

Healthy Kids Silver Benefit Handbook

New Hampshire

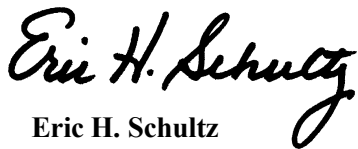
New Hampshire Healthy Kids

The Healthy Kids program is made available to the children of New Hampshire by the New Hampshire Healthy Kids Corporation (NHHKC) and HPHC Insurance Company, Inc. (HPHC).

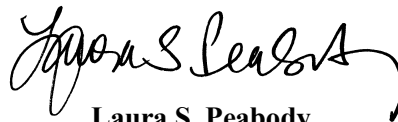
The New Hampshire Healthy Kids Corporation (NHHKC) was established by the New Hampshire legislature. It is a private, non-profit corporation deemed to be a “public instrumentality” performing “public and essential functions of the state” in accordance with NH RSA 126-H:2. One of those functions is to provide preventive health care and comprehensive health insurance coverage for children who meet the eligibility standards established by the New Hampshire Healthy Kids Corporation.

The Healthy Kids program is administered by HPHC Insurance Company, Inc. (HPHC or the Plan). HPHC is an affiliate of Harvard Pilgrim Health Care. This *Benefit Handbook (Handbook)*, including the *Schedule of Benefits*, and *Prescription Drug Brochure* is your Healthy Kids Member Evidence of Coverage. It is the legal document which defines a partnership between you, your Primary Care Physician, the New Hampshire Healthy Kids Corporation and HPHC Insurance Company, Inc. It describes benefits, limitations, conditions, exclusions, and other important information relevant to Member’s enrolled in the Healthy Kids program.

Please read this document carefully and keep it for future reference.



Eric H. Schultz
President
HPHC Insurance Company



Laura S. Peabody
Clerk
HPHC Insurance Company

Introduction

Welcome to HPHC and the Healthy Kids program!

With this Plan, your health care is provided or arranged through our network of Primary Care Physicians, specialists and other providers. You must choose a Primary Care Physician (PCP) when you enroll in the Plan.

When enrolled, the Plan provides the covered health care services described in this Handbook, the Summary of Benefits and the Prescription Drug Brochure. Such services must be provided or arranged by your Primary Care Physician, except in a Medical Emergency or when you are temporarily outside the Plan's Service Area. (The Service Area is the state in which you live.)

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

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

- Choosing or changing a Primary Care Physician
- Your Benefit Handbook
- Your Benefits
- Your Claims
- Provider Information
- Requesting a Member Kit
- Requesting ID cards
- Registering a concern

Non-English speaking Members may simply call our Member Services Department to have their questions answered. The Plan offers free language interpretation services in more than 120 languages. Deaf and hard-of-hearing Members who own or have access to a Teletypewriter (TTY) may communicate directly with the Member Services Department by calling our TTY machine at **1-800-637-8257**.

We value your input, so we would appreciate hearing from you with any comments or suggestions you may have.

**HPHC Insurance Company, Inc.
Member Services Department
1600 Crown Colony Drive
Quincy, MA 02169**

1-888-333-4742

Internet: www.harvardpilgrim.org

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SECTION A. Summary of Benefits - Silver Plan

This Summary is part of your Benefit Handbook. It states the Cost Sharing amounts that you must pay for Covered Benefits and some important limitations on your coverage. It also identifies any supplemental medical benefits included in your Plan.

For complete information on Covered Benefits, including limitations on your coverage, you must refer to Section C of the Benefit Handbook. For information on how the Tiered-Copayment HMO works, please see Section B of the Benefit Handbook.

Covered Benefits:	Your Cost Sharing:
Outpatient Professional Services	
• Ambulance Transport, Non-Emergency	Nothing
• Cardiac Rehabilitation	Nothing
• Diagnostic Laboratory and X-rays	Nothing
• Dialysis	Nothing
• Early Intervention Services - \$3,200 per calendar year, up to \$9,600 per lifetime	Tier 1: \$10 Copayment
• Formulas and Low Protein Foods	Nothing
• Home Care and Hospice	Nothing
• Physical therapy - limited to 24 visits per calendar year • Occupational therapy - limited to 24 visits per calendar year	Tier 1: \$10 Copayment
• Physician Services, except the three services listed below:	Tier 1: \$10 Copayment Tier 2: \$20 Copayment
Prenatal and Postpartum Care	Nothing
Allergy Injections	Tier 1: \$10 Copayment
Preventive Care, including: <ul style="list-style-type: none"> - Well child visits and immunizations - Routine physical exams (including vision and hearing screenings) - Annual gynecological exam (including family planning) - Nutritional counseling and health education - Mammograms, pap smears, lead screening, prostatic specific antigen (PSA) screening 	Nothing
• House Calls	Tier 1: \$10 Copayment Tier 2: \$20 Copayment
• Speech therapy - limited to 24 visits per calendar year	Tier 1: \$10 Copayment

SECTION A. Summary of Benefits

Covered Benefits:	Your Cost Sharing:
<ul style="list-style-type: none"> • Urgent Care Services 	50% of your Emergency Room Care Copayment
<ul style="list-style-type: none"> • Surgical Day Care 	Nothing
<ul style="list-style-type: none"> • Vision Hardware for Special Conditions 	Nothing
Emergency Services	
<ul style="list-style-type: none"> • Ambulance Transport, Emergency 	Nothing
<ul style="list-style-type: none"> • Emergency Dental Care - in a professional office within 72 hours of injury 	Tier 1: \$10 Copayment
<ul style="list-style-type: none"> • Emergency Room Care 	\$100 Copayment This Copayment is waived if admitted directly to the hospital from the emergency room
Inpatient Services	
<ul style="list-style-type: none"> • Acute Hospital Care • Maternity Care • Rehabilitation Hospital Care - limited to 60 days per calendar year • Skilled Nursing Facility Care - limited to 100 days per calendar year 	Nothing
Mental Health Services	
Important Note: Benefit limits do not apply to care for Serious Mental Illnesses. See Section C.5.a for details.	
<ul style="list-style-type: none"> • Inpatient Care - limited to 15 days per calendar year 	Nothing
<ul style="list-style-type: none"> • Partial Hospitalization - limited to 30 days per calendar year <p>Please note: Each partial hospitalization day counts as one-half of an inpatient day and is deducted from the limit available for inpatient care.</p>	Nothing
<ul style="list-style-type: none"> • Outpatient Care - limited to 20 visits per calendar year 	
Group Therapy	Tier 1: \$10 Copayment
Individual Therapy	Tier 1: \$10 Copayment
<ul style="list-style-type: none"> • Medication Management 	Tier 1: \$10 Copayment
<ul style="list-style-type: none"> • Psychological Testing 	Tier 1: \$10 Copayment

SECTION A. Summary of Benefits

Covered Benefits:	Your Cost Sharing:
Drug and Alcohol Rehabilitation Services	
<ul style="list-style-type: none"> • Inpatient Care - limited to 30 days per calendar year 	Nothing
<ul style="list-style-type: none"> • Partial Hospitalization - limited to 60 days per calendar year <p>Please note: Each partial hospitalization day counts as one-half of an inpatient day and is deducted from the limit available for inpatient care.</p>	Nothing
<ul style="list-style-type: none"> • Outpatient Care - limited to 20 visits per calendar year 	
Group Therapy	Tier 1: \$10 Copayment
Individual Therapy	Tier 1: \$10 Copayment
<ul style="list-style-type: none"> • Inpatient Detoxification 	Nothing
<ul style="list-style-type: none"> • Outpatient Detoxification 	Tier 1: \$10 Copayment
Durable Medical Equipment and Prosthetic Devices	
<ul style="list-style-type: none"> • Limited to \$2,500 per calendar year for all covered equipment. This limit does not apply to the five items listed below. 	Nothing
Blood Glucose Monitors, Insulin Pumps and Infusion Devices	Nothing
Breast Prostheses, including Replacements and Mastectomy Bras	Nothing
Medical Equipment and Supplies for Diabetes Treatment	Nothing
Oxygen and Respiratory Equipment	Nothing
Prosthetic Arms and Legs	Nothing
Other Health Services	
<ul style="list-style-type: none"> • Annual Eye Exam 	Tier 1: \$10 Copayment
<ul style="list-style-type: none"> • Chiropractic Care 	Tier 1: \$10 Copayment
<ul style="list-style-type: none"> • Hearing Aids limited to 2 per calendar year 	Nothing
<ul style="list-style-type: none"> • Telemedicine 	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Summary of Benefits. For example, for services provided by physician, see "Physician Services." For inpatient hospital care, see "Inpatient Services."

SECTION B. About the Plan

This section describes how to use your Benefit Handbook and how your coverage works under HPHC (the Plan).

1. HOW TO USE THIS BENEFIT HANDBOOK

a. Why This Benefit Handbook Is Important

NHHKC has entered into a contract with HPHC Insurance Company, Inc. (HPHC) to provide certain health benefits to eligible individuals. This Benefit Handbook, the Summary of Benefits and the Prescription Drug Brochure (hereinafter collectively referred to as the Benefit Handbook or Handbook) make up the legal agreement stating the terms of the Plan.

The Benefit Handbook describes how your membership works. The Handbook is also your guide to the most important things you need to know. These include:

- What is covered
- What is not covered
- The requirement that you receive services from a Plan Provider
- The requirement that you go to your Primary Care Physician (PCP) for most services

b. Words With Special Meaning

Some words in this Handbook have a special meaning. These words are capitalized and are defined in the Glossary (Section K).

c. How To Find What You Need To Know

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

The Summary of Benefits Section A. lists the Member Cost Sharing that you are required to pay, including Copayment amounts. The Summary of Benefits also lists some of the important limitations on coverage.

This Section explains important requirements for coverage. Understanding the Plan can help you avoid denials of coverage for failure to follow Plan rules.

The benefits covered by the Plan are explained in detail in Section C. Individual benefits are listed in

the same order as in the Summary of Benefits. You must review Section C for a complete understanding of your benefits.

The Handbook provides detailed information on how to appeal a denial of coverage or file a complaint. This information is set forth in Section F, titled “Appeals and Complaints.”

d. How to Use Your Provider Directory

In order to be eligible for coverage under the Plan, most services must be received from HPHC (Plan) Providers. These are the physicians, hospitals and other medical professionals who are either employed by HPHC or under contract to care for HPHC members. (This requirement is explained in detail in Section B.2.b. below.) You can find HPHC Plan Providers by using the Provider Directory.

The Provider Directory identifies the Plan’s Primary Care Physicians (PCPs). It lists providers by state and town, specialty, and languages spoken. You can get a copy of the Provider Directory by calling NHHKC. The HPHC Member Services Department can answer questions about HPHC Providers or their qualifications.

You may also view the Provider Directory on-line at the HPHC Internet site, www.harvardpilgrim.org. The on-line Provider Directory allows you to search for providers by location. The information in the on-line directory may be more current than your paper directory since it is frequently updated by HPHC.

Please note: Plan Providers participate through contractual arrangements that can be terminated either by a provider or by HPHC. In addition, a provider may leave the Plan’s network because of retirement, relocation or other reasons. This means that HPHC cannot guarantee that the physician you choose will continue to participate in the Plan’s network for the duration of your Plan membership. If your PCP leaves the network for any reason, the Plan will make every effort to notify you in advance, and will help you find a new Plan physician.

2. HOW THE PLAN WORKS

a. Primary Care Physician (PCP) Requirements

1) Choose a Primary Care Physician (PCP)

When you enroll in the Plan you must choose a Primary Care Physician (PCP) for each covered Member from the Provider Directory. You may choose a different PCP for each Member enrolled in the Plan.

A PCP may be a doctor of Internal Medicine, Family Practice, General Practice, or Pediatrics. PCPs are listed in the Provider Directory. You may call Member Services to confirm that the PCP you select is available.

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

You may change your PCP at any time by calling the Member Services Department. Just choose a new PCP from the Provider Directory. We can make the change effective on the date that you call or on a future date. You must inform the Plan when you change your PCP or care may not be covered. If you change your PCP, any Referrals from your prior PCP become invalid. You will need to get new Referrals from your new PCP.

If your PCP stops being a Plan Provider, you will be notified in writing. Whenever possible, the Plan will notify you at least 30 days before the disenrollment of your PCP and will allow continued coverage of benefits as described in this Handbook and your Summary of Benefits for at least 30 days after the PCP's disenrollment. This coverage is provided as long as the PCP has not been disenrolled for quality-related reasons or fraud. You will then need to select a new PCP. As mentioned above, you may select a new PCP by calling the Member Services Department at **1-888-333-4742**.

2) Your PCP Manages Your Health Care

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

- Care in a Medical Emergency.

- Care when you are temporarily outside the Service Area, as described in Section B.2.g. (The Service Area is the state in which you live.)
- The special services that do not require a Referral that are listed in Section B.2.h.
- Mental health and drug and alcohol rehabilitation services, for which you must call the Behavioral Health Access Center at **1-888-777-4742**. (Please see Section C.5 for information on this benefit.)

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

3) Referrals for Hospital and Specialty Care

When you need hospital or specialty care, you must call your PCP to obtain a referral. This helps your PCP coordinate and maintain the quality of your care. A referral is not required when you receive care in a hospital emergency room.

Participating Providers with recognized expertise in specialty pediatrics are covered when Medically Necessary with a Referral from your PCP. Pediatric mental health services may be obtained by calling the Behavioral Health Access Center at **1-888-777-4742**.

Your PCP may authorize a standing Referral with a specialty care provider when: 1) the PCP determines that such Referral is appropriate, 2) the specialty care provider agrees to a treatment plan for the Member and provides the PCP with necessary clinical and administrative information on a regular basis, and 3) the services provided are Covered Benefits as described in this Handbook.

There are certain specialized services for which you will be directed to a Center of Excellence for care. Please see Section B.2.d. ("Centers of Excellence") for further information.

Certain specialty services may be obtained without involving your PCP. Please see "Services That Do Not Require a Referral," Section B.2.h, for a list of these services.

SECTION B. About the Plan

If you select a new PCP, all Referrals from your prior PCP become invalid. Your new PCP will need to assess your condition and provide new Referrals.

b. Using HPHC Providers

Covered Benefits must be received from a HPHC Provider to be eligible for coverage by the Plan. However, there are four specific exceptions to these requirements. Covered Benefits rendered by a provider who is not an HPHC Provider will be covered if one of the following exceptions applies:

- 1) The service was received in a Medical Emergency. (Please see Section B.2.f for information on your coverage in a Medical Emergency.)
- 2) The service was received while you were outside of the Plan Service Area and coverage is available under the benefit for temporary travel.
- 3) The Plan replaced your prior Employer Group health plan and your prior plan was covering services by a mental health provider who is not an HPHC Provider. Please refer to Section C.5.d for the specific terms and conditions of this exception.
- 4) No HPHC Provider has the expertise needed to provide the required service. Services by a non-HPHC Provider must be authorized in advance by HPHC, unless one of the exceptions above applies.

To find out if a provider is in the HPHC network, you may look in your Provider Directory or view the directory on-line at www.harvardpilgrim.org.

c. Provider Fees for Special 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.

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 participating providers to be available by telephone 24-hours a day. However, the Plan does require PCPs to provide both an answering service that can be contacted 24-hours a day and prompt appointments when Medically Necessary.

d. Centers of Excellence

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

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

- Weight loss surgery (bariatric surgery)

IMPORTANT NOTICE: No coverage is provided under this Handbook for the service listed above unless it is received from an HPHC Provider that has been designated as a Center of Excellence. A list of Centers of Excellence may be found online in the Provider Directory. Members may view the Provider Directory at www.harvardpilgrim.org or contact the Member Services Department at **1-888-333-4742** to verify a provider’s status.

HPHC may revise the list of services that must be received from a Center of Excellence upon thirty days notice to Members. Services or procedures may be added to the list when HPHC identifies 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 HPHC determines that significant advantages in quality of care will no longer be obtained through the use of a specialized panel of providers.

e. Member Copayments

You are required to share the cost of the benefits

SECTION B. About the Plan

provided under the Plan through Copayments. Your specific Cost Sharing responsibilities under the Plan are identified in your Summary of Benefits (Section A.)

A Copayment is a fixed dollar amount that you must pay for certain Covered Benefits. Copayments are due at the time of service or when billed by the provider. The Copayment amounts that apply to your Plan are stated in your Summary of Benefits (Section A).

Your Plan has two levels of Copayments that apply to outpatient services you receive while a Member of the Plan. These are known as Tier 1 Copayments and Tier 2 Copayments. The Tier 1 Copayment is lower than the Tier 2 Copayment. Your specific Copayment amounts are listed in your Summary of Benefits (Section A)

i. Tier 1 Copayments

Tier 1 Copayments apply to the following outpatient services:

- Services provided by your PCP, except for preventive care which is covered in full
- Services provided by obstetricians and gynecologists, except for preventive care which is covered in full
- Services provided by nurse practitioners who bill independently, except for preventive care which is covered in full
- Services provided by certified midwives, except for preventive care which is covered in full
- Mental health and drug and alcohol rehabilitation services
- Physical, occupational and speech therapies
- Audiology services
- Allergy injections
- Chiropractic care

ii. Tier 2 Copayments

The Tier 2 Copayment applies to covered outpatient services not specifically listed above as requiring payment of a Tier 1 Copayment. For example, specialty care requires payment of the Tier 2 Copayment.

The Tier 2 Copayment is higher than the Tier 1 Copayment.

If a Provider is both a Tier 1 Provider and a Tier 2 Provider, the Tier 1 Copayment applies. For example, if a Provider is both a PCP and a Cardiologist, you will be responsible for the Tier 1 Copayment.

f. Medical Emergency Services

You always have coverage for care in a Medical Emergency. A Referral from your PCP is not needed. In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. Your emergency room Copayment is listed in your Summary of Benefits.

A Medical Emergency means the sudden and unexpected onset of a condition with symptoms so severe, that a person, possessing average knowledge of health and medicine, would expect that without prompt medical attention:

- His or her health would be in serious jeopardy; or
- His or her health, body organs or parts, or some bodily function, would be seriously impaired.

Examples of Medical Emergencies are:

- Heart attack or suspected heart attack
- Stroke
- Shock
- Major blood loss
- Choking
- Severe head trauma
- Loss of consciousness
- Seizures
- Convulsions

Please remember that if you are hospitalized, you must call your PCP within 48 hours, or as soon as you can. Your PCP will arrange for any follow-up care you may need.

SECTION B. About the Plan

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

If you are temporarily outside the Service Area and you get hurt or sick, don't worry. You do not have to call your PCP before getting care. We will cover any Medically Necessary services for sickness or injury except the following:

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

If you are hospitalized, you must call your PCP within 48 hours, or as soon as you can. Your PCP will help to arrange for any follow-up care you may need.

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

h. Services That Do Not Require a Referral

While in most cases you will need a Referral from your PCP to get covered care from any other Plan Provider, you do not need a Referral for the services listed below. However, you must get these services from a Plan Provider. Plan Providers are listed online in the online Provider Directory. We urge you to keep your PCP informed about such care so that your medical records are current and up-to-date. Your PCP should be aware of your entire medical situation. (Please note, although these services do not require a Referral, any inpatient services requires Plan approval.)

Family Planning Services:

- Annual gynecological exam
- Family planning consultation, including pregnancy testing
- Contraceptive monitoring

Prenatal Services:

- Consultation for expectant parents
- Prenatal and Postpartum care
- Genetic testing (office visits do require a Referral)

Gynecological Services:

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

Dental Services:

- Emergency Dental Care

Other Services:

- Annual eye examination
- Chiropractic care

SECTION C. Covered Benefits

This Section contains detailed information on the benefits covered under the Plan. Member Copayment amounts that apply to your Plan, are listed the Summary of Benefits Section A of the Handbook. Your benefits for outpatient prescription drugs are described in Section N.

1. BASIC REQUIREMENTS FOR COVERAGE

To be covered, all services and supplies must be:

- Medically Necessary;
- A Covered Benefit;
- Not excluded in Section D;
- Received while an active Member of the Plan;
- Provided by or upon Referral from your PCP. This requirement does not apply to care needed in a Medical Emergency. (Please see Section B.2.b for other exceptions that apply.); and
- Provided by a Plan Provider. This requirement does not apply to care needed in a Medical Emergency. (Please see Section B.2.b for other exceptions that apply.)

Please see specific benefits in this section and in the Summary of Benefits for any special limits on your coverage. Please see Section D for exclusions from coverage.

2. OUTPATIENT PROFESSIONAL SERVICES

a. Ambulance Transport, Non-Emergency

The Plan covers non-emergency ambulance transport between hospitals or other covered health care facilities or from a covered facility to the Member's home when Medically Necessary. Services must be arranged by a Plan Provider and approved by HPHC.

b. Cardiac Rehabilitation

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

c. Diagnostic Laboratory and X-Rays

The Plan covers outpatient diagnostic laboratory and x-ray services to diagnose illness, injury, or pregnancy. The Plan also covers human leukocyte antigen testing or histocompatibility locus antigen

testing for A, B or DR antigens necessary to establish bone marrow transplant donor suitability. At the time of testing the Member must complete and sign an informed consent form that authorizes the results of the test to be used for participation in the National Marrow Donor Program. Services must be provided by a Plan Provider.

d. Dialysis

The Plan covers dialysis on an inpatient, outpatient or at home basis. Coverage for dialysis in the home includes non-durable medical supplies, and drugs and equipment necessary for dialysis. Installation of home equipment is covered up to \$300 in a Member's lifetime.

Dialysis services must be provided by a Plan Provider. All home care services must be approved by HPHC.

If you are temporarily outside the Service Area, the Plan covers dialysis services when approved by HPHC. You must make arrangements in advance with your PCP.

e. Early Intervention Services

The Plan covers early intervention services for children with an identified developmental disability or delay. Coverage is provided for children from birth until three years of age. The Plan covers up to \$3,200 per calendar year, up to a lifetime maximum of \$9,600.

Coverage under this benefit is only available for services rendered by the following types of providers:

- Occupational Therapists
- Physical Therapists
- Speech-Language Pathologists
- Clinical Social Workers

SECTION C. Covered Benefits

f. Formulas and Low Protein Foods

The Plan covers the following:

- Enteral formulas for inherited diseases of amino and organic acids and the treatment of impaired absorption of nutrients caused by disorders effecting the absorptive surface, functional length, or motility of the gastrointestinal tract
- Low protein foods for inherited diseases of amino and organic acids. This coverage is limited to \$1,800 per Member per calendar year

RELATED EXCLUSIONS:

Unless otherwise specified in this Benefit Handbook or the Summary of Benefits the Plan does not cover food or nutritional supplements, including FDA-approved medical foods obtained by prescription.

g. Home Health Care

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

Care on a “short-term intermittent basis” means care that is provided (1) fewer than eight hours per day, on a less than daily basis, up to 35 hours per week, or (2) up to 8 hours per day of combined services, for up to 21 consecutive days. If you receive more than one type of skilled service in the home, these time limits apply to all services combined.

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

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

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

Medically Necessary prenatal and postpartum homemaker services are covered when on the recommendation of her attending healthcare provider, a woman is confined to bed rest or her normal functions of daily life (including walking, speaking, sleeping, eating, drinking and using the toilet) are restricted.

RELATED EXCLUSIONS:

- Home health care extending beyond short-term intermittent basis care as described above.
- Private duty nursing at home

h. Hospice Services

The Plan covers hospice services for terminally ill Members who need the skills of qualified technical or professional health personnel for palliative care. Care may be provided at home or on an inpatient basis. Inpatient respite care is covered for the purpose of relieving the primary caregiver 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:

- Physician services
- Nursing care
- Social services
- Counseling
- Care to relieve pain
- Home health aide services
- Occupational, physical, speech and respiratory therapy
- Medical supplies
- Durable medical equipment appliances
- Drugs that cannot be self-administered
- Respite care

SECTION C. Covered Benefits

Your PCP must arrange for all hospice services and obtain HPHC approval for coverage.

i. Physical and Occupational Therapies

Outpatient physical and occupational therapies are each covered up to the benefit limit described in the Summary of Benefits (Section A). Services are covered only (1) when needed to improve your ability to perform normal functions of daily life (including walking, speaking, sleeping, eating, drinking and using the toilet) and (2) when, in the opinion of your PCP, there is likely to be significant improvement in your condition within the period of time benefits are covered. Normal functions of daily life do not include special functions needed for occupational purposes or sports. Your PCP or an HPHC Provider will order therapy for you based on your condition and needs.

If you are in an approved course of pulmonary rehabilitation, physical and occupational therapies are covered to the extent that they are a Medically Necessary component of the pulmonary rehabilitation. Services must be approved by HPHC.

Physical and occupational therapies are also covered under your inpatient hospital and home health benefits. When such therapies are part of an approved home care treatment plan they are available on a short-term intermittent basis as described in Section C.2.g. (Home Health Care). Please see that Section for information on in-home coverage.

RELATED EXCLUSIONS:

- Educational services or testing. 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
- Sensory integrative praxis tests
- Testing of central auditory processing
- Vocational rehabilitation, or vocational evaluations focused on job adaptability, job placement, or therapy to restore function for a specific occupation
- Myotherapy
- Massage therapy when performed by anyone other than a licensed physical therapist, physical therapy assistant, occupational therapist, or certified occupational therapy assistant

j. Physician Services

Your Plan provides coverage for the physician services described below. Physician services include the services of a nurse practitioner, physician assistant, certified midwife, and certified registered nurse anesthetist working under the supervision of a licensed physician.

1) Preventive Care in the Physician's Office

The Plan covers preventive care according to your individual medical needs. Your PCP generally provides these services. Covered preventive care includes:

- Physical examinations
- Immunizations
- Vision and hearing screening
- Diagnostic screening and tests, including mammograms
- Health education and nutritional counseling
- School, sports, camp and premarital examinations.
- Medication management services

RELATED EXCLUSIONS:

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

2) Sick or Injured Care

The Plan covers care when you are sick or injured. Services include, but are not limited to:

- Physician office visits
- Diagnostic tests and x-rays
- Changes and removal of dressings, sutures, and casting
- Injections
- Radiation therapy

Services must be provided by, or upon Referral from, your PCP.

SECTION C. Covered Benefits

3) Second Opinion

There may be times when you want a second opinion. The Plan will cover a second opinion as long as you have a Referral from your PCP and obtain the second opinion from an Plan Provider.

4) Family Planning Services

Family planning services are covered when provided by your PCP. The following services can also be obtained from any Plan Provider without a Referral:

- Annual gynecological examination
- Family planning consultation
- Pregnancy testing
- Follow-up care provided by an obstetrician or gynecologist for obstetrical or gynecological conditions identified during maternity care or annual gynecological visit
- Contraceptive monitoring
- Injection of birth control medication and the insertion or removal of birth control implants or devices is covered.

Please refer to Section B.2.h. for additional services that do not require a Referral.

6) Temporomandibular Joint Dysfunction Services

Your coverage for Temporomandibular Joint Dysfunction (TMD) treatment is limited to medical services only. Your PCP will refer you to a Plan Provider. The Plan covers only the following medical services:

- Initial consultation
- X-rays
- Physical therapy, subject to the visit limit for outpatient physical therapy as listed in the Summary of Benefits (Section A)
- Surgery

RELATED EXCLUSIONS:

- All services of a dentist for TMD

7) Coverage During Qualified Clinical Trials

The Plan provides coverage for Medically Necessary care provided to a Member who is participating in a qualified clinical trial. Coverage includes Medically Necessary drugs and devices, which are not the subject of the clinical trial and their administration. All such services, drugs and devices must be otherwise covered under the Plan.

The above coverage will be provided if:

- The clinical trial is approved by the National Institute of Health (NIH) or an NIH cooperative group or center, the FDA, the U.S. Department of Veterans Affairs, the Defense Department or a New Hampshire institutional review board.
- Providing any existing standard treatments to the Member has been or would be ineffective and there is no superior non-investigational treatment alternative.
- The facility and personnel providing the clinical trial treatment have the necessary experience, training and volume of patients treated to maintain expertise.
- Available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as any non-investigational alternative treatments.

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

8) Prenatal and Postpartum Care

A Referral from your PCP is not required for prenatal care; however, services must be provided by a Plan Provider. A Plan Provider must make all arrangements for inpatient care.

The Plan covers the following prenatal and postpartum care:

- Prenatal exams
- Diagnostic tests

SECTION C. Covered Benefits

- Diet regulation
- Postpartum care
- Charges for covered newborn care up to 31 days after birth. (Coverage beyond 31 days will only be provided if the newborn is enrolled under this Plan.)
- Prenatal homemaker services (cooking, cleaning, laundry, shopping and other light housekeeping) for a woman who (1) is confined to bed rest or (2) whose normal functions of daily life (including walking, speaking, sleeping, eating, drinking and using the toilet) are restricted. Services must be Medically Necessary, as determined by your attending Plan Provider, who shall consult with the Plan case manager, when applicable.
- Postpartum homemaker services, when Medically Necessary, as determined by your attending Plan Provider, who shall consult with the Plan case manager, when applicable.

9) Allergy Treatment

The Plan covers testing, antigens and allergy treatments. Services must be provided by, or upon Referral from, your PCP.

10) House Calls

The Plan covers Medically Necessary house calls within the Service Area by a Plan Provider. A Referral from your PCP is required for all specialist visits.

11) Diabetes Treatment

The Plan covers the following:

- a) Outpatient Care
 - Diabetes self-management training and education, including medical nutritional counseling provided by a physician or upon Referral from your PCP to an appropriate licensed and certified health care provider
 - Medically Necessary laboratory tests
- b) Durable Medical Equipment, as described in Section C.6.

c) Pharmacy supplies, including:

- Insulin
- Oral agents for controlling blood sugar
- Blood glucose, urine and ketone test strips
- Lancets
- Insulin needles and syringes

For coverage of pharmacy items listed above, you must get a prescription from your Plan Provider and present it at an HPHC network pharmacy. A list of HPHC participating pharmacies is available from the Member Services Department.

Pharmacy supplies for the treatment of diabetes are subject to the applicable Pharmacy Copayments listed on your ID card.

k. Speech Therapy

Outpatient speech therapy is covered up to the benefit limit described in the Summary of Benefits (Section A). Services are covered only when needed to improve your ability to perform normal functions of daily life (including walking, speaking, sleeping, eating, drinking and using the toilet) and when, in the opinion of your PCP, there is likely to be significant improvement in your condition while Covered Benefits are being provided. Your PCP or a Plan Provider will order therapy for you based on your condition and needs.

Speech therapy is also covered under your inpatient hospital and home health benefits. When such therapy is part of an approved home care treatment plan it is available on a short-term intermittent basis as described in Section C.2.g. (Home Health Care). Please see that Section for information on in-home coverage.

RELATED EXCLUSIONS:

- Educational services or testing. 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
- Sensory integrative praxis tests
- Testing of central auditory processing

SECTION C. Covered Benefits

- Vocational rehabilitation, or vocational evaluations focused on job adaptability, job placement, or therapy to restore function for a specific occupation
- Myotherapy
- Massage therapy when performed by anyone other than a licensed physical therapist, physical therapy assistant, occupational therapist, or certified occupational therapy assistant

I. Surgical Day Care

The Plan covers Surgical Day Care, including related services, provided by a Plan Provider. Surgical Day Care is defined as any surgery or procedure in a day surgery department, ambulatory surgery department or outpatient surgery center that requires operating room, anesthesia and recovery room services. A Referral from your PCP is required for care received from any other Plan Provider.

There are certain specialized services for which you will be directed to a Center of Excellence for care. See Section B.2.d. (“Centers of Excellence”) for further information.

m. Surgical Day Care Expenses for Dental Care

The Plan covers the expenses of a hospital or Surgical Day Care facility and expenses for general anesthesia administered by a licensed anesthesiologist or certified registered nurse anesthetist for the performance of Dental Care if:

- A Member is a child under the age of 6 who is determined by a licensed dentist and his or her PCP to have a dental condition that is so complex as to require the necessary dental procedures be performed in a hospital or surgical day care facility; or
- A Member (of any age) is determined by his or her PCP to require dental treatment in a hospital or surgical day care facility due to exceptional medical circumstances or a developmental disability, which places the Member at serious risk.

Your PCP must arrange for all hospital or Surgical Day Care. The only expenses covered under this benefit are hospital charges, Surgical Day Care facility charges and anesthesia charges. No coverage is provided for dental services or diagnostic testing.

n. Urgent Care Services

The Plan covers care that you receive at an Urgent Care Center. Coverage is provided for services that are required to prevent deterioration to your health resulting from an unforeseen sickness or injury. You do not need to obtain a referral from your PCP or receive services from a Plan Provider to be covered for services at an Urgent Care Center.

Services you may obtain at an Urgent Care Center include, but are not limited to, the following:

- Treatment for minor illnesses and infections, including ear aches
- Care for minor cuts, burns, rashes or abrasions, including suturing
- Treatment for minor sprains or strains

No referral is required for care received at an Urgent Care Center. Whenever possible, a Member should contact his or her PCP prior to obtaining care at an Urgent Care Center. 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. Please refer to your Summary of Benefits for your specific Cost Sharing requirements under your plan.

Important Note: Urgent care is not emergency care. You should go directly to a hospital emergency room if you suspect you have any life threatening condition. These include heart attack or suspected heart attack, shock, major blood loss, or loss of consciousness. Please see Section B.2.f. titled “Medical Emergency Services” for more information.

o. Vision Hardware for Special Conditions

The Plan provides limited coverage for contact lenses or eyeglasses needed for these certain eye conditions. Your PCP must refer you for these services. The coverage provided for these conditions is as follows:

- 1) Post cataract surgery with an intraocular lens implant (pseudophakes). Coverage is limited to \$140 per surgery toward the purchase 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

SECTION C. Covered Benefits

also covered up to a limit of \$140. No Member Cost Sharing applies to this benefit.

- 2) Post cataract surgery without lens implant (aphakes). One pair of eyeglass lenses or contact lenses is covered per year. Coverage up to \$50 per 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 year.
- 3) Keratonconus. One pair of contact lenses is covered per year. The replacement of lenses, due to a change in the Member's condition, is limited to 3 per affected eye per year.
- 4) 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 year after the date of surgery. For Members who have not previously worn eyeglasses or contact lenses, the Plan covers the full cost of a pair of eyeglass lenses and up to \$50 toward the purchase of the frame or the full cost of a pair of contact lenses.

3. EMERGENCY SERVICES

a. Ambulance Transport, Emergency

In the event of a Medical Emergency, coverage is provided for ambulance transport to the nearest hospital that can render Medically Necessary care to a Member.

b. 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 teeth needed to avoid infection of teeth damaged in the injury
- Suturing and suture removal
- Reimplantation and stabilization of dislodged teeth
- Repositioning and stabilization of partly dislodged teeth
- Medication received from the provider

RELATED EXCLUSIONS:

- All other Dental Care.

c. Emergency Room Care

In the event of a Medical Emergency, you are always covered for care in a hospital emergency room. Please remember, if you need follow-up care after you are treated in an emergency room, you must call your PCP. He or she will provide or arrange for the care you need.

RELATED EXCLUSIONS:

- Follow-up care, unless provided by, or upon Referral from your PCP

4. INPATIENT SERVICES

When you need inpatient care, your PCP will make all the necessary arrangements. He or she will coordinate any diagnostic or pre-admission work-ups. Your PCP is responsible for getting HPHC approval for an admission. All you need to do is follow your PCP's instructions. The Plan covers the following inpatient services:

- 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 and speech therapy
- Reconstructive surgery related to (1) surgery that is incidental to, or follows, surgery resulting from trauma, infection or other diseases of the involved body part, or (2) congenital disease or anomaly of a covered child which has resulted in a functional defect

SECTION C. Covered Benefits

Specific inpatient care benefits are described below.

a. Acute Hospital Care

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

In order to be eligible for coverage under this Handbook, the following service must be received at a Center of Excellence:

- Weight loss surgery (bariatric surgery)

Please see Section B.2.d. (“Centers of Excellence”) for further information.

As part of Acute Hospital care, the following additional services are also covered.

1) Cosmetic Surgery

For purposes of this Handbook, cosmetic surgery is any procedure to change or restore appearance. Your PCP will refer you to a Plan Provider for such surgery. Your PCP must also obtain HPHC approval for coverage of cosmetic surgery.

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

2) Human Organ Transplant Services

The Plan covers Medically Necessary human organ transplants, including bone marrow transplants for a Member with metastasized breast cancer in accordance with the criteria of the National Cancer Institute. A Referral from your PCP is required for specialty care. Your PCP must also obtain HPHC approval for coverage of human organ transplant services.

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.

b. Maternity Care

The Plan covers the following inpatient maternity care:

- Delivery, including a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a 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.)
- Charges for covered newborn care up to 31 days after birth. (Coverage beyond 31 days will only be provided if the newborn is enrolled under this Plan. Please contact NHHKC for information on eligibility and adding new Dependents.)

c. 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 Rehabilitative Services that must be provided in an inpatient setting. The benefit limit is stated in the Summary of Benefits (Section A). Rehabilitative care includes physical, speech and occupational therapies.

d. Skilled Nursing Facility Care

The Plan covers care in a health care facility licensed to provide skilled nursing care on an inpatient basis. Coverage is provided only when you need daily skilled nursing care that must be provided in an inpatient setting. The benefit limit is stated in the Summary of Benefits (Section A).

RELATED EXCLUSIONS FOR ALL INPATIENT CARE:

- Personal items, including telephone and television charges
- All charges over the semi-private room rate, except when a private room is Medically Necessary

SECTION C. Covered Benefits

- Rest or Custodial Care
- Private duty nursing
- Charges after your hospital discharge
- Charges after the date on which your membership ends
- 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

e. Bariatric Surgery

The plan covers the surgical treatment of obesity and morbid obesity (bariatric surgery). Services are covered when Medically Necessary and in accordance with the patient qualification and treatment standards set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons. Coverage may be limited or excluded under your Plan unless services are performed at a designated Center of Excellence. Please see the section titled “Centers of Excellence” in your Benefit Handbook for important information concerning your coverage for this service.

Important Notice: HPHC uses clinical guidelines to evaluate whether bariatric surgery is Medically Necessary. If you are planning to receive bariatric surgery services HPHC recommends that you review the current guidelines. To obtain a copy, please call Member Services at **1-888-333-4742**.

RELATED EXCLUSIONS

- Commercial diet plans or weight loss programs, and any services in connection with such plans or programs
- Exercise programs and exercise equipment
- Drugs primarily used for weight loss

5. MENTAL HEALTH AND DRUG AND ALCOHOL REHABILITATION SERVICES

Before you receive mental health and drug and alcohol rehabilitation services, you must call the Behavioral Health Access Center at **1-888-777-4742**. The Behavioral Health Access Center phone line is staffed by licensed mental health clinicians. A clinician will assist you in (1) determining the type of care you need, (2) finding appropriate mental health providers in the network, and (3) arranging the services you require.

To be covered by the Plan, all mental health and drug and alcohol rehabilitation services must be arranged through the Behavioral Health Access Center and provided by contracted providers. The only exceptions apply to: (1) care required in a Medical Emergency, (2) care when you are temporarily outside of the Service Area, and (3) care when you were being treated by a mental health provider under a prior plan. The first two exceptions are described in Section B. If you were being treated by a mental health provider under a prior health plan, please see "Mental Health Provider Continuation" in subsection b, below.

Coverage for New Hampshire Parity Conditions

The Plan covers Medically Necessary treatment of Serious Mental Illness at the same level as for any other medical condition. Serious Mental Illnesses are the following diagnoses: schizophrenia and other psychotic disorders, schizoaffective disorder, bipolar disorder, anorexia nervosa and bulimia nervosa, major depressive disorder, obsessive-compulsive disorder, panic disorder, pervasive developmental disorder or autism, and chronic post-traumatic stress disorder.

Coverage for Other Conditions

In addition to the coverage discussed above, the Plan will provide coverage for the care of all other 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.) Medically Necessary services for conditions other than those Serious Mental Illnesses listed above will be covered subject to the benefit limits as set forth in the Summary of Benefits (Section A).

Please refer to the Summary of Benefits (Section A) for the Member Cost Sharing and any benefit limits that apply to the coverage of these services.

Covered mental health and drug and alcohol rehabilitation services include the following:

a. Mental Health and Drug and Alcohol Rehabilitation Services

Subject to the Member Cost Sharing and any benefit limits stated in the Summary of Benefits (Section A), the Plan provides coverage through the Behavioral Health Access Center for the following Medically Necessary mental health and drug and alcohol rehabilitation services:

SECTION C. Covered Benefits

1. Inpatient Services

- Mental health services
- Drug and alcohol rehabilitation services
- Detoxification services

2. Partial Hospitalization Services

- Partial hospitalization is an intensive outpatient program that provides coordinated services in a therapeutic setting. Partial hospitalization will only be covered if you and your doctor agree that this treatment is best for you.

3. Outpatient Services

- Care by a licensed mental health professional or provider
- Drug and alcohol rehabilitation services
- Detoxification services
- Medication management
- Psychological testing

Please note: A Member requesting mental health services will be referred for at least five (5) visits per calendar year to an HPHC-NE network mental health provider. The Plan will not review Medical Necessity of those five (5) visits.

b. Mental Health Provider Continuation

If the Plan replaced your prior health plan and you were being treated by a mental health provider under the prior plan, you may be eligible to continue seeing your previous health care provider. Such eligibility may continue for up to one year after the Plan replaced your prior health plan.

You may be eligible to continue treatment with a mental health provider not under contract with HPHC if you received mental health services under a previous employer group health plan and either:

- a. You received mental health services for two, three, or five separate days during the 30-day, 90-day, or 12-month period, respectively, immediately prior to joining the Plan; or

- b. You were hospitalized for mental health purposes during the 12-month period immediately prior to joining the Plan.

You must obtain a Referral for the service. HPHC may refuse to cover the service if it is not Medically Necessary as determined by HPHC. HPHC may require you to provide reasonable proof of the prior services, such as an explanation of benefits from the previous insurance carrier or a letter from the provider. HPHC may limit the amount it pays to your mental health provider to the amount it would pay to a contracting provider in HPHC's network.

RELATED EXCLUSIONS FOR ALL MENTAL HEALTH AND DRUG AND ALCOHOL REHABILITATION SERVICES:

RELATED EXCLUSIONS:

- Educational services or testing. 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
- Sensory integrative praxis tests
- Methadone Maintenance
- Health resorts, recreational programs, camps, wilderness programs, outdoor skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs
- Services for any condition with only a "V Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder

6. DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES

The Plan covers durable medical equipment including prosthetic devices when Medically Necessary and ordered by an Plan Provider. HPHC will rent or buy all equipment. The cost of the repair and maintenance of covered equipment is also covered.

Coverage is only available for:

- The least costly equipment or prosthesis adequate to allow you to perform normal functions of daily life

SECTION C. Covered Benefits

(These functions include walking, speaking, sleeping, eating, drinking and using the toilet. Normal functions of daily life do not include special functions needed for occupational purposes or sports.); and

- One item of each type of equipment that meets the Member's need. No back-up items or items that serve a duplicate purpose are covered. For example, the Plan covers a manual or an electric wheelchair, not both.

Durable medical equipment and prosthetic devices are covered up to the limit described in the Summary of Benefits (Section A). Any Cost Sharing amounts you are required to pay are based on the cost of equipment to HPHC.

When you are temporarily outside of the Service Area, coverage is provided for equipment available under this Handbook only when the need for it cannot be foreseen before leaving the Service Area. (Please see Section B.2.g. for more information.)

In order to be covered, all equipment must be:

- Able to withstand repeated use;
- Not generally useful in the absence of disease or injury;
- Suitable for home use; and
- Normally used in the treatment of an illness or injury or for the rehabilitation of an abnormal body part. (This does not apply to prostheses).

Covered equipment includes:

- Respiratory equipment
- Certain types of braces
- Oxygen and oxygen equipment
- Hospital beds
- Wheelchairs
- Walkers
- Crutches
- Canes
- Blood glucose monitors

Covered prostheses include:

- Artificial arms and legs
- Artificial eyes
- Breast prostheses, including replacements and mastectomy bras
- Ostomy supplies
- A scalp hair prosthesis (wig) when Medically Necessary as a result of alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment from any form of cancer or leukemia or permanent loss of scalp hair due to injury

Covered Diabetes Equipment and Supplies includes:

- Blood glucose monitors
- Insulin pumps (including supplies) and infusion devices
- Therapeutic molded shoes and inserts
- Voice synthesizers
- Visual magnifying aids
- Dosage gauges
- Injectors
- Lancet devices

7. ANNUAL EYE EXAMINATIONS

The Plan covers one routine eye examination per calendar year with a Plan ophthalmologist or optometrist. A Referral from your PCP is not required; however, services must be provided by a Plan Provider.

8. CHIROPRACTIC CARE

The Plan covers chiropractic care by adjustment or manipulation. A Referral from your PCP is not required; however, services must be provided by Plan Provider.

Only the following services are covered:

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

9. HEARING AIDS

The Plan covers hearing aids, including repair, up to the benefit limit listed in the Summary of Benefits.

10. TELEMEDICINE SERVICES

The Plan covers Medically Necessary telemedicine services for the purpose of diagnosis, consultation or treatment in the same manner as an in-person consultation between you and your HPHC Provider. Telemedicine services are limited to the use of real-time interactive audio, video or other electronic media telecommunications as a substitute for in-person consultation with HPHC Providers.

Cost Sharing for telemedicine services is the same as the Cost Sharing for the same type of service if it had been provided through an in-person consultation. Please refer to your *Summary of Benefits* for specific information on Cost Sharing you may be required to pay.

RELATED EXCLUSIONS:

- Telemonitoring, telemedicine services involving e-mail, fax, or audio-only telephone, telemedicine services involving stored images forwarded for future consultation, i.e. “store and forward” telecommunication.

SECTION D. General Exclusions

a. The Plan does not cover:

1. Services your PCP or an HPHC Provider has not provided, arranged or approved except: (1) in a Medical Emergency, (2) when you are outside of the Service Area; or (3) the special services that do not require a referral, listed in Section B.2.h.
2. Services for cosmetic purposes, except as described in this Handbook.
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.
5. Dental Care, except the specific dental services covered under this Benefit Handbook.
6. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational..
7. Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of myopia, hyperopia and astigmatism.
8. Transportation other than by ambulance.
9. Cost for any services for which you are entitled to treatment at government expense, including military service connected disabilities.
10. Costs for services for which payment is required to be made by a Workers' Compensation plan or an employer under state or federal law.
11. Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy.
12. Educational services or testing. 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.
13. Sensory integrative praxis tests.
14. Testing of central auditory processing.
15. Physical examinations and testing for insurance, licensing or employment.
16. Routine foot care, biofeedback, pain management programs, and sports medicine clinics.
17. Vocational rehabilitation or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
18. Charges after the date on which your membership ends.
19. Charges for missed appointments.
20. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary.
21. Inpatient charges after your hospital discharge.
22. Follow-up care after an emergency room visit, unless provided or arranged by your PCP.
23. Rest or Custodial Care.
24. Personal comfort or convenience items (including telephone and television charges).
25. Exercise equipment.
26. Wigs, except as required by state law.
27. Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.
28. Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services.
29. Any devices or special equipment needed for sports or occupational purposes.
30. Any home adaptations, including, but not limited to home improvements and home adaptation equipment.
31. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal.)
32. Any form of surrogacy.
33. Infertility treatment for Members who are not medically infertile.
34. Routine maternity care when you are traveling outside the Service Area.

SECTION D. General Exclusions

35. 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.
36. 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.
37. Services for which no charge would be made in the absence of insurance.
38. 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.
39. Services for non-Members.
40. Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
41. Birth control drugs, implants, injections and devices, unless your Plan includes coverage for prescription drugs.
42. Home health care services that extend beyond care on a short-term intermittent basis.
43. Private duty nursing
44. A provider's charge to file a claim or to transcribe or copy your medical records.
45. Any service or supply furnished along with a non-Covered Benefit.
46. Taxes or governmental assessments on services or supplies.
47. Planned home births.
48. Eyeglasses, contact lenses and fittings, except as listed in this Benefit Handbook.
49. Acupuncture, aromatherapy, treatment with crystals and alternative medicine.
50. Myotherapy.
51. Methadone maintenance.
52. Services for which no coverage is provided in this Benefit Handbook or Prescription Drug Brochure (if applicable).
53. Massage therapy when performed by anyone other than a licensed physical therapist, physical therapy assistant, occupational therapist, or certified occupational therapy assistant.
54. Health resorts, recreational programs, camps, wilderness programs, outdoor skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs.
55. Unless otherwise specified in this Benefit Handbook or the Summary of Benefits (and required by New Hampshire law), the Plan does not cover food or nutritional supplements, including FDA-approved medical foods obtained by prescription.
56. Preventive Dental Care for children.
57. Infertility consult or evaluation
58. Therapeutic donor insemination, including related sperm procurement and banking.
59. Advanced reproductive technologies, including, but not limited to, in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intra-cytoplasmic sperm injection (ICSI), and donor egg procedures, including related egg and inseminated egg procurement, processing and banking.
60. Voluntary sterilization, including tubal ligation and vasectomy.
61. Voluntary termination of pregnancy.
62. Foot orthotics
63. Extraction of teeth impacted in bone
64. Telemonitoring, telemedicine services involving e-mail, fax, or audio-only telephone, telemedicine services involving stored images forwarded for future consultation, i.e. "store and forward" telecommunication
65. 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

SECTION E. Reimbursement and Claims Procedures

The information in this section applies when you receive services from a non-HPHC Provider.

Generally, this would happen only when you get care:

- In a Medical Emergency; or
- When you are temporarily outside the Service Area.

In most cases, you should not receive bills from an HPHC Provider.

1. BILLING BY PROVIDERS

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

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

2. REIMBURSEMENT FOR BILLS YOU PAY

If you pay a provider who is not an HPHC Provider for a Covered Benefit, we will reimburse you. Just send receipts from the provider or pharmacy that shows proof of payment.

Claims for Mental Health or Drug and Alcohol Rehabilitation Services:

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

For 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

Here is the information we need to process your claim:

- The Member's full name and address;
- The Member's date of birth;
- The Member's Plan ID number (on the front of the patient's Plan ID card);
- The name and address of the person or institution providing the services for which a claim is made and their tax identification number;
- The Member's diagnosis;
- The date the service was rendered;
- The CPT code (or a brief description of the illness or injury) for which payment is sought; and
- The amount of the provider's charge.

For pharmacy items, you must also send a drug store receipt stating: the Member's name and Plan ID number; the name of the drug or medical supply; the drug National Drug Code ("NDC") number; the quantity; the number of day supply; the date the prescription was filled; the prescribing physician's name; the pharmacy name and address; and the amount you paid.

Member's can contact the MedImpact help desk at 1-800-788-2949 regarding pharmacy claims.

Please note that we may need more information for some claims. If you have any questions about claims, please call our Member Services Department.

3. LIMITS ON CLAIMS

To be eligible for payment, we must get claims within one year of the date care was received. We will send you reimbursement within 35 days of receipt of all information needed to process your claims.

We limit the amount we will pay for services that are not rendered by HPHC Providers. The most we will pay for such services is the Usual, Customary and Reasonable Charge. You may have to pay the balance if the claim is for more than the Usual, Customary and Reasonable Charge.

SECTION F. Appeals

1. BEFORE YOU FILE AN APPEAL

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

2. MEMBER APPEAL PROCEDURES

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

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

You may also obtain assistance from the New Hampshire Insurance Department. The Department may be contacted by calling **603-271-2261** or **1-800-852-3416**. For TDD access Members may call Relay NH at **1-800-735-2964**. Members may also write the Department at 21 South Fruit Street, Suite 14, Concord, NH 03301.

If HPHC does not provide you with a timely appeal or expedited appeal in accordance with the time limits stated below, HPHC will promptly notify you of your right to proceed to external review from the New Hampshire Insurance Department without having received a decision from HPHC. Please see below for information on external review.

a. Initiating Your Appeal

To initiate your appeal, you or your representative should write or FAX a letter to us about the coverage you are requesting and why you feel it should be granted. (If your appeal qualifies as an expedited appeal, you may contact us by telephone. See Section F.2.c. for the expedited appeal process.)

Please be as specific as possible in your appeal request. We need all the important details in order to make a fair decision, including pertinent medical records and itemized bills. We must get this information within one hundred and eighty (180) days of the denial of coverage.

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

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

**HPHC Member Appeals
Member Services Department
HPHC Insurance Company, Inc.
1600 Crown Colony Drive
Quincy, MA 02169.**

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

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

**Behavioral Health Access Center
c/o United Behavioral Health
Appeals Department
100 East Penn Square, Suite 400
Philadelphia, PA 19107**

**Telephone: (888) 777-4742
FAX: (888) 881-7453**

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

SECTION F. Appeals

b. Appeal Process

Your Appeal Coordinator will investigate your appeal and determine if additional information is required. Such information may include medical records, statements from your doctors, and bills and receipts for services you have received. You may also provide HPHC with any written comments, documents, records or other information related to your claim. Should HPHC need additional information to decide your appeal, your Appeal Coordinator will notify you and request the specific information needed. You will have 45 days to provide the requested information. After 45 days your appeal may be closed. However, a new appeal may be submitted with the required information as long as it is submitted within 180 days of the denial of coverage.

HPHC will review your appeal and send to you a written decision within 30 days of receiving your appeal. If HPHC requests additional information from you, the 30-day time period will not run while HPHC is awaiting the requested information. After we receive all the information needed to make a decision, your Appeal Coordinator will inform you in writing of whether we have approved or denied your appeal. HPHC's decision of your appeal will include: (1) the titles and qualifying credentials of your Appeal Coordinator and any other person reviewing your appeal; (2) a summary of the facts and issues in the appeal; (3) a summary of the documentation relied upon; and (4) the specific reasons for the decision, including the clinical rationale, if any. 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 below.

If your appeal involves a decision on a medical issue, your Appeal Coordinator will obtain the opinion of a qualified physician or other appropriate medical specialist. Upon your request your Appeal Coordinator will provide you with a copy, free of charge, of any written clinical criteria used to decide your appeal and the identity of the physician (or other medical specialist) consulted concerning the decision.

No one involved in the initial decision to deny a claim under appeal will be a decision-maker in any stage of the appeal process. You have the right to receive, free of charge, all documents, records or other information relevant to the initial denial and your appeal.

c. Expedited Review Procedure:

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

- (1) if delayed, could seriously jeopardize your life or health or ability to regain maximum function,
- (2) in the opinion of a physician with knowledge of your medical condition, would result in severe pain that cannot be adequately managed without the care or treatment, or
- (3) involves the continuation of inpatient services following emergency care.

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

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

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

To enable us to conduct such a quick review of the expedited appeal, we must limit the expedited appeal process to the circumstances listed above. Your help in promptly providing all necessary information is essential for us to provide you with this quick review. If we do not have sufficient information necessary to decide your appeal, HPHC will notify you that additional information is required within 24 hours after receipt of your appeal.

3. OPTIONS FOR FURTHER REVIEW IF YOUR APPEAL IS DENIED

If you disagree with the decision of your appeal, you may have a number of options for further review. These options are (1) reexamination of appeals that are subject to clinical review for medical necessity by an HPHC review committee, (2) assistance from NHHKC, (3) assistance from Department of Health and Human Services (DHHS), or (4) External Review by an Independent Review Organization (IRO) appointed by the New Hampshire Insurance Department. Below is a summary of these options.

a. Reexamination by HPHC

If you disagree with a decision concerning an appeal that is subject to clinical review for medical necessity, you may choose to have your appeal reexamined by an HPHC review committee. You must request such review within 45 days of the date of your denial letter. You, or your representative, may participate via telephone conference call to discuss your case.

You may also request that the committee review your case based upon the documents and records in your appeal file without participating in the meeting. You 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 on the reexamination of your appeal.

Reexamination is not available for the following types of appeals:

- Decisions involving a benefit limitation where the limit is stated in the Handbook
- Decisions involving excluded services, except Experimental, Unproven, or Investigational services
- Decisions concerning Member Cost Sharing requirements; or
- Decisions that do not involve clinical review for medical necessity

HPHC's reexamination process is optional. You may request reexamination by an HPHC review committee before seeking external review from the New Hampshire Insurance Department, as discussed below, or you may proceed directly to external review. You may also request such

reexamination if the Insurance Department has determined that your appeal is not eligible for external review. However, HPHC will not reexamine an appeal that has been accepted for external review by the Insurance Department.

b. Assistance from New Hampshire Healthy Kids Corporation

You may contact the New Hampshire Healthy Kids Corporation. A Healthy Kids staff will work with you to review the claim and help clarify any misunderstandings. Please call **1-877-464-2447** for assistance.

c. Assistance from the Department of Health and Human Services.

You may contact the office of the Ombudsman at the New Hampshire Department of Health and Human Services. Please call **1-800-852-3345 (extension 6941)** for assistance.

d. Independent External Review of Appeals

The New Hampshire Insurance Department has prepared a publication that explains your rights to appeal certain health care service denials to an Independent Review Organization selected by the Department. The Department has also issued a form for requesting an external appeal. This form can be found at the end of this Handbook. The following text is the Insurance Department's Managed Care Consumer Guide to External Appeal as published September 1, 2000:

MANAGED CARE CONSUMER GUIDE TO EXTERNAL APPEAL

New Hampshire law gives you the right to an external appeal when health care services are denied by your managed care insurer on the basis that the services are not medically necessary or that the services are experimental or investigational.

What is an External Appeal?

- An external appeal is a request that you make to the state for an independent review of a denial of services by your managed care insurer.
- Reviews are conducted by Independent Review Organizations (IROs) that are certified by the state and have a network of medical experts to review your health insurer's denial of services.

SECTION F. Appeals

- You must complete the attached application and submit the application and all supporting documentation to the New Hampshire Insurance Department to request an external appeal.

When is my Appeal eligible for Independent External review?

To be eligible for independent external review, the following conditions must be met:

- The service that is the subject of the appeal request must be a Covered Benefit under the terms of your health insurance policy or at least something that could be a Covered Benefit in some circumstances.
- You must have completed the internal appeal process provided by your insurer and received a final decision from your insurer. However, this requirement need not be met if your insurer agrees in writing to submit its decision to independent external review prior to completion of internal review. In addition, if you have requested internal review and have not received a decision from your insurer within the required time frames, you may proceed to external review without having received a decision from your insurer on internal review.
- You must submit your request for independent external review to the New Hampshire Insurance Department within 180 days of the date that you were first eligible to file for review. Normally, this will be the date of the health insurer's written denial decision on internal review.
- The cost to you for the service that the health insurer has denied must amount to or is anticipated to amount to at least \$400 in a 12-month period.
- Your request for an independent external review must not be for the purpose of pursuing a claim or allegation of health care provider malpractice, professional negligence, or other professional fault.

Types of health insurance for which External Review is not available

In general, independent external review is available only for private, managed care health insurance coverage. Service denials relating to the following types of insurance coverage or health benefit

programs are not reviewable under New Hampshire's external review law:

- Medicaid, the State Children's Health Insurance Program, Medicare, or services provided under these programs but through a contracted health insurer.
- All other government-sponsored health insurance or health services programs.
- Health benefit plans that are self-funded by employers.

Can someone else represent me in my External Appeal?

Yes, you may designate anyone you would like, including your treating health care provider, to represent you. To do so, you must fill out the section of the external appeal request form entitled, "Appointment of Authorized Representative." You may also revoke this authorization at any time.

Filing the External Appeal

You, or someone acting on your behalf with your written consent, may request an independent external review by filling out the attached external appeal request form and submitting it to the New Hampshire Insurance Department together with the required supporting documentation. There is no cost to you for an external review. Please be sure to include all of following with your appeal:

- A completed external appeal request form.
- A copy (if you received one) of the letter from your health insurer denying your request at the second and final level of their internal appeal process.
- A photocopy of your insurance card or other evidence that you are insured by the health insurance company named in your external appeal request form.
- A copy of your certificate of coverage or your insurance policy benefit booklet, which lists your benefits.
- Any medical records, statements from your treating health care providers, or other information that you would like the independent review organization to consider in reviewing your case.

SECTION F. Appeals

You may call the Insurance Department at **800-852-3416** or **271-2261** if you need help with the application or if you do not have one or more of the above items and would like information on alternative ways to complete your request for independent external review.

If you are requesting a standard appeal, send all paperwork to:

**Independent External Review
New Hampshire Insurance Department
21 South Fruit Street
Suite 14
Concord, NH 03301**

If you are requesting an expedited appeal, call the Insurance Department before sending your paperwork, and you will receive instructions on the quickest way to submit the application and supporting information.

What is the standard appeal process and time frame?

Within 7 business days after receiving your request for an independent external review, the Insurance Department will complete a preliminary review to determine whether your request is complete and whether your case is eligible for external review. If the request is not complete, the insurance department will inform you or your representative what information or documents are needed to make the request complete and to process the request. You will have 10 days to supply the needed information or documents.

- If the request for external review is accepted, the insurance department will select and retain an independent review organization to conduct the review and notify you and the insurer.
- Within 10 days after receiving notice of the acceptance of the appeal, the insurer must provide the selected independent review organization and you all information in its possession that is relevant to the appeal. You, or your representative, will then have another 10 days to submit new or additional information to the independent review organization and the insurer if you would like. During this 10-day period, you or your representative may also present oral testimony via teleconference to the independent review organization and the insurer.

However, oral testimony will be permitted only in cases when the commissioner determines that it would not be feasible or appropriate to present only written information. If you or your representative would like to discuss your case with the independent review organization and your insurer in a telephone conference, you can request this by checking the appropriate box in the external appeal request form or by contacting the Insurance Department no later than 10 days after receiving notice of the acceptance of the appeal.

- At the end of this second 10-day period, the record of the case will be closed and no new information may be provided. The independent review organization will then have 20 days to review all of the information and documents received and render a decision upholding or reversing the determination of the insurer.

Expedited External Review

Because the standard process for handling external review can take over 47 days, expedited (fast-tracked) external review is available for those persons who would be significantly harmed by having to wait. You may request expedited review by checking the appropriate box on the appeal request form and by having your treating health care provider fill out a certification form, which is attached to the appeal request form, verifying that adherence to the time frame for standard review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. Expedited review must be completed in at most 72 hours.

If you are pursuing an internal appeal with your insurer and anticipate that you may be requesting external review on an expedited basis, please call the Insurance Department at **800-852-3416** or **271-2261** in advance, so that accommodations can be made to receive and process your request as quickly as possible.

What happens when an independent review organization makes its decision?

If your appeal was expedited, in most cases you and your health insurer will be notified of the independent review organization's decision immediately by telephone or fax. Written notification will follow.

- If your appeal was not expedited, you and your health insurer will be notified in writing.

SECTION F. Appeals

- The decision of the independent review organization is binding on the health insurer and is enforceable by the Insurance Department. The decision is binding on you as well, except that it does not prevent you from pursuing any other claim or remedy you may have under federal or state law.

If you have any questions, please contact the New Hampshire Insurance Department at 800-852-3416 or 271-2261 and ask to speak to a consumer assistant.

4. ALTERNATIVE DISPUTE RESOLUTION OR LEGAL ACTION

You may have other voluntary alternative dispute resolution options, such as mediation. You may also be able to bring legal action against HPHC.

5. MEMBER COMPLAINTS

If you have any Complaints about your care under HPHC's coverage or about HPHC's service, we want to know about it. We are here to help. For all complaints, except mental health or drug and alcohol rehabilitation concerns, please call or write to us at:

**HPHC Member Services Department
HPHC Insurance Company, Inc.
1600 Crown Colony Drive
Quincy, MA 02169**

**Attn: Member Concerns
Telephone: (888) 333-4742**

For a complaint involving mental health or drug and alcohol rehabilitation services, please call or write to us at:

**Behavioral Health Access Center
c/o United Behavioral Health
Appeals Department
100 East Penn Square, Suite 400
Philadelphia, PA 19107**

**Telephone: (888) 777-4742
FAX: (888) 881-7453**

We will respond to you as quickly as we can. Member complaints sent to us in writing will be investigated and responded to within twenty (20) business days of request.

SECTION G. Eligibility

This section describes requirements concerning eligibility under the Plan. This document incorporates by reference an Agreement issued by NHHKC and HPHC, which includes information on dependent eligibility. It is important to understand that eligibility of dependents and effective dates of coverage are determined by NHHK. Please see NHHK for descriptions of eligibility and effective dates of coverage.

1. ELIGIBILITY REQUIREMENTS

To be eligible for coverage under this Plan, the following criteria must be met:

- You must be a resident of the state of NH
- You must be at least one year old, but less than 19 years old, and
- You cannot be eligible for public health programs including Medicaid and Medicare, and
- With certain exceptions (as determined by the New Hampshire Healthy Kids Corporation), you cannot have been enrolled in a health plan for at least six months prior to the effective date of this Certificate.

2. WHEN COVERAGE BEGINS

Your coverage begins on the effective date as determined by the New Hampshire Healthy Kids Corporation.

3. PERSONS NOT ELIGIBLE FOR MEMBERSHIP

- Children who do not meet the eligibility criteria listed in this Section.
- Children who were previously enrolled in Healthy Kids or Healthy Kids Silver whose coverage lapsed due to nonpayment of premium. Upon the first instance of cancellation for nonpayment of premium, the child will be eligible to reenroll no sooner than three months following the cancellation date.

4. NOTIFICATION

A condition of membership is your agreement to notify New Hampshire Healthy Kids Corporation in writing immediately of any changes in address or any changes in status which would affect your eligibility. This includes changes in family income, family size, enrollment in public health programs, and/or if you obtain other insurance coverage.

Please note that HPHC must have your current address on file in order to correctly process claims for care outside the Service Area.

5. DISCLOSURE OF COVERAGE

Another condition of membership is your agreement to provide information regarding all other health coverage(s) under which you may be entitled to Benefits.

SECTION H. Termination

TERMINATION OF THIS BENEFIT HANDBOOK

Subject to the provisions of this Section, your coverage under this plan will terminate in certain circumstances. These circumstances are described below.

Coverage under this Benefit Handbook is provided according to the terms of a contract between HPHC and the New Hampshire Healthy Kids Corporation (NHHKC). The NHHKC contract is effective for a fixed term and may be renewed by HPHC and NHHKC. Upon termination of the NHHKC contract, HPHC will no longer provide any Benefits to Members.

1. DEFAULT IN PAYMENT OF PREMIUMS

If the NHHKC does not receive payment on time, coverage under this Certificate will terminate on a date stated in a notice to be mailed by HPHC to the Member.

2. TERMINATION FOR LOSS OF ELIGIBILITY

The NHHKC will determine the date that your coverage ends if you become ineligible to participate in this program.

3. WHEN YOU BECOME ELIGIBLE FOR MEDICARE

If you believe that you may be eligible for Medicare coverage, you should notify the NHHKC immediately. If Medicare becomes your primary coverage, you will have no further coverage under this program.

4. TERMINATION BY THE SUBSCRIBER

You may end your membership under this Handbook with NHHKC's approval. We must receive notice of disenrollment from NHHKC of the date you want your membership to end.

PLEASE NOTE THAT HPHC MAY NOT HAVE CURRENT INFORMATION CONCERNING MEMBERSHIP STATUS. NHHKC DETERMINES ELIGIBILITY AND WILL NOTIFY US OF ENROLLMENT CHANGES. AS A RESULT, THE INFORMATION WE HAVE MAY NOT BE CURRENT. ONLY NHHKC CAN CONFIRM MEMBERSHIP STATUS.

5. MEMBERSHIP TERMINATION FOR CAUSE

HPHC may end your coverage for any of the following causes:

- Providing false or misleading information on an application for membership;
- Committing, or attempting to commit, fraud against the Plan;
- Obtaining or attempting to obtain benefits under this Handbook for a person who is not a Member;
- The commission of acts of physical or verbal abuse by a Member that poses a threat to providers or other Members and that are unrelated to the Member's physical or mental condition.

Termination of membership will be effective thirty (30) days after notice from the Plan.

SECTION I. When You Have Other Coverage

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

1. BENEFITS IN THE EVENT OF OTHER INSURANCE

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

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

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

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

a. Dependent/Non-Dependent

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

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

The order of benefits is determined as follows:

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

c. Dependent Child/Separated or Divorced Parents

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

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

d. 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.

2. PAYMENT WHEN HPHC COVERAGE IS PRIMARY OR SECONDARY

When HPHC is primary, HPHC is responsible for processing and paying claims for Covered Benefits first. Coverage will be provided to the full extent of benefits available under this Handbook.

When HPHC is secondary, HPHC is responsible for processing claims for Covered Benefits after the primary plan has been issued a benefit determination. HPHC will first review the primary plan's benefit determination. HPHC will then pay or provide Covered Benefits as the secondary payor. HPHC's benefits will be reduced so that the total amount paid by all plans for a Covered Benefit will not exceed the amount payable under this Handbook. HPHC may recover any payments made for services in excess of the HPHC's liability as the secondary plan, either before or after payment by the primary plan.

3. WORKER'S COMPENSATION/ GOVERNMENT PROGRAMS

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

4. SUBROGATION

Subrogation is a means by which HPHC and other health plans recover expenses of services where a third party is legally responsible for your injury or illness.

If another person or entity is, or may be, liable to pay for services related to your illness or injury which have been paid for or provided by HPHC, HPHC will be subrogated and succeed to all rights to recover against such person or entity up to the value of the services paid for or provided by HPHC. HPHC will have the right to seek such recovery from, among others, the person or entity that caused the injury or illness, his/her liability carrier or your own auto insurance carrier, in

cases of uninsured or underinsured motorist coverage. HPHC's right to recovery shall apply even if a recovery the Member receives for the illness or injury is designated or described as being for injuries other than health care expenses.

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

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

5. MEDICAL PAYMENT POLICIES

If you are entitled to coverage under the medical payment benefit of a motor vehicle, motorcycle, boat, homeowners, hotel, restaurant or other insurance policy, the benefits under this Handbook shall not duplicate any benefits for medical expenses to which you are entitled under such policy. With the exception of a Motor Vehicle Liability Policy, as defined below, HPHC has the right to coordinate benefits with other insurance carriers with respect to any benefits for medical payments that may be available for services covered under this Handbook. HPHC shall have the right to receive reimbursement for services paid under this Handbook that are covered under a medical payment benefit or policy other than benefits paid under a Motor Vehicle Liability Policy.

For the purpose of this section, the term "Motor Vehicle Liability Policy" means a private motor vehicle liability policy, as defined in New Hampshire law under RSA 259:61, that covers a private passenger automobile that is registered or principally garaged in the State of New Hampshire. The term "Motor Vehicle Liability Policy" shall not include (1) a commercial policy covering more than four automobiles, or (2) any commercial policy covering a garage, automobile sales agency, repair shop, service station, trucking operation or public parking place operation hazards.

If you are injured in a motor vehicle accident in which medical payments coverage is available under a Motor Vehicle Policy, you have a right to submit a claim under either the medical payments coverage or this Handbook, or both. However, you are not entitled to duplicate payments for the same expense under the medical payments coverage and this Handbook.

6. MEMBER COOPERATION

You agree to cooperate with HPHC in exercising its rights of subrogation and coordination of benefits under this Handbook. HPHC agrees that subrogation payments will be made on a just and equitable basis. Such cooperation will include, but not be limited to, a) the provision of all information and documents requested by HPHC, b) the execution of any instruments deemed necessary by HPHC to protect its rights, c) the prompt assignment to HPHC of any monies received for services provided or paid for by HPHC, and d) the prompt notification to HPHC of any instances that may give rise to HPHC's rights. You further agree to do nothing to prejudice or interfere with HPHC'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 HPHC for any expenses HPHC may incur, including reasonable attorneys fees, in enforcing its rights under this Handbook.

7. HPHC'S RIGHTS

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

SECTION J. Administration of this Benefit Handbook

1. COVERAGE WHEN MEMBERSHIP BEGINS WHILE HOSPITALIZED

a. General Coverage Rules

If your membership begins while you are hospitalized, coverage begins from the time membership is effective. To obtain coverage, you must call both your PCP and HPHC and allow HPHC to manage your care. This may include transfer to an HPHC affiliated facility, if medically appropriate. All other terms and conditions of coverage under this Handbook will apply.

b. Coverage for Members who live outside the Enrollment Area

You must live within the Enrollment Area to be eligible for full benefits under this Handbook. The benefits available to Members temporarily traveling outside the Service Area, described in Section B.2.g. are not available to Members who live outside of the Enrollment Area.

2. MISSED APPOINTMENTS

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

3. DISAGREEMENT WITH RECOMMENDED TREATMENT

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

4. LIMITATION ON LEGAL ACTIONS

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

5. ACCESS TO INFORMATION

You agree that except where restricted by law, HPHC may have access to (1) all health records and medical data from health care providers providing services covered under this 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 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 records.

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

6. CONFIDENTIALITY

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

When you enrolled with HPHC, you consented to certain uses and disclosures of information which are necessary for the provision and administration of services and benefits, such as: coordination of care, including referrals and authorizations; conducting quality activities, including member satisfaction surveys and disease management programs; verifying eligibility; fraud detection and certain oversight

reviews, such as accreditation and regulatory audits. When HPHC discloses Member information, it does so using the minimum amount of information necessary to accomplish the specific activity.

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

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

7. NOTICE

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

8. MODIFICATION OF THIS HANDBOOK

This Benefit Handbook, Summary of Benefits, and Prescription Drug Brochure, may be amended by HPHC upon sixty (60) days written notice to NHHKC. Amendments do not require the consent of Members.

This Benefit Handbook, including the Summary of

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

9. RELATIONSHIP OF HPHC PROVIDERS AND HPHC

The relationship of HPHC to providers, other than HPHC employees, is governed by separate agreements. They are independent contractors. Such providers may not modify this Handbook, Summary of Benefits or Prescription Drug Brochure, or create any obligation for HPHC. HPHC is 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. For any questions regarding this Handbook, Members may contact HPHC at **1-888-333-4742**.

10. PROVIDER COMPENSATION ARRANGEMENTS

Under New Hampshire law HPHC is required to inform you of the types of financial arrangements contained in its contracts with providers. They are described below.

HPHC's compensation programs are designed to reward providers for the delivery of cost effective services, including those referral services that your physician determines to be Medically Necessary. Providers may also receive additional compensation when established goals for quality and Member satisfaction are met.

There are three main types of HPHC Provider payment arrangements, as follows:

1. Capitation. One of the ways that HPHC pays providers is through a method called "capitation." Under a capitation arrangement a provider organization receives a set dollar amount for each HPHC patient for which it is responsible. Sometimes capitation is paid directly on a monthly basis. At other times the capitation payment is based on a budget. In budgeted capitation arrangements claims are paid at contracted rates minus a percentage that is withheld by HPHC. At the end of the year, claims payments are reconciled against a budget. All or part of the amount that had

been withheld is returned to the provider organization or retained by HPHC based on that reconciliation. Providers receive a share in any surplus after reconciliation. Some capitation arrangements only apply to professional services. Others apply to professional, hospital and ancillary services.

2. **Salary.** HPHC pays a salary to some of its doctors in New Hampshire. A small percentage of the salary is withheld by HPHC. The amount withheld is paid to the doctor if specific goals, related to quality of care, Member satisfaction and financial performance, have been achieved.
3. **Fee-for-Service.** Under certain circumstances, HPHC pays a contracted rate for the services provided. This arrangement does not include any additional payments or bonuses. Fee-for-service payment is usually used for specialty care and ancillary services.

In the capitation method above, HPHC provides financial protection, ("stop-loss" insurance) from excessive costs in providing medical care to HPHC patients. This means that HPHC Providers are responsible only up to a certain dollar amount for the care of an individual Member. As a result, the compensation of HPHC Providers' is not unduly affected by an unusually large medical expense that might be necessary for care of an individual Member.

11. MAJOR DISASTERS

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

12. EVALUATION OF NEW TECHNOLOGY

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

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

SECTION K. Glossary

This section lists the words with special meaning in this Benefit Handbook.

Behavioral Health Access Center

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

Benefit Handbook (or Handbook)

This legal document, including the Summary of Benefits and the Prescription Drug Rider sets forth the services covered by the Plan, the exclusions from coverage and the conditions of coverage for Members.

Centers of Excellence

Certain specialized services are only covered when received from designated providers with special training, experience, facilities or protocols for the service. HPHC refers to these providers as “Centers of Excellence.”

Centers of Excellence are selected based on the findings of recognized specialty organizations or government agencies such as Medicare. The fact that a facility is an HPHC Provider does not mean that it is a Center of Excellence.

Please see Section B.2.d. (“Centers of Excellence”) for a list of the services that must be received at a Center of Excellence to be covered under this Benefit Handbook. A list of Centers of Excellence may be found in the Provider Directory. Members may view the Provider Directory at www.harvardpilgrim.org or contact the Member Services Department at 1-888-333-4742 to verify a provider’s status.

Coinsurance

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

Copayment

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

Cost Sharing

The responsibility of Members to assume a share of the cost of the benefits provided under the Plan. Cost Sharing may include Copayments and Coinsurance. Please refer to your Summary of Benefits (Section A) for the specific Cost Sharing amounts that apply to your Plan.

Covered Benefits

The medical services and supplies that a Member is eligible to receive, or obtain payment for under the plan.

Custodial Care

Services that are furnished mainly to assist a person in normal functions of daily life (including walking, speaking, sleeping, eating, drinking and using the toilet). Examples of such services include: room and board, routine nursing care, help in personal hygiene, and supervision in daily activities.

Dental Care

Any service provided by a person licensed as a 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) shall not be considered Dental Care within the meaning of this definition.

Elective Procedures

Any procedure that is scheduled to be performed at least 48 hours in advance. This applies only to Members who are able to return to the service area by non-medical transportation.

Enrollment Area

A list of cities and towns where HPHC Providers are available to manage Members' care. Members must maintain residence in the Enrollment Area, and live there at least nine months of the year. HPHC may add or delete cities and towns from time to time.

Experimental, Unproven, or Investigational

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

- a. The product or service is not recognized in accordance with generally accepted medical standards as being safe and effective for the use in the evaluation or treatment of the condition in question. In determining whether a service has been recognized as safe or effective in accordance with generally accepted evidence-based medical standards, primary reliance will be placed upon data from published reports in authoritative medical or scientific publications that are subject to established peer review by qualified medical or scientific experts prior to publication. In the absence of any such reports, it will generally be determined that a service, procedure, device or drug is not safe and effective for the use in question.
- b. In the case of a drug, the drug has not been approved by the United States Food and Drug Administration (FDA). (This does not include off-label uses of FDA approved drugs).

HPHC Insurance Company, Inc. (HPHC)

HPHC Insurance Company, Inc. (HPHC) is an insurance company licensed in the state of New Hampshire that is affiliated with Harvard Pilgrim Health Care.

HPHC Provider

Providers of health care services who are employed by HPHC, or who are under contract to provide care to Plan Members. Providers include, but are not limited to hospitals; skilled nursing facilities; and medical professionals including: physicians, psychiatrists, nurse practitioners, physician assistants, certified midwives, certified registered nurse anesthetists, and licensed mental health professionals including psychologists, clinical social workers, marriage and family therapists, psychiatric/mental health advanced registered nurse practitioners, alcohol and drug counselors, clinical mental health counselors, and pastoral psychotherapists (except when providing services to a Member of his church or congregation in the course of his or her duties as a pastor, minister or staff person). HPHC Providers are listed in the Provider Directory.

Medical Emergency

A sudden and unexpected onset of a condition with symptoms so severe, that a person possessing average knowledge of health and medicine would expect that without prompt medical attention, his or her health (physical or mental) would be in serious jeopardy; or his or her body organs or parts, or some bodily function, would be seriously impaired.

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

Medically Necessary or Medical Necessity

Those medical services which are provided to a Member for the purpose of preventing, stabilizing, diagnosing or treating an illness, injury or disease, or the symptoms thereof, in a manner that is (a) consistent with generally accepted standards of medical practice, (b) clinically appropriate in terms of type, frequency, extent, location of service and duration, (c) demonstrated through scientific evidence to be effective in improving health outcomes, (d) representative of best practices in the medical profession, and (e) not primarily for the convenience of the enrollee or physician or other health care provider.

Member

Any Subscriber covered by this Handbook.

Plan

A package of health care benefits known as HPHC's New Hampshire Healthy Kids Silver plan. For coverage under this Plan, Covered Benefits must be obtained from an HPHC Provider.

Primary Care Physician (PCP)

A specialist in internal medicine, family practice, general practice, or pediatrics who is employed by HPHC, or under contract to provide and authorize Members' care. A Primary Care Physician may designate other HPHC Providers to provide or authorize a Member's care.

Provider Directory

A directory that identifies HPHC Providers. HPHC may revise the Provider Directory from time to time without notice to Members.

Referral

An instruction from your Primary Care Physician (PCP), or his or her designee, to obtain a Covered Benefit from another provider. Although Referrals may be given orally or in writing, depending on the circumstances, the presence of your PCP's current HPHC provider number on the claim submission will be evidence from the HPHC Provider, when required by the plan that a Referral was given for the Covered Benefit that is the subject of the claim.

Rehabilitative Services

Health care services designed to restore a person's ability to perform normal functions of daily life (including walking, speaking, sleeping, eating, drinking and using the toilet) after a disabling injury or illness. Only the following Rehabilitative Services are covered: physical therapy; speech therapy; occupational therapy; cardiac rehabilitation; or an organized program of these services.

Serious Mental Illness

The term Serious Mental Illness means any of the following conditions: (a) schizophrenia and other psychotic disorders; (b) schizoaffective disorder; (c) bipolar disorders; (d) anorexia nervosa and bulimia nervosa; (e) major depressive disorder; (f) obsessive compulsive disorder; (g) panic disorder; (h) pervasive developmental disorder or autism; and (i) chronic post-traumatic stress disorder.

Service Area

The state in which a Member lives. When you are in the Service Area you must call your PCP for care unless you have a Medical Emergency, or you seek the special services that do not require a Referral.

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 eligibility requirements as determined by NHHKC.

Surgical Day Care

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

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.

Tier 1 Copayment

The Copayment that applies to certain outpatient services provided by your PCP, obstetrician, gynecologist, nurse practitioner or certified midwife. The Tier 1 Copayment also applies to mental health and drug and alcohol rehabilitation services, physical, speech and occupational therapies, audiology services, and allergy injections. Tier 1 Copayments applicable to your plan are stated in your Summary of Benefits.

Tier 2 Copayment

A higher Copayment that applies to most outpatient specialty care services. Please refer to your Summary of Benefits for additional information on Covered Benefits subject to the Tier 2 Copayment.

Urgent Care Center

A facility, other than a hospital emergency room, that provides walk-in health services that are required to prevent deterioration of your health resulting from an unforeseen sickness or injury.

Usual, Customary and Reasonable Charge

An amount that is consistent, in the judgment of HPHC, with the normal range of charges by health care providers for the same, or similar, products or services in the geographical area where the product or service was provided to a Member. (If HPHC cannot reasonably determine the normal range of charges where the products or services were provided, HPHC will utilize the normal range of charges in Boston, Massachusetts.) The Usual, Customary, and Reasonable charge is the maximum amount that HPHC will pay for Covered Benefits.

SECTION L. Information on Patient Rights

The following information is provided to inform you of your rights under New Hampshire law.

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

1. The patient shall be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care.
2. The patient shall be fully informed of a patient's rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in writing before or at admission, except for emergency admissions. Receipt of the information must be acknowledged by the patient in writing. When a patient lacks the capacity to make informed judgments, the signing must be by the person legally responsible for the patient.
3. The patient shall be fully informed in writing in language that the patient can understand, before or at the time of admission and as necessary during the patient's stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. A statement of services that are not normally covered by Medicare or Medicaid shall also be included in this disclosure.
4. The patient shall be fully informed by a health care provider of his or her medical condition, health care needs, and diagnostic test results, including the manner by which such results will be provided and the expected time interval between testing and receiving results, unless medically inadvisable and so documented in the medical record, and shall be given the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment, and to be involved in experimental research upon the patient's written consent only. For the purposes of this paragraph "health care provider" means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing health care services, including, but not limited to, a physician, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist, and any officer, employee, or agent of such provider acting in the course and scope of employment or agency related to or supportive of health care services.
5. The patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for the patient's welfare or that of other patients, if the facility ceases to operate, or for nonpayment for the patient's stay, except as prohibited by Title XVIII or XIX of the Social Security Act.
6. The patient shall be encouraged and assisted throughout the patient's stay to exercise the patient's rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination, or reprisal.
7. The patient shall be permitted to manage the patient's personal financial affairs. If the patient authorizes the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with the patient's rights under this subdivision and in conformance with state law and rules.
8. The patient shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion.
9. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.
10. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records, for a reasonable cost, upon request.
11. The patient shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by the patient, such services may be included in a plan of care and treatment.

SECTION L. Information on Patient Rights

12. The patient shall be free to communicate with, associate with, and meet privately with anyone, including family and resident groups, unless to do so would infringe upon the rights of other patients. The patient may send and receive unopened personal mail. The patient has the right to have regular access to the unmonitored use of a telephone.
13. The patient shall be free to participate in activities of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients.
14. The patient shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients.
15. The patient shall be entitled to privacy for visits and, if married, to share a room with his or her spouse if both are patients in the same facility and where both patients consent, unless it is medically contraindicated and so documented by a physician. The patient has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.
16. The patient shall not be denied appropriate care on the basis of race, religion, color, national origin, sex, age, disability, marital status, sexual preference, or source of payment.
17. The patient shall be entitled to be treated by the patient's physician of choice, subject to reasonable rules and regulations of the facility regarding the facility's credentialing process.
18. The patient shall be entitled to have the patient's parents, if a minor, or spouse, or next of kin, or a personal representative, if an adult, visit the facility, without restriction, if the patient is considered terminally ill by the physician responsible for the patient's care.
19. The patient shall be entitled to receive representatives of approved organizations as provided in RSA 151:28.

If you believe that any of your rights have been violated by a participating provider, you have the right to file a complaint with HPHC or its designee. All complaints must be submitted in writing and addressed to HPHC or one of the regulatory offices listed.

**HPHC Member Services Department
HPHC Insurance Company, Inc.
1600 Crown Colony Drive
Quincy, MA 02169**

Attn: Member Concerns

For Massachusetts Physicians:

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

Massachusetts Department of Public Health
250 Washington Street
Boston, MA 02108-4619
(617) 624-5200

For New Hampshire Physicians:

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

State of New Hampshire Insurance Department
21 South Fruit Street
Suite 14
Concord, NH 03301

For Maine Physicians:

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

Maine Bureau of Insurance
34 State House Street
Augusta, ME 04333

For Vermont Physicians:

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

Director of Consumer Services
89 Main Street
Drawer 20
Montpelier, VT 05620-3101

SECTION M. Member Rights and Responsibilities

- Members have a right to receive information about Harvard Pilgrim, its services, its practitioners and providers, and Members' rights and responsibilities.
- Members have a right to be treated with respect and recognition of their dignity and right to privacy.
- Members have a right to participate with practitioners in decision-making regarding their health care.
- Members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Members have a right to voice complaints or appeals about Harvard Pilgrim or the care provided.
- Members have a right to make recommendations regarding the organization's members' right and responsibilities policies.
- Members have a responsibility to provide, to the extent possible, information that Harvard Pilgrim and its practitioners and providers need in order to care for them.
- Members have a responsibility to follow the plans and instructions for care that they have agreed on with their practitioners.
- Members have a responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

Three-Tier
Prescription Drug Brochure

This brochure is a legal document that explains the prescription drug benefits provided by HPHC Insurance Company, Inc. (the “Plan”) to Members covered through the New Hampshire Healthy Kids plan.

Effective date: 07/01/09

NH Healthy Kids 07/09

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. Your benefit covers most outpatient prescription drugs and some non-prescription drugs and medical supplies.

In this brochure, you'll find information about:

- The Plan's three-tier prescription drug benefit
- Copayments
- Covered and non-covered drugs
- Where to buy your prescriptions
- The 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 of your *Benefit Handbook*.

THREE-TIER PRESCRIPTION DRUG BENEFIT

The Plan places all covered drugs into one of three levels or "tiers." Each tier has its own Copayment amount, which is listed on your Member identification (ID) card. The three tiers are described below.

Tier 1

Tier 1 is primarily made up of generic drugs. These drugs contain the same active ingredients as their brand-name counterparts. Tier 1 may also include brand-name drugs that the Plan has determined to be more effective, less costly or to have fewer side effects than similar medications. You pay the lowest Copayment amount for Tier 1 drugs.

Tier 2

Tier 2 is primarily made up of brand name drugs for which generic equivalents are not available. These drugs have been selected by the Plan based on review of the relative safety, effectiveness and cost of the many brand-name drugs on the market. Tier 2 may also include generic drugs that the Plan has determined to be more costly than their brand name alternatives.

Tier 3

Tier 3 is made up of drugs that the Plan has not included in Tier 1 or Tier 2. You pay the highest Copayment amount for Tier 3 drugs.

Getting a Copy of the Drug List

You can get a copy of the Plan's Three-Tier Prescription Drug List by calling the Member Services Department at **1-888-333-4742**. The list is also available online at **www.harvardpilgrim.org**.
Click Pharmacy Program.

MEMBER COST SHARING

Members are required to share the cost of the benefits provided under the Plan. Your payments, called Cost Sharing, include Copayments.

This section describes how the Plan administers your Copayments. The specific Copayments that apply to your Plan are listed on your Member 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 the Plan has negotiated with participating pharmacies. The Discount Rate is the basis for calculating your Cost Sharing under the Plan.

Note: The Discount Rate is not a fixed discount. The Plan may modify the discount 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 Cost Sharing is always based on the lower amount.

Note: The Plan’s cost for covered drugs is generally lower than the Discount Rate.

Copayments

This Plan provides 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 apply to each of the three drug tiers. Your Copayment amount is 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	Non-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.	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.

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 the Plan. If your physician prescribes less than a 30-day supply of a medication, each Copayment covers the amount prescribed. The Plan may limit the quantity of a drug available per 30-day period or per Copayment.

WHAT IS COVERED

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

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

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, as long as one or more agents within the compound is FDA approved and requires a prescription	<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

Buying Prescriptions

Participating Pharmacies

You should fill prescriptions at a Plan participating pharmacy whenever possible. If you use a participating pharmacy, you only have to show your Plan ID card and pay the applicable cost sharing amounts. 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 45,000 Plan participating pharmacies in the United States, including:

- Brooks Pharmacy
- CVS/pharmacy
- Eckerd
- Kmart Pharmacy
- Rite Aid
- Star Market
- Stop & Shop
- Walgreens
- Wal-Mart
- Many independent drug stores

You can get more information on participating pharmacies by calling our Member Services Department at **1-888-333-4742**. Members may also search for participating pharmacies in any area of the country on our website at www.harvardpilgrim.org. *Click Pharmacy Program.*

The Specialty Pharmacy Program

The Plan has designated pharmacies that you must use to obtain certain specialty medications. These include drugs for the treatment of 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 Specialty Pharmacy Program*). This information may also be obtained by calling our Member Services Department at **1-888-333-4742**.

The Plan's 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 in the administration of the drugs they provide. Additional drugs may be added to the specialty pharmacy program from time to time.

Your Cost Sharing at the specialty pharmacies is the same as at other participating pharmacies. (Please see page P3 for a description of Member Cost Sharing.) The specialty pharmacies are not part of the Plan's Mail Order Prescription Drug Program, to which different Cost Sharing rules may apply.

Non-Participating Pharmacies

No benefits are provided for prescriptions obtained at a non-participating pharmacy, except in the event of unforeseen illness or injury.

If you fill a prescription for a covered drug at a non-participating pharmacy, you must pay the retail price for the drug, and then submit a claim for reimbursement from the Plan. The reimbursement procedures for pharmacy items are explained in your *Benefit Handbook*. Reimbursement for drugs purchased at non-participating pharmacies will be paid minus the Copayment. Payment will be limited to the Usual, Customary and Reasonable Charge for the drug.

Mail Service Prescription Drug Program

The Plan provides 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, there may be lower Copayments for drugs purchased through the Plan's Mail Service Program.

Although most maintenance medications are available from the Mail Service Program, the Plan 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 Copayments. The Mail Service Copayments listed on your ID card apply only to the Plan's 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 either not covered by the Plan or for which coverage is limited. The Plan covers 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.)

The Plan also limits the coverage of specific drugs for reasons of cost and to assure their safe and effective use. Limitations may be placed on either the quantity of a drug covered or the medical conditions for which a covered drug may be prescribed.

Drugs that are excluded, limited, or require prior authorization are listed in the Plan's Three-Tier Prescription Drug List. You may request a copy of this list by calling the Member Services Department at 1-888-333-4742 or view it online at www.harvardpilgrim.org. **Click Pharmacy Program.**

Non-Covered or Limited Coverage Prescription Drugs

The Plan does not cover the following:

- Drugs that are not Medically Necessary for preventive care or for treating illness, injury or pregnancy.
- Drugs that the Plan specifically excludes, 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 either the quantity of a drug covered or the medical conditions for which a drug may be prescribed.)
- Non-prescription items, other than those specifically listed above.
- Drugs that have not been approved by the FDA.
- Drugs prescribed as part of a course of treatment that the Plan does not cover.
- Drugs that must be administered by a health care professional. (Such drugs may be covered through the provider but may not be purchased by you under the pharmacy benefit.)
- Drugs that must be obtained through the Specialty Pharmacy Program if not purchased from one of the program's specially designated pharmacies. The Specialty Pharmacy Program is described on page P5.
- No benefits are provided for medications prescribed by providers who are not authorized to do so by the Plan 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.

Exception Policy

The Plan may require prior authorization for coverage of certain drugs. The Plan 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 Plan's Provider Service Center at **1-800-708-4414**. The Plan will act on any such request within 48 hours of receiving the clinical rationale for the exception.

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

ABOUT YOUR DRUG BENEFIT

Pharmacy and Therapeutics Committee

The Plan's Pharmacy and Therapeutics Committee is an advisory group that makes recommendations for the placement of drugs in the different tiers, as well as setting exclusions and limitations on drug coverage. The Committee is made up of physicians and pharmacists, who are advised by physician consultants from a large number of medical specialties.

Tier Changes

The Plan regularly reviews and updates the Three-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. You can get an updated Three-Tier Drug List by calling the Member Services Department at **1-888-333-4742** or view it online at www.harvardpilgrim.org. *Click Pharmacy Program.*

Deletions from Coverage

On occasion the Plan may discontinue coverage for a drug or other product covered under this Brochure. In such event, the Plan 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 45 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 *Schedule of Benefits* for information on your coverage.

APPENDIX A. NH Insurance Forms



New Hampshire Insurance Department

REQUEST FOR INDEPENDENT EXTERNAL APPEAL OF A HEALTH CARE DECISION

ENROLLEE INFORMATION

Enrollee's Name: _____ Patient's Name: _____
Mailing Address: _____
Phone Number: Daytime (_____) _____ Evening (_____) _____
Enrollee's Insurance ID #: _____ Insurance Claim/Reference #: _____

INFORMATION ABOUT YOUR EMPLOYER

Employer's Name: _____
Employer's Phone Number: _____
Is the insurance you have through your employer a self-funded plan? _____ If you are not certain please check with your employer. These types of plans are not eligible for external review.

INFORMATION ABOUT YOUR MANAGED CARE INSURANCE COVERAGE

Health Insurance Company's Name: _____
Insurer Mailing Address: _____
Insurer Telephone Number: (_____) _____
Person at Health Insurance Company Involved with Your Appeal: _____

INFORMATION ABOUT YOUR TREATING HEALTH CARE PROVIDER

Name of Health Care Provider: _____
Type of Provider: Medical Doctor Other (please specify): _____
Provider Mailing Address: _____
Provider Phone Number: (_____) _____

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

(Fill out this section only if someone else will be representing you in this appeal.)

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your personal representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

Signature of Enrollee (or legal representative)*

Date

*(Parent, Guardian, Conservator, or Other – Please Specify)

Address of Authorized Representative: _____

Phone Number: Daytime (_____) _____ Evening (_____) _____

REQUEST FOR A TELEPHONE CONFERENCE

(Fill out this section only if you would like to request a telephone conference.)

If you, your representative or your treating health care provider would like to discuss your case with the independent review organization and your insurer in a telephone conference, check the box below and explain why you think it is important to be allowed to speak about your case. If you do not request a telephone conference, the reviewer will base its decision on the written information only. Your request for a telephone conference will be granted only if there is a good reason why the written information would not be sufficient.

Yes, I want a phone conference. My reason for requesting a phone conference is that _____

HEALTH CARE DECISION IN DISPUTE

Describe your health insurer’s decision in your own words. Include any information you have about the health care services, supplies or drugs being denied, including dates and names of health care providers. Explain why you disagree with the insurer. Attach additional pages if necessary. Also attach pertinent medical records and (if possible) a statement from your treating health care provider indicating why the disputed service, supply, or drug is medically necessary.

EXPEDITED REVIEW

You may request that your external appeal be handled on an expedited basis. To complete this request, your treating health care provider must fill out the attached form stating that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

Is this a request for an expedited appeal? Yes _____ No _____

REQUEST FOR EXTERNAL REVIEW AND RELEASE OF MEDICAL RECORDS

I, _____, hereby request an external appeal and authorize my insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization and the New Hampshire Insurance Department. I understand that the independent review organization and the Insurance Department will use this information to make a determination on my appeal and that the information will be kept confidential and not be released to anyone else. I understand that neither the Commissioner nor the external appeal entity may authorize services in excess of those covered by my health care plan. This release is valid for one year.

Signature of Enrollee (or legal representative)*
*(Parent, Guardian, Conservator, or Other – Please Specify)

Date

WHAT TO SEND AND WHERE TO SEND IT

- This completed application form signed and dated (see section above).
- A copy of the letter from your health insurer denying your request at the second and final level of their internal appeals process.
- A photocopy of your insurance card or other evidence that you are insured by the health insurance company named in this application.
- A copy of your certificate of coverage or your insurance policy benefit booklet, which lists your benefits.
- Any medical records, statements from your treating health care providers or other information that you would like the independent review organization to consider in reviewing your case.

Call the Insurance Department at 800-852-3416 or 271-2261 if you need help with this application or if you do not have one or more of the above items and would like information on alternative ways to complete your request for independent external review.

If you are requesting a standard review, send all paperwork to:

Independent External Review
New Hampshire Insurance Department
21 South Fruit Street
Suite 14
Concord, NH 03301-7317

If you are requesting an expedited review, call the Insurance Department before sending your paperwork, and you will receive instructions on the quickest way to submit the application and supporting information.



New Hampshire Insurance Department

CERTIFICATION OF TREATING HEALTH CARE PROVIDER
FOR EXPEDITED CONSIDERATION OF A PATIENT'S EXTERNAL APPEAL

NOTE TO THE TREATING HEALTH CARE PROVIDER:

Patients can request an independent external appeal when a managed care insurer has denied a health care service, supply or drug on the basis of a utilization review determination that the requested service, supply or drug does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness. The New Hampshire Insurance Department oversees external appeals. The standard process for handling external review can take up to 52 days. Expedited review is available only if the patient's treating health care provider certifies that adherence to the time frame for standard review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. Expedited review must be completed in at most 72 hours. This form is for the purpose of providing the certification necessary to trigger expedited review.

GENERAL INFORMATION:

Name of Treating Health Care Provider: _____

Mailing Address: _____

Phone Number: (____) _____ Fax Number: (____) _____

Licensure and Area of Clinical Specialty: _____

Name of Patient: _____

Patient's Health Insurer Member ID #: _____

CERTIFICATION:

I hereby certify that: I am a treating health care provider for _____ (hereafter referred to as "the patient"); that adherence to the time frame for conducting a standard review of the patient's external appeal would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function; and that, for this reason, the patient's appeal of the denial by the patient's health insurer of requested medical services should be processed on an expedited basis.

Treating Health Care Provider's Name (Please Print)

Signature

Date

HPHC INSURANCE COMPANY, INC.

1600 Crown Colony Drive
Quincy, MA 02169

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