorder Treatment		

8 . Physical Appearance

1. Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, (3) post-mastectomy care, and (4) gender affirming procedures and related services.
2. Electrolysis or laser hair removal, except for what is Medically Necessary as part of gender affirming services.
3. Gender Affirming Services, unlessfijqxwdCder

Procedures and Treatments (Continued)	
	5. 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). 6. Physical examinations and testing for insurance, licensing or employment. 7. Services for Members who are donors for non-Members, except as described under Human Organ Transplant Services. 8. Testing for central auditory processing. 9. Group diabetes training, educational programs or camps.
10 . Providers	

1. Charges for services provided after the date on which your membership ends.
2. Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit under this Handbook.
3. Charges for missed appointments.
4. Concierge service fees. Please see section *I.H. PROVIDER FEES FOR SPECIAL SERVICES (CONCIERGE SERVICES)* for more information.
5. Follow-up care after an emergency room visit, unless provided orCovered.'oomxKajKL9.

2. Charges to,

Reproduction (Continued)	
	9. Intrauterine Insemination (IUI) services provided in the home. 10. Infertility treatment, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. 11. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). 12. Sperm collection, freezing and storage except as described in section *III. Covered Benefits*. 13. Sperm identification when not Medically Necessary (e.g., gender identification). 14. The following fees: wait list fees, non-medical costs, shipping and handling charges etc. 15. Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. 16. Voluntary termination of pregnancy, unless the life of the mother is in danger or unless it is specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.
12 . Services Provided Under Another Plan	
	1. Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. 2. Costs for services for which payment is required to be made by a Workers' Compensation plan or an employer under state or federal law.
13 . Telemedicine Services	
	1. Telemedicine services involving e-mail or fax. 2. Provider fees for technical costs for the provision of telemedicine services.
14 . Types of Care	
	1. Recovery programs including rest or domiciliary care, sober houses, transitional support services, and therapeutic communities. 2. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. 3. Pain management programs or clinics. 4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. 5. Private duty nursing. 6. Sports medicine clinics. 7. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.

15 . Vision and Hearing	
	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 to determine if your Plan provides coverage for this benefit. 3. Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD. 4. Over the counter hearing aids. 5. Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism. 6. Routine eye examinations, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.
16 . All Other Exclusions	
	1. All food or nutritional supplements except those covered under the benefits for (1) low protein foods and (2) medical formulas and prescribed for Members who meet HPHC policies for enteral tube feedings. 2. 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. Please see section *III. Covered Benefits* for further details. 3. Any service or supply furnished in connection with a non-Covered Benefit. 4. Any service or supply (with the exception of contact lenses) purchased from the internet. 5. Any service, supply or medication when there is a less intensive Covered Benefit or more cost-effective alternative that can be safely and effectively provided. 6. Any service, supply or medication that is required by a third party that is not otherwise Medically Necessary (examples of a third party are an employer, an insurance company, a school or court). 7. Beauty or barber service. 8. Diabetes equipment replacements when solely due to manufacturer warranty expiration. 9. Donated or banked breast milk. 10. Externally powered exoskeleton assistive devices and orthoses. 11. Guest services. 12. Medical equipment, devices or supplies except as listed in this Benefit Handbook. 13. Medical services that are provided to Members who are confined or committed to jail, house of correction, prison, or custodial facility of the Department of Youth Services. 14. Reimbursement for travel expenses, except when specifically listed as a Covered Benefit.

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- The amount of the provider's charge
- Proof that you have paid the bill
- Other insurance information

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

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

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

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

2. External Review

If you disagree with the denial of your appeal you may be entitled seek external review 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 nd 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 b

- Denials of coverage based on the Member Cost Sharing requirements stated in your Plan.

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

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

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

3. Legal Action

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

D. THE FORMAL COMPLAINT PROCESS

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H. SPECIAL ENROLLMENT RIGHTS

If an employee declines enrollment for the employee and his or her Dependents (including his or her spouse) because of other health insurance coverage, the employee may be able to enroll himself or herself, along with his or her Dependents in this Plan if the employee or his or her Dependents lose eligibility for that other coverage (or if the employer stops contributing toward the employee's or Dependents' other coverage). However, you must request enrollment from the Plan Sponsor within 30 days after the other coverage ends (or after the employer stops contributing toward the employee's or Dependents' other coverage).

In addition, if an employee has a new Dependent as a result of marriage, birth, adoption or placement for adoption, the employee may be able to enroll himself or herself and his or her Dependents. However, you must request enrollment from the Plan Sponsor within 30 days after the marriage, birth, adoption or placement for adoption.

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

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

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

A. BENEFITS IN THE EVENT OF OTHER INSURANCE

Bene□ts under this Handbook, Schedule of Bene□ts, and Prescription Drug Brochure (if applicable) will be coordinated to the extent permitted by law with other plans covering health bene□ts, including: motor vehicle insurance, medical payment policies, governmental bene□ts (including Medicare), and all Health Bene□t Plans. The term "Health Bene□t Plan" means all group HMO and other group prepaid health plans, medical or hospital service corporation plans, commercial health insurance and self-insured health plans. There is no coordination of bene□ts with Medicaid plans or with hospital indemnity bene□ts amounting to less than $100 per day.

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

When a Member is covered by two or more Health Bene□t Plans, one plan will be “primary” an

or laid off or as a dependent of an individual who is retired or laid off.

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

5. Longer/Shorter Length of Coverage
If none of the above rules determines the order of bene□ts, the bene□ts 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 Bene□t Plan that does not have provisions governing the coordination of bene□ts between plans, that plan will be the primary plan.

B. PROVIDER PAYMENT WHEN PLAN COVERAGE IS SECONDARY

When your Plan coverage is secondary to your coverage under another Health Bene□t 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' COMPENSATIONjGBORuBYOyfBuLdH4l7TjH6uYLLOyLyTdH4:7TjHOuRYBUyLyTdH4F7TjHKuXYBUyLyTdH4V7TjH

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for the evaluation and treatment of common health conditions.

- **Performance monitoring** – HPHC participates in collecting data to measure outcomes related to the Health Care Effectiveness Data and Information Set (HEDIS) to monitor health care quality across various domains of evidence-based care and practice.
- **Quality program evaluation**- Annually HPHC develops, plans and implements initiatives to improve clinical service and quality for our members. The Quality Program is documented, tracked and evaluated against milestones and target objectives. The full program description and review is available on our website at **https://www.harvardpilgrim.org/public/about-us/quality**.

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

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

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seek recovery of such payments from the Provider or Member to whom the payments were made, and (2) offset subsequent bene□t payments to a Provider (regardless of payment source) or Member by the amount of any such overpayment.

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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 o[ETsjpFE0A•ATdp]T"pJxEWJ3A•ATdpMyOTjpRxEE0UA•A
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