NHP Prime HMO Plan for GIC Members

Commonwealth of Massachusetts
Group Insurance Commission

Neighborhood Health Plan
Group Insurance Commission
Member Handbook

Issued June 1, 2017 and effective July 1, 2017

nhp.org

Neighborhood Health Plan™

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Welcome to Neighborhood Health Plan

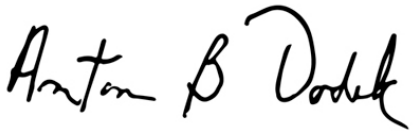
Neighborhood Health Plan (NHP) is a not-for-profit Health Maintenance Organization (HMO) based in Massachusetts. We are pleased to have you as a Member, and look forward to working with you and your Primary Care Provider (PCP) to keep you healthy.

Any time you need assistance understanding your NHP Benefits or membership, call NHP's GIC Customer Service at 1-866-567-9175 (TTY 711). Our hours of operation are 8:00 a.m. to 6:00 p.m., Monday through Friday, and Thursday from 8:00 a.m. to 8:00 p.m.

This handbook contains important information about your NHP Benefits. It also contains some technical terms you may be unfamiliar with. If you need help understanding this handbook, NHP's GIC Customer Service Representatives are available to help you. NHP also provides Members with free translation services.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see "Section 14. Notices" for more details.

David Segal
President and Chief Executive Officer



Anton Dodek, MD
Chief Medical Officer

NHP Translation Services

English

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available you. Call 1-800-462-5449 (TTY: 711).

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al. 1-800-462-5449 (TTY: 711).

Português (Portuguese)

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.
Ligue para 1-800-462-5449 (TTY: 711).

Italiano (Italian)

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti.
Chiamare il numero 1-800-462-5449 (TTY: 711).

Kreyòl Ayisyen (Haitian/French Creole)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou.
Rele 1-800-462-5449 (TTY: 711).

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-462-5449 (TTY: 711)。

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-800-462-5449 (TTY: 711).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-800-462-5449 (TTY: 711).

ខ្មែរ (Khmer/Cambodian)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-462-5449 (TTY: 711).

ພາສາລາວ (Laotian)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-462-5449 (TTY: 711).

Ελληνικά (Greek)

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-462-5449 (TTY: 711).

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-462-5449 (رقم هاتف الصم والبكم:711).

Français (French)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-462-5449 (ATS : 711).

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-462-5449 (TTY: 711).

Polski (Polish)

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-462-5449 (TTY: 711).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-462-5449 (TTY: 711) 번으로 전화해 주십시오.

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-462-5449 (TTY: 711) पर कॉल करें।

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Your NHP Prime HMO Schedule of Benefits

The following is a Schedule of Benefits available to you. This list is only a general description of your coverage as a member of NHP. For more information about your benefits, read the complete text found in the section 7 called "Your NHP Covered Health Care Services," which describes each Member's Coverage in more detail and provides important information about requirements for, and any limits of, Coverage. These Benefits are covered when Medically Necessary, authorized by NHP, ordered by your Primary Care Provider (PCP), and provided by an NHP Network Provider. Before Coverage begins for certain services, you pay a Copayment and/or a Deductible each benefit period.

The NHP Prime HMO plan for GIC includes a Deductible. Once the Deductible is satisfied, you no longer need to pay a Deductible for any service through the remainder of the benefit period.

Effective 7/1/2017 through 6/30/2018, your medical deductible is $500 for an Individual policy and $1,000 for a Family policy. Your pharmacy deductible is $100 for an Individual policy and $200 for a Family policy.

Your Out-of-Pocket Maximum from 7/1/2017 through 6/30/2018 will be $5,000 for an Individual policy and $10,000 for a Family policy.

For some services you are first required to pay a Copayment and then the Deductible before coverage begins. For example: Outpatient Surgery requires a Copayment of $250 per Surgery and then the Deductible applies. Inpatient Hospital admissions require a Copayment of $275 and then the Deductible applies. All Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum. A maximum of one Inpatient Copayment per quarter and a maximum of four Outpatient Surgical Copayments apply per benefit period.

In addition, the Inpatient Hospital Copayment will be waived for re-admission to a hospital for any reason if the re-admission occurs within 30 days of release from a hospital (waiver is not automatic and depends on your notifying NHP of the re-admission). Members should keep receipts for all visits and Copayments. Contact NHP's GIC Customer Service at 1-866-567-9175 (TTY 711) about reimbursement if Copayments were made after the maximum was reached.

Specialty Providers are assigned to different Copayment "Tiers." For an explanation of Provider Tiering, please see "Section 3. Your NHP Providers" or "Section 17. Glossary."

Coverage/Benefit	Copayments
Medical Deductible per benefit period	**$500 Individual, $1,000 Family**
Prescription Drug Deductible per benefit period	**$100 Individual, $200 Family**
Out-of-Pocket Maximum per benefit period	**$5,000 Individual/$10,000 Family**

The Deductible, Coinsurance, and Copayments for Medical, Behavioral Health Services, and Prescription Drug expenses apply to the annual Out-of-Pocket Maximum.

OUTPATIENT MEDICAL CARE

Preventive Services

Annual Gynecological Exams*	No Member Cost-Sharing
Family Planning*	No Member Cost-Sharing
Annual Physical Exams	No Member Cost-Sharing
Immunizations & Vaccinations	No Member Cost-Sharing
Preventive Laboratory Tests	No Member Cost-Sharing
Screening Colonoscopy	No Member Cost-Sharing
Screening Mammography	No Member Cost-Sharing
Well Child Visits	No Member Cost-Sharing

*Services for specific conditions during an annual exam may be subject to cost sharing.

OTHER PRIMARY & SPECIALTY CARE OFFICE VISITS COPAYMENTS

(Some specialty copayments are tiered: Tier 1 l Tier 2 l Tier 3)	***Tier 1 l Tier 2 l Tier 3***
Office Visits for Other Primary Care	$20 copayment
Allergy/Immunology	$30 l $60 l $90
Cardiology	$30 l $60 l $90
Dermatology	$30 l $60 l $90
Endocrinology	$30 l $60 l $90
ENT/Otolaryngology	$30 l $60 l $90
Gastroenterology	$30 l $60 l $90
General Surgery	$30 l $60 l $90
Hematology & Oncology	$30 l $60 l $90
Nephrology	$30 l $60 l $90
Neurology	$30 l $60 l $90
OB/GYN	$30 l $60 l $90
Ophthalmology	$30 l $60 l $90
Orthopedic Surgery	$30 l $60 l $90
Podiatry	$30 l $60 l $90
Pulmonology	$30 l $60 l $90
Rheumatology	$30 l $60 l $90
Urology	$30 l $60 l $90
Office Visits for all other Specialty Care	$60 copayment
Allergy Shots	No Member Cost-Sharing
Cardiac Rehabilitation Services	No Member Cost-Sharing
Routine Eye Exams (one visit per member every 24 months)	$60 copayment
Hearing Exams	$60 copayment
Infertility Services	$60 copayment
Physical Therapy/Occupational Therapy (up to 90 consecutive days per condition)	$35 copayment
Second Opinion (PCP)	$20 copayment
Second Opinion (Tiered specialist)	$30 l $60 l $90
Second Opinion (Non-Tiered specialist)	$60 copayment
Speech Therapy	$35 copayment
Routine Prenatal and Postnatal Care (OB/GYN)	No Member Cost-Sharing

OTHER OUTPATIENT SERVICES

Diagnostic, Laboratory and X-ray	Subject to deductible
High-tech Radiology (MRI, CT, PET Scan, Nuclear Cardiac Imaging)	$100 copayment, then subject to deductible (maximum of one copayment per day)
Outpatient Surgery—Facility Fee	$250 copayment, then subject to deductible*
Outpatient Surgery—Professional Fee	No Member Cost-Sharing

INPATIENT MEDICAL CARE

Inpatient Medical Services—Facility Fee	$275 copayment, then subject to deductible*
Inpatient Medical Services—Professional	No Member Cost-Sharing
Inpatient Care in a Skilled Nursing Facility (for up to 100 days per benefit period)	Subject to deductible
Inpatient Care in a Skilled Nursing Facility—Professional Fee	Subject to deductible
Inpatient Care in a Rehabilitation Facility (for up to 60 days per benefit period)	$275 copayment, then subject to deductible*
Inpatient Care in a Rehabilitation Facility—Professional Fee	Subject to deductible
Inpatient Maternity—Facility Fee	$275 copayment, then subject to deductible*
Inpatient Maternity—Professional Fee	No Member Cost-Sharing
Routine Nursery and Newborn Care	No Member Cost-Sharing

*Per admission/occurrence with a cap of four copayments per benefit period, with a maximum of one inpatient copayment per quarter. Inpatient copayment will be waived for readmission to a hospital for any reason if the readmission occurs within 30 days of release from a

hospital; you must contact NHP to have the copayment waived.

BEHAVIORAL HEALTH SERVICES—OUTPATIENT

Mental Health or Substance Use Care . . . . . $20 copayment

BEHAVIORAL HEALTH SERVICES—INPATIENT

Mental Health Care—Facility Fee. . . . . No Member Cost-Sharing
Mental Health Care – Professional Fee . . . . . No Member Cost-Sharing
Substance Use Detoxification or Rehabilitation—Facility Fee . . . . . No Member Cost-Sharing
Substance Use Detoxification or Rehabilitation—Professional Fee . . . . . No Member Cost-Sharing

URGENT CARE

Care for an illness, injury or condition serious enough that a person would seek immediate care, but not so severe as to require Emergency room care.

Urgent Care . . . . . $20 copayment

EMERGENCY CARE

In an emergency, go to the nearest emergency room or call 911. When admitted to a hospital for emergency care, you or a family member should notify your PCP within 48 hours.

Care you receive in an emergency room, in or out of NHP Service Area . . . . . $100 copayment,then subject to deductible (copayment waived if admitted to hospital for inpatient care)
Ambulance Services (Emergency transport only). . . . . Subject to deductible
Emergency Dental Care (within 72 hours of accident or injury) . . . . . $100 copayment, then subject to deductible (copayment waived if admitted to hospital for inpatient care)

PRESCRIPTION DRUGS

With a valid prescription and purchased at a participating pharmacy for up to a 30-day supply:

- Generic:. . . . . Subject to prescription deductible, then $10 copayment
- Preferred brand-name: . . . . . Subject to prescription deductible, then $30 copayment
- Non-preferred brand-name:. . . . . Subject to prescription deductible, then $65 copayment

Access90: With a valid prescription for a 90-day supply of a maintenance medication and purchased through the mail or at a participating pharmacy:

- Generic:. . . . . Subject to prescription deductible, then $25 copayment
- Preferred brand-name: . . . . . Subject to prescription deductible, then $75 copayment
- Non-preferred brand-name: . . . . . Subject to prescription deductible, then $165 copayment

OVER-THE-COUNTER DRUGS

For a complete list of over-the-counter drugs, visit www.nhp.org or call NHP Customer Service at 866-567-9175 (TTY 711).
Select generic over-the-counter medicines and products with a valid prescription and purchased at a participating pharmacy.
. . . . . $0– Subject to prescription deductible, then $30 copayment (depending on drug prescribed)

ADDITIONAL SERVICES

Diabetic Supplies	No Member Cost-Sharing
Dialysis (inpatient or outpatient)	No Member Cost-Sharing
Disposable Medical Supplies	Subject to deductible
Durable Medical Equipment	Subject to deductible
Early Intervention (from birth up to age three)	No Member Cost-Sharing
Fitness Program Reimbursement	Up to $150/Individual, $300/Family per calendar year
Hearing Aids (age 21 and under)	Covered up to $2,000 for each affected ear every 36 months
Hearing Aids (age 22 and older)	Covered up to $1700 every 2 years
Home Health Care	No Member Cost-Sharing
Hospice Care	No Member Cost-Sharing
Orthotics	Subject to deductible
Oxygen Supplies and Therapy	No Member Cost-Sharing
Prosthetic Devices	Subject to deductible
Radiation and Chemotherapy	No Member Cost-Sharing
Routine Foot Care (covered for diabetes and some circulatory diseases)	$60 copayment
Tobacco Cessation (up to 300 minutes of counseling per benefit period, including telephonic counseling)	No Member Cost-Sharing
Wigs (when medically necessary for hair loss due to cancer treatment or other conditions)	Subject to deductible

Section 1.

Your NHP Evidence of Coverage (EOC)

Your Neighborhood Health Plan (NHP) *Member Handbook* and Schedule of Benefits represent your complete NHP Evidence of Coverage (EOC). Once you have enrolled, NHP will send you, as the Subscriber, an EOC.

If NHP changes any:

- Covered Health Care Service
- Your financial obligations for coverage
- Makes any material change to your EOC

We will send you notice at least 60 days before the change. Unless the law requires it, such changes will be made only when the GIC agrees.

NHP will do this by sending you an amendment to your EOC and ask that you keep it with this *Member Handbook.*

Words with Special Meaning

Some words in this *Member Handbook* have special meaning. These words will start with upper case letters, and are defined in the glossary at the end of the *Handbook*. In this *Member Handbook*, the word "you" means "Members of NHP."

The NHP GIC Provider Directory

NHP makes a Provider Directory available to new Members when they enroll. NHP also provides a directory to prospective or current Members upon request. The NHP GIC Provider Directory lists NHP Network:

- Primary Care Sites
- Primary Care Providers
- Hospitals
- NHP-affiliated Specialists
- Mental Health and Substance Use Care Providers in the NHP Network

To ask for a copy of the Provider Directory, call NHP's GIC Customer Service at 1-866-567-9175 (TTY 711). You may also visit our website at www.nhp.org for the most up-to-date listing of Providers in your plan.

Information about NHP Providers

More information about physicians, Nurse Practitioners and Physician Assistants licensed to practice in Massachusetts is available from the Board of Registration in Medicine. Visit www.massmedboard.org to find information on your Provider's education, hospital affiliations, board certification status and more. You can find information about Nurse Practitioners at the Massachusetts Division of Health Professions Licensure website located at www.mass.gov and information about Physician Assistants at www.mass.gov/eohhs/Provider.

The following websites also provide useful information in selecting quality health care Providers:

- **Leapfrog:** www.leapfroggroup.org—For information on health care quality, so you can compare hospitals)
- **Massachusetts Quality health partners**—To learn how different medical groups treat the same type of illness, which allows you to make comparisons.
- **Joint Commission for the Accreditation of Healthcare Organizations (JCAHO):** www.qualitycheck.org—For information that allows you to compare quality of care at many hospitals, homecare agencies, laboratories, nursing homes, and Behavioral Health programs.

For information about NHP you may contact the Office of Patient Protection (OPP) at any time by phone at 1-800-436-7757, by fax at 1-617-624-5046, or online at www.mass.gov/hpc/opp.

The following information is available to you from the OPP:

- A list of sources of independently-published information rating insurance plan members' satisfaction about the quality of Covered Health Care Services offered by NHP
- The percentage of physicians who voluntarily and involuntarily ended contracts with NHP during the last calendar year, plus the three most common reasons why they left
- The medical loss ratio, which is percentage of premium revenue spent by NHP for health care services provided to members for the most recent year for which information is available
- A report detailing, for the previous calendar year, the total number of filed grievances , the type of medical or behavioral health treatment at issue where applicable, the number of grievances that

were approved internally, the number of grievances that were denied internally, and the number of grievances that were withdrawn before resolution;

- The number of grievances which resulted from an adverse determination, the type of medical or behavioral health treatment at issue, and the outcomes of those grievances;
- The percentage of members who filed internal grievances with NHP;
- The total number of internal grievances that were reconsidered, the number of reconsidered grievances that were approved internally, the number of reconsidered grievances that were denied internally, and the number of reconsidered grievances that were withdrawn before resolution; and
- The total number of external reviews pursued after exhausting the internal Grievance process and the resolution of all such external reviews.

NHP's Member Portal

Visit nhp.org and log into your own secure, Member portal called mynhp.org. Mynhp.org has everything you need to manage your plan 24 hours a day, 7 days a week. You can:

- Access your Benefits, coverage, and out of pocket costs
- Select or change your Primary Care Provider
- Manage your pharmacy Benefits
- Order or print a temporary ID card
- Estimate the cost of services
- Shop, compare and earn incentives

Visit nhp.org/member to register and log in to mynhp.

NHP's GIC Customer Service

Whenever you have a question or concern about your NHP membership or Benefits, our highly trained Customer Service Representatives are available to help you.

Just call 866-567-9175 (TTY 711) and a representative will assist you. Our hours of operation are 8:00 a.m. to 6:00 p.m., Monday through Friday, and Thursday from 8:00 a.m. to 8:00 p.m.

Section 2.

Eligibility and Enrollment

Enrollment

There is no pre-existing condition limitation or exclusion under your plan with NHP. NHP does not use the results of genetic testing in making any decisions about Enrollment, renewal, payment or coverage of health care services nor does NHP consider any history of domestic abuse or actual or suspected exposure to diethylstilbestrol (DES) in making such decisions. NHP will accept you into our plan regardless of your income status, source of income, physical or mental condition, age, expected length of life, gender, gender identity, sexual orientation, religion, creed, ethnicity or race, color, physical or mental disability, personal appearance, national origin, English proficiency, ancestry, marital status, veteran's status, occupation, political affiliation, Claims experience, duration of medical coverage, pre-existing conditions, actual or expected health status, need for Health Care Services, ultimate payer for services or your expected health status as a Member. For questions concerning a waiting period before you can become enrolled with NHP, please see the GIC's Human Resources Department.

Upon receipt of your completed enrollment, NHP will mail you a Member ID Card which you should use to access Covered Services from NHP's In-network Providers. NHP is not responsible for any services you receive prior to your Effective Date of Enrollment with NHP.

Your NHP Member Identification Card

NHP will mail you a permanent NHP Member Identification Card (NHP Member ID Card) within ten business days following receipt of a complete and accurate Enrollment. Your NHP Member ID Card has important information about you and your Benefits. It also informs Providers and pharmacists that you are a Member of NHP and how much your Copay for services should be. Additional cost-sharing may apply and may not be reflected on your ID card. Your EOC will show your cost-sharing amounts due for services. Be sure to show your NHP Member ID Card whenever you get health care or fill a prescription. Always carry your Member ID card with you so it will be handy when you need care.

Please read your card carefully to make sure all the information is correct. If you have questions or concerns about your NHP Member ID Card, or if you lose it, call NHP's GIC Customer Service at 866-567-9175 (TTY 711). Do not allow anyone else to use your NHP Member ID Card for any purpose, including obtaining Health Care Services.

The NHP Service Area

As an Eligible Individual, you may enroll in NHP if you reside within the NHP Service Area. NHP's Service Area includes most communities in Massachusetts:

- Barnstable
- Bristol
- Dukes
- Essex
- Hampden
- Middlesex
- Nantucket
- Norfolk
- Plymouth
- Suffolk
- Worcester

Eligibility

To enroll and get health coverage from NHP, a person must meet all eligibility requirements that apply. See the next section for the list of requirements.

Individuals must satisfy any eligibility requirements of the Group Insurance Commission (GIC). The GIC requires the Subscriber to give proof, satisfying to the GIC, on any family Member's eligibility, such as a marriage certificate, birth certificate, court order for support, or a divorce decree.

Subscriber Eligibility

To be eligible to enroll as a Subscriber, a person must:

- Be an employee of the Commonwealth of Massachusetts, certain Municipalities or other entities that participate with the GIC and is entitled on his or her own (and not as a Dependent) to receive Coverage under the Group Insurance Commission's health Benefit plan, or
- Be a retiree of the Commonwealth of Massachusetts, certain Municipalities or other entities that participate with the GIC and is entitled on his or her own (and not as a Dependent) to receive Coverage under the Group Insurance Commission's health Benefit plan and not be enrolled in Medicare.

- To be a Subscriber to NHP, you must be an employee or retiree as indicated above, in accordance with eligibility guidelines approved by the GIC and NHP. This includes GIC's up-to-date payment of applicable Premium for Coverage.
- To be eligible for Coverage by NHP, you must live, and have a permanent residence in certain areas of Massachusetts (see NHP Service Area in the glossary section of this handbook), at least nine months of a year. This requirement does not apply to a Dependent Child who is enrolled as a full-time student attending an accredited school. Coverage will begin for a new employee on the first day of the month following 60 days of employment or two calendar months, whichever is less. Employees who do not choose to join a health plan when first eligible must wait until the next annual Enrollment period to join. If you declined coverage when you were first eligible, you may be able to enroll outside of the annual Enrollment period if you apply to the GIC with proof of a qualifying status change event.

Eligibility Rules for Dependents

To be eligible to enroll as a Dependent, a person must be:

- The employee or retiree's spouse or surviving spouse (until remarriage) or a divorced spouse who is eligible for Dependent Coverage pursuant to Massachusetts General Laws Chapter 32A, as amended; or
- The former spouse of the Subscriber, until the Subscriber or the former spouse remarries or until such time as may be specified in the divorce judgment consistent with state law, whichever occurs first; or
- A child of the employee or the employee's spouse, by birth, legal adoption (including a child for whom legal adoption proceedings have been initiated), under custody pursuant to a court order, or under legal guardianship, until age twenty-six (26) in accordance with the Patient Protection and Affordable Care Act; or
- A child who depends upon the employee, retiree or surviving spouse for support, lives within the NHP Service Area with such an employee, retiree or surviving spouse, and where there is evidence of a parent-child relationship satisfactory to the Group Insurance Commission until age twenty-six (26); or
- A physically or mentally disabled child age twenty-six (26) and older who was incapable of earning his/her own living (self-support) before his/her 19th birthday, as determined by the Group Insurance Commission; or
- Orphan coverage is also available for some surviving dependents.

If you have questions about coverage for someone whose relationship is not listed above, please contact the GIC.

Handicapped Dependents

A dependent child who is mentally or physically incapable of earning his or her own living and who is enrolled under the subscriber's plan will continue to be covered after he or she would otherwise lose dependent eligibility, so long as the child continues to be mentally or physically incapable of earning his or her own living.

Dependents that, at age 26, are mentally or physically incapable of earning their own living may be eligible for handicapped dependent coverage, if the onset of disability occurred before their 19th birthday. Please contact GIC and submit GIC's Handicapped Dependent Coverage application to apply for this coverage.

Residence

To be eligible for NHP Membership, all Subscribers and their Dependents must reside at least nine months of each year within the NHP Service Area. NHP's Service Area covers most Massachusetts counties, cities and towns; see "NHP Service Area" in this section of this handbook. Service Areas and Provider Networks can change, so it is important that you check that Providers in your area are part of the NHP Provider Network.

Effective Date and Enrollment Requirements

Persons who meet the requirements of the section titled "Eligibility and Enrollment" and subsections titled "Subscriber Eligibility," "Eligibility Rules for Dependents," "Handicapped Dependents," and/or "Residence" may enroll in NHP. To enroll, active employees should submit an Enrollment application to their GIC Coordinator, and retirees should contact the GIC. The GIC determines the Effective Date of coverage.

At the time of Enrollment, each Member will need to choose an NHP PCP to whom he or she must go for primary care. Members of a family may each choose a different NHP PCP for their care. Each Member chooses a PCP who provides or arranges for a

Member's Covered Services. If you do not choose a PCP when enrolling in the plan, NHP may assign one for you. You can change your PCP by calling NHP's GIC Customer Service.

Effective Date

Coverage under the plan starts as follows:

For new employees: New employee coverage begins on the first day of the month following 60 calendar days from the first date of employment, or two calendar months, whichever comes first.

For persons applying during an annual enrollment period: Coverage begins each year on July 1.

For spouses and dependents: Coverage begins the later of:

1. The date your own coverage begins, or
2. The date that the GIC has determined your spouse or dependent is eligible

Individuals may be eligible to enroll in NHP throughout the year with certain qualifying status change events if:

1. The employee's spouse or eligible Dependent involuntarily lost other insurance.
2. The employee marries.
3. The employee has a newborn or adopts a child.

Enrollment deadlines and Effective Date of coverage will be determined by the GIC.

New Dependents

You must enroll dependents when they become eligible. Newborns (including grandchildren, if they are eligible dependents of your covered dependents) must be enrolled within 60 days of birth and adopted children within 60 days of placement in the home. Spouses must be enrolled within 60 days of marriage.

You must complete an enrollment form to enroll or add dependents. Additional documentation may be required as follows:

- **Newborns:** copy of hospital announcement letter or the child's certified birth certificate
- **Adopted children:** photocopy of proof of placement letter or adoption
- **Foster children ages 19-26:** photocopy of proof of placement letter or court order
- **Spouses:** copy of certified marriage certificate

New Dependents of a Subscriber with Individual Coverage, including newborn children, will be covered as Dependents only if the Subscriber obtains Family Coverage within 60 days of the date dependency is established and applies for and has been approved for Family Coverage. To apply for Family Coverage, active employees should contact their GIC Coordinator, and retirees should contact the GIC directly.

Existing Family Members

Eligible family Members may be added as Dependents when the Subscriber changes from Individual to Family Coverage if application is made to the GIC within 60 days of a qualifying status change event.

Adoptive Dependents

A legally adopted child under the age of twenty-six (26) can enroll within 60 days from the date the child is physically placed in the custody of the home of the Subscriber for the purpose of adoption; or if the child resided previously in the Subscriber's home as a foster child, from the date of the filing of the petition to adopt.

Enrollment While Hospitalized

If a covered person is in the hospital on the date that his or her coverage takes effect, coverage shall be provided by the Plan as of that date. The covered person, if physically capable, must notify the Plan within 48 hours of the date his or her Coverage takes effect. Following notification, he or she must comply with the Plan's instructions for further care.

Status Changes

It is your responsibility to notify the Group Insurance Commission about any changes that may affect you or your dependents' eligibility for coverage, such as:

- An addition to the family
- The marriage of a Dependent
- Death of a dependent
- Change in marital status

To make status changes, please contact your GIC Coordinator at your work site or, if you are retired, please contact the GIC.

Disenrollment

Voluntary Termination by the Subscriber

You may end your NHP Membership with the GIC's approval.

Termination for Loss of Eligibility

NHP may end or refuse to renew a Member's Coverage for failing to meet any of the eligibility requirements. The NHP Subscriber will be notified in writing if Coverage ends for loss of eligibility. You may be eligible for continued coverage under federal or state law, if your Membership is terminated. See "Continuation of Employer Group Coverage" for more information.

Please note that NHP may not have current information concerning Membership status. The GIC may notify NHP of Enrollment changes retroactively. As a result, the information we have may not be current—only the GIC can confirm Membership status.

Membership Termination for Cause
NHP may terminate or refuse to renew a Member's coverage only for the following reasons:

- The failure by the Member or other responsible party to make payments required under the contract.
- Making an intentional misrepresentation of a material fact or performing an act, practice, or omission that constitutes fraud.
- Acts of physical or verbal abuse by a Member that poses a threat to Providers, staff at Providers' offices, or other Members and are unrelated to the Member's physical or mental condition.
- Relocation of an individual to outside NHP's designated Service Area.
- Non-renewal or cancellation of the group contract through which an eligible subscriber receives coverage.

Termination of Membership for intentional misrepresentation of fraud will be made retroactive to the date of the misrepresentation, act, practice, or omission. You will be provided with written notification 30 days in advance of the retroactive termination taking place.

Your coverage ends on the earliest of:

1. The end of the month covered by your last contribution toward the cost of coverage
2. The end of the month in which you cease to be eligible for coverage
3. The date of death
4. The date the surviving spouse remarries, or
5. The date the plan terminates

A dependent's coverage ends on the earliest of:

1. The date your coverage under the plan ends
2. The end of the month covered by your last contribution toward the cost of coverage
3. The date you become ineligible to have a spouse or dependents covered
4. The end of the month in which the dependent ceases to qualify as a dependent
5. The date the dependent child, who was permanently and totally disabled by age 19, marries
6. The date the covered divorced spouse remarries (or the date the enrollee marries)
7. The date of the spouse or dependent's death, or
8. The date the plan terminates

Continuation of Employer Group Coverage Required by Law

Contact the GIC for more information if Membership ends due to:

- Loss of dependency due to age
- Loss of employment or reduction of work hours

If you lose Group coverage you may be eligible to continue group Coverage under the federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Divorce or Legal Separation

Your former spouse will not cease to qualify as a dependent under the plan solely because a judgment of divorce or separate support is granted. (For the purposes of this provision, "judgment" means only a judgment of absolute divorce or of separate support.) Massachusetts law presumes that he or she continues to qualify as a dependent, unless the divorce judgment states otherwise.

If you get divorced, you must notify the GIC within 60 days and send the GIC a copy of the following sections of your divorce decree: Divorce Absolute Date, Signature Page, and Health Insurance Provisions.

If you or your former spouse remarries, you must also notify the GIC. If you fail to report a divorce or remarriage, the Plan and the GIC have the right to seek recovery of health claims paid or premiums owed for your former spouse.

Under M.G.L. Ch. 32A as amended and the GIC's regulations, your former spouse will no longer qualify as a dependent after the earliest of these dates:

1. The end of the period in which the judgment states he or she must remain eligible for coverage
2. The end of the month covered by the last contribution toward the cost of the coverage
3. The date he or she remarries
4. The date you remarry. If your former spouse is covered as a dependent on your remarriage date, and the divorce judgment gives him or her the right to continue coverage, coverage will be available at full premium cost (as determined by the GIC) under a divorced spouse rider. Alternatively, your former spouse may enroll in COBRA coverage.

Group Health Continuation Coverage Under COBRA General Notice

This notice explains your COBRA rights and what you need to do to protect your right to receive it. You will receive a COBRA notice and application if the Group Insurance Commission (GIC) is informed that your current GIC coverage is ending due either to (1) end of employment, (2) reduction in hours of employment; (3) death of employee/retiree; (4) divorce or legal separation; or (5) loss of dependent child status. This COBRA notice contains important information about your right to temporarily continue your health care coverage in the Group Insurance Commission's (GIC's) health plan through a federal law known as COBRA. If you elect to continue your coverage, COBRA coverage will begin on the first day of the month immediately after your current GIC coverage ends.

You must complete the GIC COBRA Election Form and return it to the GIC by no later than 60 days after your group coverage ends by sending it by mail to the Public Information Unit at the GIC at P.O. Box 8747, Boston, MA 02114 or by hand delivery to the GIC, 19 Staniford Street, 4th floor, Boston, MA 02114. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage.

What is COBRA Coverage?

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called 'Qualifying Events.' If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

Who is Eligible for COBRA Coverage?

Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an independent right to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts or municipality covered by the GIC's health benefits program, you have the right to choose COBRA coverage if;

- You lose your group health coverage because your hours of employment are reduced; or
- Your employment ends for reasons other than gross misconduct.

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies;
- Your spouse's employment with the Commonwealth or participating municipality ends for any reason other than gross misconduct or his/her hours of employment are reduced; or
- You and your spouse legally separate or divorce.

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies;
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours or employment are reduced;
- The parents legally separate or divorce; or
- The dependent ceases to be a dependent child under GIC eligibility rules

How Long Does COBRA Coverage Last?

By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a total of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce - occurs during the 18 months of COBRA coverage. **You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage.** Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18 month COBRA period ends in order to extend the coverage.**

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid in full when due (see section on paying for COBRA);
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);
- The Commonwealth of Massachusetts or your municipal employer no longer provides group health coverage to any of its employees; or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud).

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

How and When Do I Elect COBRA Coverage?

Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60–day election period, you will lose all rights to COBRA coverage.**

In considering whether to elect COBRA coverage you should take into account that you have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your GIC coverage ends due to a qualifying event. You will also have the same special enrollment right at the end of COBRA coverage if you get continuation coverage for the maximum time available to you.

How Much Does COBRA Coverage Cost?

Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically; current COBRA rates are included with this notice.

How and When Do I Pay for COBRA Coverage?

If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period.** After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement.** Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

Can I Elect Other Health Coverage Besides COBRA?

Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance 'conversion' policy with your current health plan without providing proof of insurability. Alternately, if you are a Massachusetts resident, you may purchase health insurance through the Commonwealth's Health Connector Authority, or for employees in other states, through a Health Insurance Marketplace where available. The GIC has no involvement in conversion programs, and only very limited involvement in Health Connector programs. You pay the premium to the plan sponsor for the coverage. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

Your COBRA Coverage Responsibilities

- You must inform the GIC of any address changes to preserve your COBRA rights;
- You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above. If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- You must make the first payment for COBRA coverage within 45 days after you elect COBRA. If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill. If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
- The employee's job terminates or his/her hours are reduced;
- The insured dies;
- The insured becomes legally separated or divorced;
- The insured or insured's former spouse remarries;
- A covered child ceases to be a dependent under GIC eligibility rules;
- The Social Security Administration determines that the employee or a covered family member is disabled; or
- The Social Security Administration determines that the employee or a covered family member is no longer disabled.

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. **To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114.**

If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617-727-2310, ext. 1 or write to the Unit at P.O. Box 8747, Boston, MA 02114.

You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at **ww.dol.gov/ebsa** or call their toll free number at 866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit **www.healthcare.gov** or, in Massachusetts visit, **www.mahealthconnector.org**.

Members Eligible for Medicare

NHP does not offer health plans for individuals eligible for Medicare. You may contact the GIC for information about health plans for people eligible for Medicare.

Section 3.

Your NHP Providers

NHP GIC Provider Directory

At the time of Enrollment, NHP gives a Provider Directory to new Members. NHP also gives directories to potential or current Members upon request. To request a copy, call NHP's GIC Customer Service or visit our website at www.nhp .org for the most current listing of Providers. The NHP *GIC Provider Directory* lists Primary Care Sites, Primary Care Providers, Hospitals, NHP affiliated Specialists, and Mental Health and Substance Use Care Providers in the NHP Network.

Your Primary Care Provider (PCP)

All Members must choose a PCP upon Enrollment in NHP. Your PCP provides or arranges all of your health care. The PCP you select can be a health care professional specializing in Internal Medicine, Family Practice or General Practice, a Physician Assistant or a Nurse Practitioner. You have the right to designate any PCP who participates in our Network and who is available to accept you or your family members. For children you may designate a pediatrician as a PCP.

To select or change a PCP or Primary Care Site, go to our secure member portal mynhp.org or call NHP's GIC Customer Service. You should choose a Primary Care Site close to your home or place of work.

NHP provides coverage on a Nondiscriminatory Basis for Covered Services delivered or arranged for by a Nurse Practitioner or Physician Assistant when acting as a PCP.

GIC Centered Care Program

Efficiency. Quality. Innovation.

NHP has partnered with the GIC to launch Centered Care, an innovative program that makes it even easier for our members to get the care they need, when they need it—all at a price they can afford. With Centered Care, GIC members can get access to high quality providers who provide enhanced services such as:

- Coordination with Specialists to ensure patients get the very best in personalized care
- Easy access to Urgent Care through convenient expanded hours
- Helpful reminders about necessary tests, checkups, and follow ups

Centered Care providers must meet certain standards for quality and efficiency. Qualifying providers are marked with the Centered Care logo in the NHP Find a Doctor online search tool. Visit nhp.org/gic to see if your providers are part of a Centered Care organization and to learn more about this innovative program.

Concierge Services

NHP is aware that there are some Providers who charge a once a year fee to patients as a condition to be part of the Provider's panel of patients to receive special customer service from the Provider (e.g. access to the Provider's cell phone, a more personal service). Members who use Providers who give additional customer service for a fee (concierge service) should know that those concierge services are not part of NHP's health plan coverage.

Members are asked to notify NHP if their Provider approaches them to offer/deliver such services for additional fees. NHP does not support this practice.

Changing Your PCP or Primary Care Site

Your PCP can provide better care when he or she knows you and your medical history. For this reason, NHP encourages you to have an ongoing relationship with your PCP. If you need to change your PCP, you may do so at any time, for any reason, including changing your PCP to a Nurse Practitioner or Physician Assistant.

To change your PCP, go to our secure member portal mynhp.org or call NHP's GIC Customer Service at 866-567-9175 (TTY 711). A Customer Service representative can assist you with your choice and process the change. If you choose a new PCP/Primary Care site, the change will be effective immediately or a future date you choose.

For the most current information about any NHP Provider in our Network, visit www.nhp.org/find-a-doctor or call the number on the back of your Member ID card.

Why It's Best to Call Your Primary Care Site

Calling first can save you a needless trip to the Emergency room—and hours of waiting and worrying. You will get the quickest and best advice from people who know you well. For example, your Primary Care Site's Doctor, Physician Assistant or nurse on call may tell you how to treat your problem at home. If the Doctor, Physician Assistant or nurse thinks that you

need to go to the Emergency room, he or she will tell you exactly where to go. The Doctor, Physician Assistant or nurse can also let the Emergency room know you are coming.

Get to Know Your Primary Care Provider

It is a good idea to meet your new PCP before you need care. To make an appointment, call your Primary Care Site. When you call, be sure to say that you are an NHP Member. You should ask your old PCP to send your health records to your new PCP before this visit.

When you go to your appointment, show your NHP Member ID Card. You and your PCP can use this appointment to get to know each other. After this first visit, call your Primary Care Site whenever you need health care.

Behavioral Health (Mental Health and Substance Use) Providers

NHP Members have access to a full range of Behavioral Health (mental health and substance use) services. Beacon Health Options (Beacon) is the company that manages NHP's Behavioral Health program.

Some examples of Behavioral Health services are individual, group and family counseling and medication management. For a complete listing of Behavioral Health Services, refer to "Section 8: Behavioral Health Services.".

If you need Behavioral Health Services, you may choose any Provider in NHP's Behavioral Health Network.

You can make the appointment on your own or call Beacon's clinical department at 800-414-2820 (TTY 781-994-7660) to help you find a Provider. You may also ask your PCP for help. For information about NHP's Behavioral Health Network Providers, refer to the "Behavioral Health" section of your NHP Provider Directory, call Beacon's clinical department at 800-414-2820 (TTY 781-994-7660), or call NHP's GIC Customer Service at 866-567-9175 (TTY 711)

Specialty Providers and Care

At times, your PCP may suggest that you see a Specialist. Specialists are Doctors who focus on one area of medicine. Examples of Specialists are cardiologists, dermatologists and allergists. NHP requires Referrals for visits to NHP In-network Specialists, except for the following services:

- Gynecologist or Obstetrician for routine, preventive, or Urgent Care
- Family planning services
- Outpatient and Diversionary Behavioral Health Services (see Section 4 for additional information)
- Emergency services
- Routine Eye Exams (ophthalmologist or optometrist)
- Physical Therapy
- Occupational Therapy
- Speech Therapy

Before making your appointment with an In-network Specialist, your PCP can discuss the situation, consider options and help decide where you can get the services you need. Some specialty care providers will require a clinical summary from your doctor before they will see you. For example, a neurologist may want to obtain your PCP's opinion. These Specialists require a Referral ID number from NHP prior to rendering services. When you have an established connection with your PCP, he or she can help you address all aspects of your health care and assist you in coordinating all the services you need. If necessary and your PCP approves, your PCP can authorize a standing Referral for an In-network Provider. A standing approval allows you to continue to see a Specialist without getting a new Referral for each visit once the initial specialty visit is approved by your PCP. In the event you require a standing Referral, the Specialist must adhere to NHP policies and agree to a treatment plan for you and provide the PCP with all necessary clinical and administrative information on a regular basis. The Specialist must also provide care consistent with the terms of your EOC and the Specialist cannot authorize any additional Referrals to other providers without NHP approval.

It is your responsibility to make sure that the Specialist you wish to see participates with NHP and is available in NHP's Network. When you use In-network Providers, you know that they have been credentialed by NHP and that they will work with our medical staff to help ensure you get the care you need. If you have a medically necessary service at an In-network location but it is performed by an out-of-network provider, you will not be responsible to pay more than the amount required for In-network services. However, NHP may not cover the service if you had a reasonable opportunity to choose to have the service performed by an In-network Provider. For example, if your In-network Provider refers you to a dermatologist, you must ensure that the dermatologist is in the NHP Network. This process

helps NHP ensure that the PCP is coordinating the Member's care. It is the Member's responsibility to ensure they have a Referral prior to seeing a Specialist. It is a good idea after you have received confirmation from your PCP that a Referral was sent to check with the Specialist office at the time of your appointment. If you don't have a Referral you can ask the Specialist's office to contact your PCP's office to send the Referral while you wait. Failure to obtain a Referral can result in you being financially responsible for your appointment.

Sometimes a Specialist will recommend you see another Specialist. Always check with your PCP before seeing a Specialist because your PCP needs to issue the Referral. *A Specialist isn't able to refer you to another Specialist.*

When you use In-network Providers, you know that they have been credentialed by NHP and that they will work with our medical staff to help ensure you get the care you need. You may search our Provider Directory or call NHP's GIC Customer Service at 866-567-9175 (TTY 711).

If, at any time, you or your PCP has trouble finding needed medical services in NHP's Network, you or your PCP can call NHP for Referral help.

Specialty Care provider Tiers

When choosing a Specialist, please note that NHP Tiers the following specialties: Allergy/Immunology, Cardiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gastroenterology, General Surgery, Hematology & Oncology, Nephrology, Neurology, OB/GYN, Ophthalmology, Orthopedic Surgery, Podiatry, Pulmonology, Rheumatology, and Urology services. NHP based this Specialty Provider Tiering on quality and cost- efficiency data provided by the GIC through its Clinical Performance Improvement (CPI) initiative. Each contracted Allergy/Immunology, Cardiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gastroenterology, General Surgery, Hematology & Oncology, Nephrology, Neurology, OB/GYN, Ophthalmology, Orthopedic Surgery, Podiatry, Pulmonology, Rheumatology, and Urology Specialist has been given a quality and cost-efficiency score based on the CPI data that places it into one of three Tiers:

*** Tier 1 (excellent)
** Tier 2 (good)
* Tier 3 (standard)

Specialists with the best combined quality and cost-efficiency scores have been assigned to Tier 1. Specialists with scores that fall within the middle range are assigned to Tier 2. Specialists with standard scores are assigned to Tier 3. Your choice of Allergy/Immunology, Cardiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gastroenterology, General Surgery, Hematology & Oncology, Nephrology, Neurology, OB/GYN, Ophthalmology, Orthopedic Surgery, Podiatry, Pulmonology, Rheumatology, and Urology Specialist will determine your office visit Copayment based on his/her Tier.
The office visit Copayment for Tier 1 Specialists is $30 per office visit, Tier 2 Specialists is $60 and Tier 3 Specialists is $90 per office visit. The office visit Copayment for Tiered specialty Providers with insufficient data for comparison (ID) and for Providers whose specialty is not tiered (NT) is $60 per office visit. Your office visit Copayment for outpatient Mental Health or Substance Use Providers is $20.

Please refer to the NHP *GIC Provider Directory* to verify your Specialty Provider's Tier. To obtain the most up-to-date information on NHP Providers, please refer to the online Provider directory located at www.nhp.org and click on the "Provider Directory" link. You may also contact NHP Custom Service for assistance.

Out-of-Network Specialty Care

You may visit an Out-of-Network Specialist only if NHP approves it in advance. Services given by Out- of-Network Specialists require prior Authorization. If there are In-network Providers who offer the service, NHP will usually deny the request to cover services provided by Out-of-Network Specialists. Before you make an appointment or seek medical care from an Out-of-Network Specialist, ask your PCP or treating Doctor to send an Authorization request to NHP. After reviewing the request, we will notify you and your Doctor of our decision in writing. If you do not receive written approval from NHP for Out-of-Network specialty care, the plan will not cover the services. If you do receive Authorization for Out-of-Network specialty care, Cost Sharing, if any, will remain the same.

Relationship of NHP to NHP Providers

NHP Providers are private contractors. NHP's relationships with its Providers are governed by separate contracts. Providers may not change the Evidence of Coverage or create or imply any obligation for NHP. NHP is not liable for statements about this contract made by Providers, their employees, or agents. NHP cannot ensure the availability of specific Providers or Provider groups. NHP may change arrangements with Providers, including the addition or removal of Providers. Please note that all Providers listed in any of the NHP Provider Directories were

available to NHP Members at the time the directories were printed. For the most current information on NHP Providers, refer to our online *Provider Directory* located at www.nhp.org.

Continuity of Medical Care

In order to ensure consistent care, there are some instances when NHP will provide coverage for health services from a physician (includes Nurse Practitioners and Physician Assistants) who is not participating in NHP's Network.

If you are enrolling in NHP as a new Member and your employer only offered you a choice of Carriers in which your existing PCP or an actively treating physician was not a participating physician, NHP will provide coverage for up to thirty calendar (30) days from the coverage Effective Date of coverage. With respect to a Member in her second or third trimester of pregnancy, this provision applies to services rendered through the first postpartum visit by the physician caring for her pregnancy. With respect to a Member with a terminal illness, this provision applies to services rendered until death.

If your Provider has been disenrolled from NHP's Network, for reasons unrelated to quality of care or fraud, NHP will provide coverage for up to 30 calendar days if the Provider is your Primary Care Provider, or up to 90 calendar days if the Provider, including a PCP, is providing you with active treatment care for a chronic or acute medical condition, or until that active treatment is completed, whichever comes first. For any Member who is in her second or third trimester this coverage will continue through the first postpartum visit. For any Member who is terminally ill, this coverage will continue through the Member's death.

To continue care in the above examples, the Provider must adhere to the quality assurance standards of NHP and provide NHP with required information on the provided medical care. Also, the Provider must adhere to NHP's policies and procedures, including guidelines on prior Authorizations and providing services before starting a treatment plan, if any, approved by NHP. In the case of disenrolled Providers, they must also agree to accept repayment from NHP at the rates set prior to notice of Disenrollment as payment in full, and not charge any remaining amount to the Insured that would exceed the total repayment if the Provider had not been disenrolled. Failure of a Provider to agree to these standards may result in a denial of coverage for the provided service. If you have any questions about this matter please call NHP's GIC Customer Service at 1-866-567-9175 (TTY 711).

Section 4.

Accessing Care

Emergency Care

In an Emergency, go to the nearest Emergency facility, call 911, or call your local Emergency Service Program (ESP). You are always covered for care in an Emergency.

An Emergency is defined as a medical condition, whether physical, behavioral, related to substance use disorder, or a mental disorder, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part. With respect to a pregnant woman who is having contractions, an Emergency also includes having an inadequate time to affect a safe transfer to another hospital before delivery or a threat to the safety of the Member or her unborn child in the event of transfer to another hospital before delivery.

You or your representative (such as another Member of your family) must call your Primary Care Site for Emergency medical conditions within 48 hours of any Emergency care. Notification by the attending Emergency physician to NHP or to your PCP within 48 hours of receiving Emergency services will also satisfy this requirement. Your PCP will arrange for any follow-up care you may need. You will not be denied coverage for medical and transportation expenses incurred as a result of any such Emergency.

After you have been stabilized for discharge or transfer, NHP may require a Hospital Emergency department to contact a physician on-call designated by NHP or its designee for Authorization of post-stabilization services to be provided. The Hospital Emergency department shall take all reasonable steps to initiate contact with NHP or its designee within 30 minutes of stabilization. Such Authorization shall be deemed granted if NHP or its designee has not responded to said call within 30 minutes. In the event the attending physician and the on-call physician do not agree on what constitutes appropriate medical treatment, then the attending physician's opinion will prevail. That treatment will be considered appropriate treatment for an Emergency medical condition, provided that the treatment follows the general accepted principles of professional medical practice and is a Covered Health Care Service under the policy or contract with NHP.

Urgent Care

Urgent Care is care for a health problem that needs medical attention right away but you do not think it is an Emergency. For an Urgent Care visit, call your PCP first as there may be an Urgent Care Center at your Primary Care Site. You can contact your site twenty-four (24) hours a day, seven (7) days a week. Urgent Care does not include care that is elective, Emergency, preventive or health maintenance. Examples of conditions requiring Urgent Care include, but are not limited to: fever, sore throat, and earache.

After-Hours Care

No matter when you are sick—day or night, any day of the year—call your Primary Care Site. All NHP Primary Care Sites have a Doctor, Physician Assistant or nurse on call 24 hours a day, seven days a week. The Doctor, Physician Assistant or nurse on call is there to help with any urgent health problems.

When you call your Primary Care Site after-hours, the site's answering service will answer your call. The service will take your name and phone number and then contact the Doctor, Physician Assistant or nurse on call. That Doctor, Physician Assistant or nurse will call you back to talk about your problem and help you decide what to do next.

For Behavioral Health after hours care, call your Behavioral Health Provider first. You may also call Beacon's clinical department 24 hours a day, seven days a week.

If you think your health problem is an Emergency and needs immediate attention, call 911 or the ESP in your area at once, or go to the nearest Emergency room.

Non-Emergency Hospital Care

If you need hospital care and it is not an Emergency, your PCP will make the arrangements for your hospital stay. You must go to the hospital specified by your PCP in order for NHP to cover your hospital care. NHP will cover hospital care only if your PCP or Primary Care Site arranges such care. The only exception is for Emergency care.

Behavioral Health Hospital Care

If you need Inpatient hospital care for Behavioral Health needs, call 911 or go to the nearest Emergency room, or contact the ESP in your area. A Behavioral Health clinician at the ESP or the Emergency room will screen and evaluate you for a potential admission. For a listing of ESPs and Emergency Rooms in all areas of

the state, see your NHP Provider Directory. You can also call your PCP or Beacon's Clinical Department.

Diversionary Behavioral Health Services

NHP offers an array of Behavioral Health services to our Members. "Section 8: Behavioral Health Services" provides detailed information on Behavioral Health services that NHP covers and how to access these services.

As an adjunct to traditional outpatient services (which includes individual, couples, family and group counseling as well as medication management), a number of diversionary services are available to NHP Members. Examples of diversionary Behavioral Health Services include: Partial Hospitalization Programs (PHP); and Community Support Services (CSP). PHPs have structured intensive therapeutic services for up to six hours a day, and CSPs offer outreach and support to assist a Member/Family in accessing their mental health or substance use treatment in the community.

Diversionary services above do not require a Referral, but these services do require a Provider to obtain prior Authorization from Beacon. You may learn more about these services by calling Beacon directly or speaking to your outpatient therapist, if you have one.

Structured Outpatient Addiction Programs (SOAPs) provide short-term, clinically-intensive structured day and/or evening addiction treatment services, usually provided in half- or full-day units, up to six or seven days per week. This program is designed to enhance continuity for Members being discharged from Level III or Level IV detoxification programs as they return to their homes and communities. These services do not require a prior Authorization.

Care When Outside the NHP Service Area

When Members are traveling or temporarily residing outside the NHP Service Area, including dependents living outside the NHP Service Area, NHP will cover only Emergency and Urgent Care services. To ensure coverage, be sure to take care of your routine health care needs before traveling outside of the NHP Service Area.

If you need Emergency Care or Urgent Care while you are temporarily outside the NHP Service Area, go to the nearest Doctor or Emergency room. You do not have to call your PCP before seeking Emergency or Urgent Care while outside the NHP Service Area.

You or a family Member should call your Primary Care Site within 48 hours of receiving out-of-area care and before having any follow-up services related to your urgent or emergent need. Except for Emergency or Urgent Care, failure to obtain prior Authorization for services outside the NHP Service Area may result in the Member's liability for payment.

NHP *will not* cover:

- Tests or treatment you receive outside the NHP Service Area that was requested by your PCP before you left the Service Area.
- Routine Care or follow-up care that can wait until your return to the Service Area, such as physical exams, flu shots, stitch removal, mental health counseling.
- Care that could have been foreseen prior to leaving the Service Area such as elective surgery.
- Care for childbirth or problems with pregnancy beyond the 37th week of pregnancy, or after being told that you were at risk for early delivery.

A Provider may ask you to pay for care received outside of NHP's Service Area at the time of service. If you pay for Emergency or Urgent Care you received while outside of NHP's Service Area, you may submit a Claim to NHP for reimbursement.

See "Section 12. If You Receive a Bill in the Mail" for more information and instructions on how to submit a Claim. You may also call NHP's GIC Customer Service for help with any bills that you may receive from a health care Provider.

Family Planning Services

Family Planning Services include birth control methods as well as exams, counseling, pregnancy testing and some lab tests. You may call any NHP In-network Family Planning clinic for an appointment. You may also see your PCP for Family Planning Services. Call NHP's GIC Customer Service if you need help finding a Provider for Family Planning Services.

Maternity Care

NHP covers many services to help you have a healthy pregnancy and a healthy baby. If you think you might be pregnant, call your Primary Care Site. Your site will schedule an appointment for a pregnancy test. If you

are pregnant, your Primary Care Site will arrange your maternity care with an obstetrician or nurse midwife.

You will be scheduled for regular checkups during your pregnancy. It is important to keep these appointments even if you feel well. During these appointments, your obstetrician or nurse midwife will check your baby's progress. He or she will tell you how to take good care of yourself and your baby during your pregnancy.

He or she will also take care of you when you have your baby. NHP also has a special program for pregnant Members called "For You Two". For more information about this program, see "Section 11. Care Management Programs."

Section 5.

Authorizations

An Authorization is a special approval by NHP for payment of certain services. Not all services need an Authorization. If a service does require an Authorization, it must occur before you receive the service in order for the service to be covered. Your PCP or the Specialist treating you is required to request an Authorization from NHP if it is needed.

For health plan Benefits, the request is submitted to NHP. Examples of services requiring Authorization from NHP are some surgical procedures and elective admissions, Inpatient psychiatric care, etc. NHP gives Authorizations as soon as possible.

For an initial or prior Authorization regarding a proposed elective admission, procedure or service, decisions are made within two (2) business days of receiving all required information and no longer than 14 calendar days. Providers are verbally informed of the decision within 24 hours. The Provider and the Member are sent written notification of the decision within one (1) business day of the verbal notification for Adverse Determinations and within two (2) business days for approvals.

Initial Authorization decisions categorized by NHP as urgent are made within three (3) calendar days and Providers are verbally informed of the decision within 24 hours. The Provider and the Member are sent written notification of the decision within one (1) business day of the verbal notification for Adverse Determinations and within two (2) business days for approvals.

Emergency care through the hospital Emergency department, Emergency admissions and care that must be provided during non-business hours such as home skilled nursing require notification by the next business day.

Concurrent Authorization decisions categorized by NHP as urgent are made within 24 hours. Concurrent Authorization decisions categorized by NHP as non-urgent are made within one (1) business day of receiving all required information and no longer than 14 calendar days. Providers are verbally informed of an urgent decision within twenty-four (24) hours and one (1) business day for non-urgent requests. Written or electronic notification includes the number of extended days, visits or service approved in a service date range. In the case of an Adverse Determination, written notification is sent to the Provider and Member within one (1) business day thereafter.

Once NHP reviews the request for service(s), we will inform your Provider of our decision. If we authorize the service(s), we will send you and your Provider an Authorization letter. When you get the letter, you can call your Provider to make an appointment. The Authorization letter will state the service(s) the plan has approved for coverage. Make sure you have this Authorization letter before any service(s) requiring Authorization are provided to you. If your Provider feels that you need a service(s) beyond those authorized, he or she will ask for Authorization directly from the plan.

If we approve the request for more service(s), we will send both you and your Provider an additional Authorization letter.

If we do not authorize any of the services requested, authorize only some of the services requested, or do not authorize the full amount, duration or scope of services requested, we will send you and your Provider a denial letter. NHP will not pay for any services that were not authorized. NHP will also send you and your Provider a notice if we decide to reduce, suspend, or terminate previously authorized service(s). If you disagree with any of these decisions, you can file a Grievance. For complete details on filing a Grievance, please see “Section 15: Complaint and Grievance Process” or contact NHP’s GIC Customer Service for more information.

It is your responsibility to make sure that you have written Authorization for coverage prior to receiving services that require Authorization. You may confirm the need for Authorization with your NHP Providers or by contacting NHP’s GIC Customer Service.

Section 6.

NHP's Pharmacy Benefit

NHP is committed to providing a high quality and cost effective pharmacy benefit for our members. Your coverage includes a variety of prescription drug programs that are designed to make paying for your medications and premiums affordable. The NHP pharmacy benefit places all covered drugs into one of three levels or tiers. Cost- sharing (e.g., Copays, Deductibles and/or Coinsurance) applies to each tier, and is listed in your *Schedule of Benefits*. More information about your financial obligations is included in Section 13 of this handbook.

Tier placement

NHP prescription drug Benefit places all covered drugs into one of three levels, or Tiers, including:

- Tier 1 (generic) —This Tier includes most generic medications and may include some brand name medications. Generic medications contain the same active ingredients as their brand name counterparts.
- Tier 2 (preferred brand name)—This Tier includes preferred brand name medications and may also include some high cost generic medications.
- Tier 3 (non-preferred brand name)—This Tier includes non-preferred brand name medications.

Each Tier has a different Copayment. Copayments are fixed dollar amounts that are paid to the pharmacy at the time of purchase. In most cases, the Copayment represents a fraction of the total cost for a prescription.

Each Copayment covers up to a 30-day supply of medication. When prescriptions are purchased through a Network pharmacy, you pay the lower of the Copayment or the pharmacy's discounted retail price.

NHP's Drug List includes a list of medicines covered by your plan. Doctors and pharmacists have reviewed the medications for safety, quality, effectiveness and cost. You can determine the Tier your drug is in by viewing the searchable Drug Lookup tool, which is available online at www.nhp.org.

Filling Prescriptions

To fill a prescription, bring it to one of the pharmacies in the NHP Network. Be sure to show your NHP Member ID card so the pharmacist will know you are a Member of NHP. For a listing of pharmacies, refer to www.nhp.org. Some prescription drugs need an Authorization. Your NHP provider can ask for an Authorization so you can have the prescriptions you need.

If you have any questions about which drugs do require Authorization, visit www.nhp.org, or call NHP's GIC Customer Service at 1-866-567-9175 (TTY 711) Monday–Friday 8:00 a.m.–6:00 p.m., and Thursday 8:00 a.m.–8:00 p.m.

Maintenance 90

To save money on your maintenance medications, NHP requires that you receive maintenance medications in a 90-day supply. Maintenance medications are those that treat chronic conditions such as high blood pressure, diabetes, etc. Short-term use medications (i.e. pain medication, antibiotics) do not have this requirement. To see if you must fill your medication with a 90-day supply, visit the Drug Look-up Tool on www.nhp.org.

In order to switch to 90-day supplies of your medication, you must ask your medication prescriber to write you a new prescription to allow 90 days of medication to be dispensed at a time. Besides the convenience of filling prescriptions less often, you may Benefit from 90-day prescriptions because the Copay for a 90-day supply is reduced for most medications:

Tier 1 - Generic: Subject to deductible, then $25 copayment
Tier 2 - Preferred brand-name: Subject to deductible, then $75 copayment
Tier 3 - Non-preferred brand-name: Subject to deductible, then $165 copayment

Members can opt out of the 90-day program for one or more of their medicines. This can be done for twelve months at a time. If needed, a Member can use a one-time deferral until they get a new prescription from their Provider for a 90-day supply. For a shorter, 30-day deferral, or to opt-out for more than 30 days, a Member should call NHP's GIC Customer Service.

If a Provider feels that it is Medically Necessary for a Member to get just a 30-day supply at a time, opting out of 90-day prescription would be based on a Provider request to reduce the duration and medication(s). This process would require information from the Provider: the medication(s) listed; the proposed time frame for exclusion; and the reason for only a 30-day supply.

If you have any questions regarding the mandatory 90-day supply, please call NHP's GIC Customer Service at 1-866-567-9175 (TTY 711) Monday–Friday 8:00 a.m.–6:00 p.m., and Thursday 8:00 a.m.–8:00 p.m.

Mail-order Program

For Members who prefer the convenience of receiving their prescriptions through the mail, certain maintenance medications (such as drugs used for asthma, blood pressure, high cholesterol and arthritis) are available through NHP's pharmacy vendor. This service provides Members with a 90-day supply of prescription medicines at a reduced cost. The Copayment for a 90-day supply is reduced to:

Tier 1 - Generic: Subject to deductible, then $25 copayment
Tier 2 - Preferred brand-name: Subject to deductible, then $75 copayment
Tier 3 - Non-preferred brand-name: Subject to deductible, then $165 copayment

To order your prescriptions through the mail, please visit www.nhp.org/member. Members only need to complete the form once. Refills can be ordered by calling the GIC Customer Service.

Access90

Access90 provides Members with a 90-day supply of certain maintenance medications when purchased through participating pharmacies. For a list of pharmacies, refer to www.nhp.org. The Copayment for a 90-day supply is reduced to:

Tier 1 - Generic: Subject to deductible, then $25 copayment
Tier 2 - Preferred brand-name: Subject to deductible, then $75 copayment
Tier 3 - Non-preferred brand-name: Subject to deductible, then $165 copayment

Over-the-counter Drug Benefit

Some over-the-counter (OTC) medications (including cough, cold and allergy) are covered by your NHP pharmacy benefit with a valid prescription from your Doctor. Some may be available up to a 90-day supply. Copayments may vary depending on the drug prescribed. For a complete listing of the OTC drugs, Copayment amounts and quantity limitations, please visit www.nhp.org/member/Documents/OTC_Commerical.pdf.

Quantity Limit

NHP may limit the number of units for a specific medication you may receive in a given time period to ensure safe and appropriate use. These limits are based on recommended dosing schedules, and availability of several strengths of the drug. Quantity limits apply at the time prescriptions are purchased.

Mandatory Generic Policy

NHP's generic policy requires a generic version of a medication be tried before the brand name is considered for coverage. A generic drug is the same medication and works in the same way as the brand name medication. Generic medications are approved by the US Food and Drug Administration (FDA) as safe and are the equivalent of the original brand name medication. In addition, there are usually multiple manufacturers of a generic medication that may result with a lower cost compared to the branded alternative. Prior Authorization is required for exception to NHP's generic medication pharmacy Benefit. If you have already tried a generic equivalent, and wish to appeal the mandatory generic policy, you may contact NHP's GIC Customer Service at 1-866-567-9175 (TTY 711) Monday–Friday 8:00 a.m.–6:00 p.m., and Thursday 8:00 a.m.–8:00 p.m.

Prior Authorization

Prior Authorization is a process in which a clinical review is required before a specific medication may be dispensed to a covered NHP member. The review entails the application of criteria approved by NHP's Pharmacy and Therapeutics Committee of physicians and pharmacists and is designed to assure the safe, effective, and appropriate use of a medication. These criteria are based on clinical studies and standards of care. The Prior Authorization process may entail a delay in your ability to fill the prescription until the clinical review based on all required information provided by your physician (or his/her designee) has occurred. The clinical review process may take up to 48 hours after complete information has been received.

Exceptions Requests for Non-Formulary Drugs

NHP Members, their authorized representative on file, or Provider may request NHP to perform a review process (within 72 hours) in order to make a coverage determination for a non-covered/non-formulary drug. NHP will provide the Member, his/her authorized representative, and Provider notification of the coverage determination for the non- covered/non-

formulary drug within 72 hours. If an expedited review process is requested due to an exigent (emergent) circumstance, NHP will provide the coverage determination for the non-covered/non-formulary drug within 24 hours.

To initiate the review process, an NHP Member, his/her authorized representative, or Provider must call NHP GIC Customer Service at 1-866-567-9175 (TTY 711) and provide the following information:

- Member Name
- Member Contact Information
- Diagnosis
- Provider Name
- Provider Contact Information
- Medication Requested

NHP has a number of online tools to help you understand your prescription drug benefits. Please visit www.nhp.org/member. Click on the **Benefits** tab and then **Pharmacy** for detailed information about your pharmacy coverage and information on each medication, including a list of covered drugs, and whether any tier, restrictions, or limitations applies. .

Grievance Review for Coverage of Non-Formulary Drugs

If your initial request for coverage of a non-covered/ non-formulary drug is denied, you have the right to submit a Grievance to NHP. You may request in your Grievance that coverage determination be performed by NHP or an Independent Review Organization (IRO). To submit a Grievance, you or your authorized representative on file or your Provider must contact NHP and state if you wish to have NHP or an IRO render a decision on your Grievance.

NHP will provide notification of the coverage determination for the non-covered/non-formulary drug within 72 hours of your request. If an expedited review process is requested due to an exigent (emergent) circumstance, NHP will provide notification of the coverage determination for the non-covered/non-formulary drug within 24 hours of your request. If you choose to have your Grievance performed by NHP, and NHP denies coverage, you have the right to request a second review by an IRO.

Step Therapy

NHP automates the prior Authorization criteria for some medications. NHP Members who qualify for this program may enjoy immediate coverage without the requirement of a clinical review based on the prescriptions already filled through NHP. For additional information, you may contact NHP's GIC Customer Service at 1-866-567-9175 (TTY 711) Monday–Friday 8:00 a.m. –6:00 p.m., and Thursday 8:00 a.m. –8:00 p.m.

Specialty Pharmacy Program

The NHP Specialty Pharmacy Program is a less costly way to purchase expensive medications that are used treat complex medical conditions. Certain medications are covered only when obtained from NHP's preferred list of Specialty Pharmacies. A complete list of prescriptions along with the list of participating specialty pharmacies, are available at www.nhp.org. You may also find out if your drug is included in the program through the searchable Drug Lookup Tool, also available at www.nhp.org or www.mynhp.org.

Your prescribing Provider can help you with the purchase of the covered specialty medications. NHP Specialty Pharmacies have expertise in the delivery of the medications they provide, and offer special services not available at a traditional retail pharmacy, including:

- All necessary medication and supplies needed for administration (at no extra charge)
- Convenient delivery options to your home or office with overnight or same day delivery available when Medically Necessary
- Access to nurses, pharmacists and care coordinators specializing in the treatment of your condition, who are available 24 hours a day, seven days a week, to provide support and educational information about your medications
- Compliance monitoring, adherence counseling and clinical follow-up
- Educational resources regarding medication use, side effects, and injection administration

For additional assistance, or if you have any questions about NHP's Specialty Pharmacy Program, please call NHP's GIC Customer Service at 1-866-567-9175 (TTY 711) Monday–Friday, 8:00 a.m.–6:00 p.m., and Thursday, 8:00 a.m.–8:00 p.m.

Limitations

There are a number of drugs that are either not covered or have limited coverage. NHP only covers drugs that are Medically Necessary for Preventive Care or for treating illness, injury, or pregnancy.

Exceptions

You or your Provider may request an exception for coverage of any drug that is excluded or limited. Exceptions will only be granted for clinical reasons. For additional information, please contact NHP's GIC Customer Service at 1-866-567-9175 (TTY 711) Monday–Friday, 8:00 a.m.–6:00 p.m., and Thursday, 8:00 a.m.–8:00 p.m.

Exclusions

NHP's prescription drug Benefit features a Preferred Drug List, in which the following drugs or services are excluded:

- Dietary supplements*
- Therapeutic devices or appliances (except where noted)*
- Biologicals, immunization agents or vaccines that are obtained through the medical benefit
- Blood or blood plasma**
- Medications which are to be taken by or administered to an individual, while he or she is a patient in a licensed Hospital, nursing home, or similar institution which operates a facility for dispensing pharmaceuticals**
- Charges for the administration or injection of any drug**
- If an FDA approved generic drug is available, the brand name equivalent is not covered
- Anabolic steroids
- Progesterone supplements
- Fluoride supplements/vitamins for members over age 13
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only
- Drugs labeled "Caution—limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual
- Medications for which the cost is recoverable under Worker's Compensation or Occupational Disease Law or any state or Governmental Agency, or medication furnished by any other Drug or Medical service for which no charge is made to the Member
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order

For more information about NHP's Preferred Drug List call NHP's GIC Customer Service at 1-866-567-9175 (TTY 711), or visit our website at www.nhp.org.

*Covered in certain circumstances under the Durable Medical Equipment (DME) Benefit.

**Covered in certain circumstances under Medical Benefit.

Section 7.

Your NHP Covered Health Care Services

To be covered by NHP, all Health Care Services and supplies must be:

- Provided by or arranged by the Member's PCP or NHP In-network Specialist, unless noted otherwise in this Handbook.
- Medically Necessary, as defined in this Handbook
- Listed as a Covered Health Care Service in this handbook
- Provided by a NHP Network Provider, unless prior Authorization has been obtained from NHP to see an Out-of- Network Provider.
- Provided to an eligible Member enrolled in NHP. NHP is not responsible for payment of any services provided prior to a Member's Eligibility date or after your NHP Disenrollment Date.
- Authorized by NHP when Authorization is required. For more information on Authorization requirements, see Section 5, check with your PCP, your NHP Network Provider, or call NHP's GIC Customer Service.

You should always check with your PCP or treating Provider to make sure that any required Referrals or prior Authorizations have been obtained before the services are performed or the supplies are provided. Failure to obtain necessary Referrals or prior Authorizations may result in Member liability for payment.

You do not need a Referral for: a Gynecologist or Obstetrician for routine, preventive, or Urgent Care; Family Planning Services; outpatient and Diversionary Behavioral Health Services; Emergency services; physical therapy, occupational therapy, speech therapy; and routine eye exams.

If you have questions about your NHP Benefits, please call NHP's GIC Customer Service.

Major Disasters

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

The following are Covered Services for NHP Members.

Abortion

Member cost: *$20 PCP Copayment, $30/$60/$90 Specialty Copayment*

Member cost for facility fee: *$250 Copayment,* then subject to Deductible per outpatient Surgical occurrence*

Member cost for professional fee: *$0 Copayment per outpatient surgical occurrence*

Member cost for facility fee: *$275 Copayment,* then subject to Deductible per Inpatient occurrence*

Member cost for professional fee: *$0 Copayment per Inpatient Surgical occurrence*

NHP covers abortion when services are obtained from an NHP Provider.

Acute Hospital Care

Member cost for facility fee: *$275 Copayment,* then subject to Deductible per Inpatient admission*

Member cost for professional fee: *$0 Copayment per Inpatient admission*

NHP covers acute care Hospital services when Medically Necessary. Your PCP must arrange acute care Hospital services.

Ambulance Transportation

Member cost: *Subject to the Deductible, then no Copayment*

Emergency ambulance transportation, including air ambulance, is covered. NHP covers such ambulance transport to the nearest Hospital that can provide the care you need. Ambulance calls for transportation that is refused is not covered. Except in an Emergency, ambulance transportation is covered only when arranged by an NHP Provider. We also cover Medically Necessary transfer from one health care facility to another.

Ambulatory/Day Surgery

Member cost for facility fee: *$250 copayment*, then subject to Deductible per outpatient surgical occurrence*

Member cost for professional fee: *$0 Copayment per outpatient surgical occurrence*
NHP covers Medically Necessary Outpatient surgical and related diagnostic and medical services. Your PCP must arrange Ambulatory/Day Surgery services.

Autism

Member cost is based on type of service and treating provider.

NHP covers the diagnosis and treatment of Autism Spectrum Disorders (ASD) when medically necessary. Diagnosis includes medically necessary assessments, evaluations including neuropsychologic evaluations, genetic testing or other tests to diagnose whether an individual has ASD. Autism spectrum disorders are defined as any of the pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's Disorder, and pervasive developmental disorders not otherwise specified. Treatment for autism includes habilitative or rehabilitative care, pharmacy care, psychiatric care, psychological care, and therapeutic care. Services for autism are provided by NHP autism service providers.

Habilitative or rehabilitative care includes professional, counseling and guidance services and treatment programs, including, but not limited to, applied behavior analysis supervised by a board certified behavior analyst, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of an individual. Applied behavior analysis includes the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including in the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Pharmacy care is defined as medications prescribed by a licensed physician and health- related services deemed medically necessary to determine the need or effectiveness of the medications, to the same extent that pharmacy care is provided by the policy for other medical conditions.

Therapeutic care is defined as services provided by licensed or certified speech therapists, occupational therapists, physical therapists or social workers.

NHP coverage for the treatment of Autism Spectrum Disorder does not affect an obligation to provide services to an individual under an individualized family service plan, an individualized education program or an individualized service plan. NHP coverage excludes services provided by school personnel under an individualized education program.

Behavioral Health (Mental health and Substance Use Benefits)

See "Section 8. Behavioral Health Services" for details.

Blood and Blood Products

Member cost: *$0 Copayment*

NHP covers administrative fees, supplies for administration, and self-donations for whole blood and its derivatives including Factor 8, Factor 9 and immunoglobulin.

* Per admission/occurrence with a cap of four Copayments per benefit period, with a maximum of one Inpatient Copayment per quarter. Inpatient Copayment will be waived for readmission to a hospital for any reason if the readmission occurs within 30 days of release from a hospital; you must contact NHP to have the Copayment waived.

Blood Glucose Monitoring Strips

Member cost: *$0 Copayment*
Also see "Diabetic Services and Supplies" in this section.

NHP provides coverage for blood glucose monitoring strips. Your Provider must issue a written order when Medically Necessary for the treatment of insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes.

Cardiac Rehabilitation Coverage

Member cost: *$0 Copayment*

NHP covers outpatient cardiac rehabilitation when Medically Necessary. Cardiac rehabilitation is defined as multidisciplinary, Medically Necessary treatment of persons with documented cardiovascular disease, which is provided in either a Hospital or other setting which meets the standards set by the Commissioner of the Department of Public Health. Your PCP and/or NHP Treating Provider must arrange for cardiac rehabilitation.

Cleft Lip and Cleft Palate Treatment for Children

Member cost is based on type of service and treating provider.

NHP provides coverage of cleft lip and cleft palate treatment for children under the age of 18, including oral and maxillofacial surgery, plastic surgery, speech therapy, audiology, and nutrition services as Medically Necessary. We also cover preventative and restorative dentistry and orthodontic treatment related to the treatment of cleft lip or palate. When dental and orthodontic services are covered by both NHP and a Member's dental plan, NHP and the dental plan may elect to coordinate Benefits. See "Section 10: When You Have Other Coverage" for more information on coordination of Benefits.

* Per admission/occurrence with a cap of four Copayments per benefit period, with a maximum of one Inpatient Copayment per quarter. Inpatient Copayment will be waived for readmission to a hospital for any reason if the readmission occurs within 30 days of release from a hospital; you must contact NHP to have the Copayment waived.

Clinical Trials

Member cost is based on type of service and treating provider.

If you participate in an approved clinical trial while you are a Member of NHP, NHP will cover the medically necessary Covered Health Services listed in this Section 7 during the period of the clinical trial that you are a Member of NHP as long as you meet certain requirements.

Members must qualify to participate in an approved clinical trial for the treatment of cancer or other life-threatening medical condition and have been referred to the clinical trial by a Network Provider or have provided medical and scientific information to NHP proving they meet the conditions for participation in the clinical trial.

An approved clinical trial is defined as (a) having been funded or approved by at least one of the following entities: National Institutes of Health (NIH); Center for Disease Control and Prevention; Agency for Health Care Research and Quality; Centers for Medicare & Medicaid Services; a cooperative group or center of any of the above or the Department of Defense, Veterans Affairs or the Department of Energy; or a qualified non-governmental research entity identified in NIH guidelines for grants; or (b) a study or trial under a Food and Drug Administration approved investigational new drug application; or (c) a drug trial that is exempt from investigational new drug application requirements.

NHP coverage during approved clinical trials excludes the investigational item, device or service; items and services solely for data collection and analysis; and services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Coverage is provided when services are rendered by Network Providers; prior Authorization must be obtained in order to receive coverage of services rendered by Out-of-Network Providers.

Cytologic Screening (Pap Smears)

Member cost: *$0 Copayment*

NHP covers cytologic screening for women as recommended by your provider.

Dental Services—Emergency

Member cost: *$100 Copayment, then subject to Deductible when in Emergency Room (Copayment waived if admitted to hospital).*

NHP covers Emergency dental care and oral surgery within 72 hours of an accidental injury to the mouth and natural sound teeth only when performed in a facility such as a hospital. Go to the nearest Emergency facility or call 911 or the Emergency phone number in your area.

Dental Services—Other

Member cost: *$250 Copayment*, then subject to Deductible in an outpatient surgical setting.*

Member cost facility fee: *$275 Copayment*, then subject to Deductible per Inpatient surgical setting.*

Member cost professional fee: *$0 Copayment per Inpatient surgical setting.*

Removal of seven or more permanent teeth, excision of radicular cysts involving the roots of three or more teeth, extraction of impacted teeth, gingivectomies of two or more gum quadrants in an outpatient hospital setting.

Benefits are provided for the dental services listed only when the Member has a serious medical condition that makes it essential that he or she be admitted to a general hospital as an Inpatient or to a surgical day care unit or ambulatory surgical facility as an outpatient in order for the dental care to be performed safely. Serious medical conditions include, but are not limited to, hemophilia and heart disease.

Diabetic Services and Supplies

NHP will provide coverage for Medically Necessary services and supplies used in the treatment of insulin-dependent, insulin-using, gestational and non–insulin-dependent diabetes. Services and supplies must be

prescribed by an authorized health care professional. The following services and supplies are covered for a minimum thirty (30) day supply (except an insulin pump) within the following categories of Benefits:

- Outpatient diabetes self-management training and education, including medical nutrition therapy:
  Member cost: *$20 PCP Copayment, $30/$60/$90 Specialty Copayment*
- Preventive Laboratory tests and urinary profiles:
  Member cost: *$0 Copayment*
- Blood glucose monitors, Voice-synthesizers for blood glucose monitors, and Visual magnifying aids for use by the legally blind:
  Member cost: *Subject to Deductible, then 20% of purchase price or rental cost*
- Therapeutic/molded shoes and shoe inserts:
  Member cost: Subject to Deductible, then no copayment
- Select glucose strips, ketone strips, lancets, and alcohol pads:
  Member cost: $0 Copayment with a prescription at participating pharmacies
- Other Blood glucose monitoring strips, urine glucose strips, ketone strips, lancets, syringes, pumps and pump supplies, insulin pens, insulin and oral medications.
  Member cost: *Select Diabetic Drugs and Supplies, 30-day supply, and when prescribed by NHP participating Provider:*
  Subject to deductible then $10 generic (30-day supply)
  Subject to deductible then $30 brand name preferred (30-day supply)
  Subject to deductible then $65 brand-name non-preferred (30-day supply)

Dialysis

Member cost: *$0 Copayment*

NHP covers kidney dialysis on an Inpatient or Outpatient basis, or at home. You must apply for Medicare when federal law permits Medicare to be the primary payer for dialysis. You must also pay any Medicare Premium. When Medicare is primary (or would be primary if the Member were timely enrolled) NHP will pay for services only to the extent payments would exceed what would be payable by Medicare. Your PCP must arrange dialysis services. If you are temporarily outside the Service Area, NHP covers limited dialysis services. You must make prior arrangements with your PCP, who must obtain NHP approval for this coverage except in an Emergency.

Disposable Medical Supplies

Member cost: *Subject to Deductible, then no Copayment*

NHP covers disposable medical supplies that are necessary to meet a medical or surgical purpose and are non-reusable and disposable. This includes hypodermic syringes or needles. Your treating provider must order disposable medical supplies.

Durable Medical Equipment (DME)

Member cost: *Subject to Deductible, then no Copayment*

NHP covers Durable Medical Equipment that: is used to fulfill a medical purpose; is generally not useful in the absence of illness or injury; can withstand repeated use over an extended period of time; and is appropriate for home use.

Coverage includes but is not limited to the purchase of medical equipment, replacement parts, and repairs. Your treating provider must order Durable Medical Equipment. Equipment not covered includes exercise bicycles, physio- therapy equipment and foot orthotics except for children 15 and under with symptomatic flat feet and pronation.

Early Intervention Services

Member cost: *$0 Copayment*

NHP covers Early Intervention services for Members under the age of three (3) when the Member meets established criteria. Such Medically Necessary Services may be provided by early intervention Specialists who are working in early intervention programs approved by the Massachusetts Department of Public Health. You do not need a Referral from your PCP for Early Intervention services. You may go to any NHP Early Intervention Provider for these services.

* Per admission/occurrence with a cap of four Copayments per benefit period, with a maximum of one Inpatient Copayment per quarter. Inpatient Copayment will be waived for readmission to a hospital for any reason if the readmission occurs within 30 days of release from a hospital; you must contact NHP to have the Copayment waived.

NHP reimburses for Medically Necessary Applied Behavioral Analysis provided as part of an Early Intervention plan (EI-ABA) for commercially insured children, up to age three years, who have a clinically determined diagnosis within the Autism Spectrum Disorders, and are currently receiving services through an Early Intervention Provider. EI-ABA services must be rendered by a qualified Massachusetts Department of

Public Health (MDPH) Specialty Services Program (SSP). Applied Behavior Analysis (ABA) services beyond age three may be covered through Beacon (the organization that manages NHP's Behavioral Health program).

Emergency Services

Member cost: *$100 Copayment, then subject to Deductible (Copayment waived if admitted to hospital)*

NHP covers Emergency services including ambulance services needed for transportation to the nearest facility. The Cost Sharing above includes all services you receive during the Emergency occurrence for the same hospital and date of service. If you need Emergency care, NHP will cover those services even when they are furnished by a Provider who is not an In-network Provider. You do not need a Referral from your PCP for Emergency Services. Simply go to the nearest Emergency facility or call 911 or the Emergency phone number.

An Emergency is defined as a medical condition, whether physical, behavioral, related to substance use disorder, or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

Eye Care—Examinations (Vision Care)

Member cost: *$20 PCP Copayment,*
Routine Eye Exam: $60 Specialty Copayment
Non-Routine Eye Exam: $30/$60/$90 Specialty Copayment (Ophthalmologist)

NHP covers routine eye exams for Members once every 24 months. You may use any NHP Network ophthalmologist or optometrist for routine eye exams, and you do not need a Referral from your PCP. For all other non-routine eye care services (difficult vision, blurry vision, loss of vision), you must see your PCP who will arrange a Referral to an ophthalmologist (eye care Specialist).

There is no coverage for eyeglasses or contact lenses (except when Medically Necessary for certain eye conditions such as treatment of keratoconus and following cataract surgery), or low vision aids (except for visual magnifying aids used by legally blind Members with diabetes).

Family Planning Services

Member cost: *$0 Copayment*

NHP covers consultations, examinations, procedures and other medical services provided on an outpatient basis and related to the use of all FDA approved contraceptive methods including but not limited to lab tests, birth control counseling, pregnancy testing, voluntary sterilization, IUDs, diaphragms, and implantable contraception. You can obtain services from your PCP, OB/GYN, Planned Parenthood, or any other NHP Provider who offers these services. All FDA-approved prescription contraceptive methods are covered.

Fitness Program Reimbursement

Reimbursement up to $150 per individual or $300 per family per calendar year and are provided for membership fees related to joining a qualified health club, gym, sports club or related physical fitness facility. To qualify for reimbursement, members must be enrolled in a qualified gym and NHP for at least four months and submit their reimbursement requests by March 31 of the following calendar year. Reimbursement amounts may not exceed the amount paid for the membership.

Gynecologic/Obstetric Care

Member cost: *$0 PCP Copayment, $30/$60/$90 Specialty Copayment*

NHP covers Medically Necessary gynecological and obstetrical services. You are not required to obtain a Referral or prior Authorization for Gynecological or Obstetric care provided by an obstetrician, gynecologist, certified nurse midwife or family practitioner participating in NHP's Provider Network. However, the health care professional may be required to obtain prior Authorization for certain services and to follow procedures for making Referrals.

Habilitation Services

Member cost: *$35 Copayment per outpatient visit*

Member cost for facility fee: *$275 Copayment,* then subject to Deductible per Inpatient admission*

Member cost for professional fee: *Subject to Deductible, then no copayment per Inpatient admission*

NHP covers Medically Necessary Habilitation Services for qualified members with certain conditions. These are Health Care Services that help a person keep, learn, or improve skills and functioning for daily living.

Examples include therapy for a child who isn't walking or talking at the expected age. See your Schedule of Benefits for Benefit limits.

Hearing Aids

Member cost for Members age 21 and younger: *Covered up to $2,000 for each affected ear every 36 months.*

Member cost for Members age 22 and older: *Covered up to $1700 every 2 years*
NHP provides coverage of Hearing Aids, including the initial Hearing Aid evaluation, fitting and adjustments, and supplies, including ear molds, when prescribed by an NHP Provider. If you choose a higher-priced Hearing Aid, you must pay the difference between the cost and the NHP coverage limits above. Batteries and assistive listening devices are not covered.

Hearing Examinations

Member cost: *$60 Copayment*

NHP covers exams and tests performed by a hearing Specialist. Go to any NHP Provider for these services. NHP also provides coverage for the cost of a newborn hearing-screening test performed before the infant is discharged from the hospital or birthing center.

HIV-Associated Lipodystrophy Treatment

Member cost is based on type of service and treating provider.

NHP covers medically necessary medical or drug treatments to correct or repair disturbances of body composition related to HIV-associated lipodystrophy syndrome when prior authorized. Coverage includes, but not limited to, reconstructive surgery, such as suction assisted lipectomy, approved medically necessary restorative procedures and dermal injections or fillers for reversal of facial lipoatrophy syndrome. Your NHP treating provider must arrange for these services.

Home Health Care

Member cost: *$0 Copayment*

NHP covers home health care according to a physician-approved home health care plan when such care is an essential part of medical treatment and there is a defined goal. Home Health Care Services are provided in a patient's residence by a public or private home health agency. Services include, but are not limited to, nursing and physical therapy, occupational therapy, speech therapy, medical social work, and nutritional consultation, the services of a home health aide and the use of Durable Medical Equipment (DME) and supplies if medical necessary. No limits other than medical necessity and being part of a physician approved home health services plan are placed on home care services. Your PCP or NHP Treating Provider must arrange services.

Home Infusion

Member cost: *$0 Copayment*

NHP covers home infusion services. Your PCP or NHP Treating Provider must arrange home infusion services.

Hormone Replacement Therapy

Member cost is based on type of service and treating provider.

NHP provides coverage for hormone replacement therapy services including outpatient prescription drugs for peri- and post-menopausal women under the same terms and conditions as for other outpatient services and prescription drugs (See "Section 6: NHP's Pharmacy Benefit" for more information).

Hospice

Member cost: *$0 Copayment*

NHP covers hospice care for terminally ill Members with a life expectancy of six (6) months or less. Services must be found to be suitable and authorized by the Member's PCP. Services must also be equal to those services provided by a licensed hospice program regulated by the Department of Public Health.

House Calls

Member cost: *$20 PCP Copayment, $30/$60/$90 Specialty Copayment*

NHP covers house calls in the NHP Service Area when Medically Necessary. Providers include Physicians, Nurse Practitioners and Physician Assistants. Your PCP must arrange for house calls.

Immunizations, Vaccinations

Member cost: *$0 Copayment*

NHP covers immunizations and vaccinations including travel vaccines when approved and part of an office visit.

Infertility and Treatment for Infertility

Member cost: *$60 Specialty Copayment*

Member cost for facility fee: *$250 copayment,* then Deductible in an outpatient surgical setting*

Member cost for professional fee: *$0 copayment per outpatient surgical setting*

Member cost for facility fee: *$275 copayment,* then Deductible per admission in a hospital setting*

Member cost for professional fee: *$0 Copayment per Inpatient admission*

NHP defines Infertility as the condition of an individual who is unable to conceive or produce conception during a period of one year if the female is age 35 or younger or during a period of six months if the female is over the age of 35.

* Per admission/occurrence with a cap of four Copayments per benefit period, with a maximum of one Inpatient Copayment per quarter. Inpatient Copayment will be waived for readmission to a hospital for any reason if the readmission occurs within 30 days of release from a hospital; you must contact NHP to have the Copayment waived.

For purposes of meeting the criteria for Infertility, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the one-year or six-month period, as applicable.

NHP will cover Medically Necessary expenses for the diagnosis and non-experimental treatment of Infertility to the same extent that Benefits are provided for other Medically Necessary services and prescription medications. The following procedures are covered, but are not limited to:

- Artificial Insemination (AI) and Intrauterine Insemination (IUI)
- In Vitro Fertilization and Embryo Transfer (IVF-ET)
- Gamete Intrafallopian Transfer (GIFT)
- Zygote Intra-fallopian Transfer (ZIFT)
- Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor infertility
- Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any (insurers may not limit Coverage to sperm provided by the spouse)
- Assisted Hatching
- Cryopreservation of embryos, eggs and sperm when the Member is undergoing authorized infertility services.
- Cryopreservation of eggs and sperm is covered when authorized for a member undergoing a medical treatment that may result in infertility.

NHP does not provide coverage for:

- Any experimental infertility procedure
- Surrogacy/gestational carrier
- Reversal of voluntary sterilization

Laboratory Services

Member cost: *$0 Copayment for preventive lab, subject to Deductible, then no Copayment for diagnostic laboratory tests*

NHP covers services that are Medically Necessary for the diagnosis, treatment, and prevention of disease, and for the maintenance of the health of the Member when ordered by a Provider from an In-network laboratory.

Long-Term Antibiotic Therapy for the Treatment of Lyme Disease

Member cost: *Subject to prescription deductible then $10 generic, Subject to prescription deductible then $30 brand name preferred, Subject to prescription deductible then $65 brand-name non-preferred Copayment for 30 day supply prescription drug*

NHP provides coverage for long-term antibiotic therapy for a member with Lyme disease. Your NHP treating provider must arrange for this coverage.

Mammographic Examination (Mammogram)

Member cost: *$0 Copayment*

NHP covers baseline Mammograms for women per clinical guidelines and as recommended by your provider.

Maternity Services—General Coverage

Member cost is based on type of service and treating provider.

NHP provides maternity Benefits for the expense of prenatal care, childbirth, and post-partum care to the same extent as provided for medical conditions not related to pregnancy. Coverage is provided for services rendered by an obstetrician, pediatrician, or certified nurse midwife attending the mother and child.

Maternity Services—Inpatient

Member cost facility fee: *$275 copayment,* then Deductible for Inpatient admission hospital*

Member cost professional fee: *$0 Copayment for Inpatient admission hospital*

NHP covers Inpatient maternity care provided by an attending obstetrician, pediatrician, or certified nurse midwife for a mother and newborn child for at least 48 hour following a vaginal delivery or 96 hours following a cesarean delivery. If the mother and physician agree to an early discharge, Covered Health Care Services include one home visit by a registered nurse, physician, or certified midwife. Additional home visits are covered when Medically Necessary and provided by an NHP Provider. There is no coverage for delivery outside the Service Area within 30 days of the expected delivery date, or after the Member has been told that she is at risk for early delivery. Your PCP, obstetrician, or certified nurse midwife must arrange for services.

* Per admission/occurrence with a cap of four Copayments per benefit period, with a maximum of one Inpatient Copayment per quarter. Inpatient Copayment will be waived for readmission to a hospital for any reason if the readmission occurs within 30 days of release from a hospital; you must contact NHP to have the Copayment waived.

Maternity Services—Outpatient

Member cost: *$0 PCP Copayment, $30/$60/$90 Specialty Copayment*

NHP covers prenatal and postpartum care for members when care is received from an NHP Provider. Services include: prenatal exams; diagnostic tests; prenatal nutrition; health care counseling; risk assessment; and post-partum exams. There is no coverage for obstetrical care outside the NHP Service Area within thirty (30) days of expected delivery date. Your PCP, obstetrician, or certified nurse midwife must arrange for outpatient maternity services. NHP reimburses Members up to $130 for childbirth education classes

Nutritional Formulas

Member cost: *$0 Copayment*

NHP provides coverage for nutritional formula in the following situations:

- Formulas, approved by the Commissioner of the Department of Public Health, for the treatment of infants and children with specific inborn errors of metabolism of amino acids and organic acids such as phenylketonuria (PKU), tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia and methylmalonic academia
- Formulas, approved by the Commissioner of the Department of Public Health as Medically Necessary to protect the unborn fetuses of pregnant women with phenylketonuria
- Formulas for the treatment of malabsorption caused by disorders affecting the absorptive surface, functional length, gastrointestinal tract motility, such as Crohn's disease, ulcerative colitis, gastro esophageal reflux, gastrointestinal motility and chronic intestinal false-obstruction
- Formulas for the treatment of members with an anatomic or structural problem that prevents food from reaching the stomach (e.g. esophageal cancer), or a neuromuscular problem that results in swallowing or chewing problems (e.g., muscular dystrophy)
- Formulas for the treatment of Members with a serious medical condition that either directly or indirectly impacts their ability to normally ingest regular foods and places them at substantial risk of malnutrition (e.g. cancer, AIDS, organ failure, etc.)
- Formulas for the treatment of pediatric members diagnosed with failure to thrive
- Coverage for inherited diseases of amino acids and organic acids includes food products modified to be low protein.

Obstetrical Services

See "Gynecologic/Obstetric Care" above.

Off-label Use of Drugs for the Treatment of Cancer

Member cost: *Subject to prescription deductible then $10 generic, Subject to prescription deductible then $30 brand name preferred, Subject to prescription deductible then $65 brand-name non-preferred Copayment for 30 day supply prescription drug*

NHP provides coverage for use of off-label drugs in the treatment of cancer as it would for any covered prescription drug. The drug must be recognized for treatment of cancer in one of the standard reference compendia, or in the medical literature, or by the Commissioner of Insurance. In addition, NHP will provide coverage for a drug indicated for the treatment of cancer within the Association of Community Cancer Centers Compendia-Based Drug Bulletin. Your PCP or NHP Specialist must arrange for this service. NHP provides coverage for prescribed, orally administered anticancer medication used to eliminate or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications that are covered as medical Benefits.

Off-label Use of Drugs for the Treatment of HIV/AIDS

Member cost: *Subject to prescription deductible then $10 generic, Subject to prescription deductible then $30 brand name preferred, Subject to prescription deductible then $65 brand-name non-preferred Copayment for 30 day supply prescription drug*

NHP provides coverage for use of off-label drugs in the treatment of HIV/AIDS as it would for any covered prescription drug. The drug must be recognized for treatment of HIV/AIDS in one of the standard reference compendia, or in the medical literature, or by the Commissioner of Insurance. Your PCP or NHP Specialist must arrange for this service.

Off-label use of Drugs for the Treatment of Lyme Disease

Member cost: *Subject to prescription deductible then $10 generic, Subject to prescription deductible then $30 brand name preferred, Subject to prescription deductible then $65 brand-name non-preferred Copayment for 30 day supply prescription drug*

NHP provides coverage for off-label use of drugs in the treatment of Lyme disease if the drug has been approved by the FDA. Your NHP treating provider must arrange for this coverage.

Optometric/Ophthalmologic Care

See “Eye Care/Examinations” above.

Oral Cancer Therapy

Member cost is based on type of service and treating provider.

NHP provides coverage for prescribed, orally-administered anticancer medication used to eliminate or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications that are covered as medical benefits.

Orthotics

Member cost: Subject to Deductible, then no Copayment

NHP covers non-dental braces and other mechanical or molded devices when Medically Necessary to support or correct any defects of form or function of the human body due to surgery, disease or injury. Your treating provider must arrange these services. Orthotics or Support Devices for Feet: Support devices for the feet and corrective shoes are only covered for children fifteen (15) and under with certain medical conditions such as pronation or when prescribed by the Member’s PCP and authorized by NHP.

Outpatient Surgery

Member cost for facility fee: *$250 copayment*, then subject to Deductible per outpatient Surgery occurrence when performed in a surgical setting*

Member cost for professional fee: *$0 Copayment per outpatient Surgery occurrence when performed in a surgical setting*

Member cost when performed in an office setting: *$20 PCP Copayment. $30/$60/$90 Specialty Copayment*

NHP covers Medically Necessary surgical procedures in an outpatient surgical setting (ambulatory surgical center or outpatient hospital). These services are subject to outpatient surgery cost sharing. If you have an emergency room visit resulting in surgery and you expect to be discharged the same day, emergency room cost sharing will not apply, outpatient surgery cost sharing applies. NHP also covers Medically Necessary outpatient surgery that occurs in an office setting; these services would be subject to cost sharing associated with the office in which it was performed (PCP or Specialty).

* Per admission/occurrence with a cap of four Copayments per benefit period, with a maximum of one Inpatient Copayment per quarter. Inpatient Copayment will be waived for readmission to a hospital for any reason if the readmission occurs within 30 days of release from a hospital; you must contact NHP to have the Copayment waived.

Oxygen Supplies and Therapy

Member cost: *$0 Copayment*

NHP covers oxygen therapy for Members, when medically necessary. Coverage includes oxygen and equipment rental and supplies required to deliver the oxygen. Your treating provider must arrange oxygen therapy services.

Pediatric Specialty Care

Member cost: *$30/$60/$90 Specialty Copayment*
$20 Copayment for outpatient Behavioral Health Specialist

NHP provides Coverage of pediatric specialty care, including mental health care, by persons with recognized expertise in providing specialty pediatric care. Your PCP must arrange for specialty care.

Pharmacy

Pharmacy Benefits are offered under your GIC Coverage. See "Section 6: NHP's Pharmacy Benefit" for details on your Benefits and Copayments.

Physician Services

Member cost: *$20 PCP Copayment*
$30 Copayment for Tier 1 Specialist
$60 copayment for Tier 2 Specialist
$90 Copayment for Tier 3 Specialist
$60 copayment for non-tiered Specialist
$20 Copayment for Behavioral Health Specialist

NHP covers diagnosis, treatment, consultation, nutrition counseling, health education, and minor surgery when provided by the Member's PCP or NHP In-Network Specialist.

Podiatry Services

Member cost: *$20 PCP Copayment*
$30/$60/$90 Specialty Copayment

NHP covers Medically Necessary podiatry services performed by a physician or duly licensed podiatrist.

Preventive Care Services and Tests

Member cost: *$0 Copayment*

NHP covers select preventive services and tests for adults, women (including pregnant women) and children, including coverage for annual physical exams as appropriate for the Member's age and gender, immunization visits, well child visits, and annual gynecological exams. Routine cytological screening (Pap smears) and mammographic examinations are covered as Preventive Care. You may use any NHP Provider for these services.

For a complete list of eligible Preventive Care services, please visit www.nhp.org or contact NHP's GIC Customer Service. Covered preventive services reflect the United States Preventive Services Task Force (USPSTF) grade "A" and "B" recommendations, the Advisory Committee on Immunization Practices (ACIP) recommendations, the Women's Preventive Task Force, and the Health Resources and Services Administration for Infants, Children and Adolescents. Preventive service descriptions have been adopted from content on the healthcare.gov website.
NHP will cover the following services for a Dependent from their date of birth through age six (6): physical examinations; history, measurement, sensory screening, neuropsychiatric evaluations and development screening, and assessment at the following intervals: six times during the child's first year after birth, three (3) times during the next year, and annually until age six (6). Covered services include: hereditary and metabolic screening at birth; appropriate immunizations; tuberculin test, hematocrit, hemoglobin or other appropriate blood tests and urinalysis, as recommended by the physician; and lead screening.

Prosthetic Devices

Member cost: *Subject to Deductible, then no Copayment*

NHP covers prosthetic devices, including evaluation, fabrication, and fitting: some prosthetics may require a prior Authorization. Coverage includes prosthetic devices which replace in whole or in part, an arm or leg, and includes repairs. Your treating provider must arrange prosthetic device services.

Radiation and Chemotherapy

Member cost: *$0 Copayment*

NHP covers radiation and chemotherapy by a Network Provider when arranged for by your PCP. NHP also provides coverage for prescribed, orally administered anticancer medication used to eliminate or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications that are covered as medical Benefits.

Radiology

Member cost: *Subject to Deductible, then no Copayment for Diagnostic, Laboratory and X-ray*

$100 Copayment, then subject to Deductible with a maximum of 1 Copayment per day for High Technology Radiology (outpatient MRI, CT, PET Scan, and Nuclear Cardiac Imaging)

NHP covers all Medically Necessary radiological services including X-rays, MRIs and CAT scans. Your PCP must arrange radiology services.

Reconstructive/Restorative Surgery

Member cost for facility fee: *$275 copayment*, then subject to Deductible per Inpatient surgical admission*

Member cost for professional fee: *$0 Copayment per Inpatient surgical admission*

Member cost for facility fee: *$250 copayment*, then subject to Deductible per outpatient Surgery occurrence*

Member cost for professional fee: *$0 Copayment per outpatient Surgery occurrence*

Reconstructive surgery is any procedure to repair, improve, restore or correct bodily function caused by an accidental injury, congenital anomaly or previous surgical procedure or disease. NHP covers surgery for post-mastectomy coverage including:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce symmetrical appearance,
- Prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient

Your PCP must arrange reconstructive or restorative surgery services.

Registered Nurse or Nurse Practitioner

Member cost: *$20 PCP Copayment*
$30/$60/$90 Specialty Copayment

NHP covers services given by a registered nurse, Nurse Practitioner, and nurse midwife or nurse anesthetist if such services are in the nurse's scope of practice. Your PCP must arrange these services.

Rehabilitation Hospital Care (Including Physical, Occupational, and Speech Therapy)

Member cost for facility fee: *$275 copayment*, then subject to Deductible per Inpatient admission*

Member cost for professional fee: *Subject to Deductible per Inpatient admission*

NHP covers rehabilitative care on an Inpatient basis. Coverage is provided only when you need rehabilitative services that must be provided in an Inpatient setting. Rehabilitative care includes physical, speech, and occupational therapies. Services must be arranged through your PCP. Refer to your Schedule of Benefits for limitations on Inpatient rehabilitation hospital care.

Rehabilitation Therapy – Outpatient (Includes Physical, Occupational, and Speech Therapy)

Member cost: *$35 copayment*

NHP covers evaluation and restorative, short- term treatment when needed to improve the ability to perform activities of daily living and when there is likely to be a significant improvement in the Member's level of function after illness or injury. See your Schedule of Benefits for limitations on Physical or Occupational Therapy.

Routine Nursery and Newborn Care

Member cost: *$0 Copayment*

NHP covers all Medically Necessary newborn care. Your PCP must arrange newborn care.

Second Opinions

Member cost: *$20 PCP Copayment*
$30/$60/$90 Specialty Copayment

NHP covers second opinions when provided by another NHP Provider. A Referral from your PCP is needed when seeking a second opinion for another NHP Provider. Second opinions from Out-of-Network Providers are covered only when the specific expertise requested is not available in the Network. Prior Authorization from NHP is required.

* Per admission/occurrence with a cap of four Copayments per benefit period, with a maximum of one Inpatient Copayment per quarter. Inpatient Copayment will be waived for readmission to a hospital for any reason if the readmission occurs within 30 days of release from a hospital; you must contact NHP to have the Copayment waived.

Skilled Nursing Facility Care

Member cost for facility and professional fee:
Subject to Deductible, then no Copayment

NHP covers admission to a skilled nursing facility. Coverage is provided only when you need daily skilled nursing care or rehabilitative services that must be provided in an Inpatient setting. Your PCP must arrange these services. Please see your Schedule of Benefits for limitations on Skilled Nursing Facility Care.

Specialty Care (Allergy/Immunology, Cardiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gastroenterology, General Surgery, Hematology & Oncology, Nephrology, Neurology, OB/GYN, Ophthalmology, Orthopedic Surgery, Podiatry, Pulmonology, Rheumatology, and Urology)

Member cost: *$30/$60/$90 Outpatient Specialty Copayment*

Specialty Care (All Other)

Member cost: *$60 copayment*

NHP covers specialty care when arranged by a Member's PCP. A Referral is required for Specialty Care; without a Referral, NHP will not reimburse for the Specialist visit and you could be liable for the cost. You are not required to get a Referral or prior Authorization for the following care provided by an obstetrician, gynecologist, certified nurse midwife or family practitioner participating in NHP's Provider Network:

- Annual preventive gynecologic health examinations
- Medically Necessary follow-up
- Maternity care
- Acute or Emergency gynecologic examinations
- Routine Eye exam
- Physical Therapy
- Occupational Therapy
- Speech Therapy

Speech, Hearing and Language Disorders

Member cost: *$35 copayment*

NHP provides coverage for the diagnosis and treatment of speech, hearing and language disorders by licensed speech/language pathologists or audiologists. Coverage is provided if services are rendered within the lawful scope of practice for such speech-language pathologists or audiologists, whether the services are provided in a hospital, clinic or a private office. Coverage does not extend to the diagnosis or treatment of speech, hearing and language disorders in a school-based setting. Benefits provided are subject to the same terms and conditions established for any other Health Care Service covered by NHP. You may use any NHP Provider of these services.

Surgery

Member cost for facility fee: *$275 copayment*, then subject to deductible per Inpatient hospital admission*

Member cost for professional fee: *$0 Copayment per Inpatient hospital admission*

NHP provides coverage for Medically Necessary surgery including related anesthesia. Surgery, including oral maxillofacial and reconstructive may require prior Authorization.

* Per admission/occurrence with a cap of four Copayments per benefit period, with a maximum of one Inpatient Copayment per quarter. Inpatient Copayment will be waived for readmission to a hospital for any reason if the readmission occurs within 30 days of release from a hospital; you must contact NHP to have the Copayment waived.

Telemedicine

Member cost: *$20 copayment per visit*
Additional cost sharing may apply to services ordered by the physician, such as labs and prescription drugs.

NHP provides audiovisual visits to a national network of U.S. board-certified doctors 24/7 to discuss non-emergency conditions accessed by smartphone, mobile device, or online via computer. Doctors can diagnose and treat many common illnesses. Telephone (voice only), facsimile or email communications with your provider are not considered telemedicine. For the most current information about providers in our Network, visit www.nhp.org/find-a-doctor.

Temporomandibular Joint dysfunction (TMD) Services, also known as TMJ

Member cost will be associated with the service and where it occurs. For example, Diagnostic imaging will take cost sharing associated with Diagnostic Laboratory and X-ray as it appears on your Schedule of Benefits.

NHP Covers Medically Necessary TMD services, coverage is limited to medical services only. NHP covers the following services:

- Surgical consultation
- Surgery
- Diagnostic imaging
- Physical therapy, subject to the visit limit for outpatient physical therapy

NHP does not cover: services of a dentist for TMD, services associated with orthodontic care, oral appliances, or Arthroscopy for diagnostic purposes only.

Transplants

Member cost for Inpatient facility fee: *$275 copayment*, then subject to Deductible per Inpatient hospital admission*

Member cost for Inpatient professional fee: *$0 Copayment per Inpatient hospital admission*

NHP covers transplants as follows:

- Bone marrow transplants are covered when provided within the NHP Network and approved by NHP. Coverage includes but is not limited to Members with breast cancer that has progressed to metastatic disease, provided that the Member meets criteria established by the Department of Public Health.
- Human organ transplants are covered. Transplants must be non-experimental surgical procedures provided within the NHP Network. Coverage includes donor's costs for both living and nonliving transplant donors to the extent that another insurer does not cover the charges. Your Provider will contact NHP.
- Coverage for Human Leukocyte Antigen testing for certain individuals and patients. NHP will provide for all Members or Enrollees coverage for the cost of human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish such Member's or Enrollee's bone marrow transplant donor suitability. The coverage includes the cost of testing for A, B, or DR antigens, or any combination thereof, consistent with rules, regulations and criteria established by the Department of Public Health. Your PCP must arrange all services.

* Per admission/occurrence with a cap of four Copayments per benefit period, with a maximum of one Inpatient Copayment per quarter. Inpatient Copayment will be waived for readmission to a hospital for any reason if the readmission occurs within 30 days of release from a hospital; you must contact NHP to have the Copayment waived.

Transportation

Member cost: *Subject to deductible*

Emergency ambulance transportation, including air ambulance, is covered. NHP covers such ambulance transport to the nearest Hospital that can provide the care you need. Except in an Emergency, ambulance transportation is covered only when arranged by an NHP Provider. We also cover Medically Necessary transfer from one health care facility to another.

Urgent Care

Member cost: *$20 Copayment*

NHP covers Urgent Care and Limited Service Clinics inside and outside the NHP Service Area. Urgent Care does not include care that is provided in an Emergency room or care that is elective, Emergency, preventive or health maintenance. Examples of Urgent Care conditions include but are not limited to fever, sore throat, earache and acute pain.

Vision Care

See "Eye Care/Examinations."

Wigs (Scalp Hair Prosthesis for Cancer Patients)

Member cost: *Subject to Deductible, then no Copayment*

For hair loss suffered as a result of the treatment of any form of cancer or leukemia, a written statement by the treating physician that the wig is Medically Necessary and required.

* Per admission/occurrence with a cap of four Copayments per benefit period, with a maximum of one Inpatient Copayment per quarter. Inpatient Copayment will be waived for readmission to a hospital for any reason if the readmission occurs within 30 days of release from a hospital; you must contact NHP to have the Copayment waived.

Section 8.

Behavioral Health (Mental Health and Substance Use Services)

Behavioral Health (General)

NHP's Behavioral Health treatment Benefits include non-custodial, Inpatient, intermediate and outpatient services based on medical necessity criteria for treatment in the least restrictive, clinically appropriate setting. NHP does not apply any Copayments, Deductibles, Coinsurance or maximum lifetime Benefits to Behavioral Health services that are not equally applied to other covered Health Care Services. Please see your Schedule of Benefits for more information on your Behavioral Health Benefits, or call NHP's GIC Customer Service.

Beacon Health Options (Beacon) is NHP's delegated managed Behavioral Health Organization (MBHO). All decisions to deny Behavioral Health services are made only by Licensed Mental Health Professionals. Beacon maintains a Network of clinicians, groups, clinics and practices to provide Behavioral Health treatment services within the NHP Service Area.

All Behavioral Health services must be provided by an NHP/Beacon In-network Provider. You may call Beacon to help you find the right services. You can also ask your PCP to refer you to an NHP/ Beacon participating provider.

NHP Members can call Beacon at 800-414-2820 (TTY 781-994-7660). You can also find information at www.beaconhealthstrategies.com.

NHP provides Benefits for the diagnosis and treatment of Behavioral Health disorders described in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

The amount and type of treatment are determined by medical necessity and may be subject to Authorization requirements. All Copayments and coverage limits are described in your *Schedule of Benefits*.

NHP provides coverage for the diagnosis and treatment of:

- Biologically-based mental, behavioral, or emotional disorders, including schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia, panic disorder, obsessive-compulsive disorder, delirium and dementia, affective disorders, eating disorders, post-traumatic stress disorder, substance use disorders, autism, and other psychotic disorders or other biologically- based mental disorders appearing in the Diagnostic and Statistical Manual (DSM) that are scientifically recognized.
- Rape-related mental or emotional disorders to victims of rape or victims of assault with intent to commit rape. Rape- related mental health treatment is based on medical need for the service without any predetermined annual or lifetime or annual dollar or unit limitation.
- Non-biologically-based mental, behavioral or emotional disorders, in children and adolescents under the age of 19, which substantially interfere with or substantially limit the functioning and social interactions of such a child or adolescent; provided that said interference or limitation is documented by and the Referral for said diagnosis and treatment is made by the PCP, primary pediatrician or a Licensed Mental Health Professional of such a child or adolescent or is evidenced by conduct, including, but not limited to: an inability to attend school as a result of such a disorder; the need to hospitalize the child or adolescent as a result of such a disorder; or a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others. NHP will continue to provide such Benefits to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent's nineteenth birthday until said course of treatment is completed and which such Benefits first became available remains in effect, or subject to a subsequent benefits contract which is in effect." Treatment is based on medical need for the service without any predetermined annual or lifetime dollar or unit limitation.
- All other non-biologically-based mental health conditions.
- Psychopharmacological and neuropsychological assessments are covered when Medically Necessary.

Behavioral Health Services (Outpatient)

NHP Members may seek outpatient mental health and substance use counseling or medication services from any clinician in the NHP/Beacon statewide Network. The Network includes:

- Physicians with a specialty in psychiatry
- Licensed psychologists
- Licensed independent clinical social workers

- Licensed marriage and family therapists
- Licensed mental health clinical nurse Specialists,
- Licensed mental health counselors

Members can contact In-Network Providers of these services for treatment. A Referral from your PCP is not needed.

Your mental health provider is required to contact Beacon for any authorizations needed. All Authorizations are based on the medical necessity and the Member's clinical needs. All Copayments for outpatient mental health or substance use services are listed in your Schedule of Benefits. Biologically-based mental health services are provided without annual, lifetime or visit/unit/day limitations. No other limitations, Coinsurance, Copayment, Deductible or other cost-sharing may be applied toward these Benefits except as are applied to covered medical services within the plan. Services may be provided in a licensed hospital; a mental health or substance use clinic licensed by the Department of Mental Health or Public Health; a community mental health center; or a professional office or home-based service, as long as services are rendered by a Licensed Mental Health Professional acting within the scope of his or her license.

Behavioral Health Services (Intermediate)

NHP covers Medically Necessary Intermediate Behavioral Health services. Services include:

- Partial hospitalization
- Day Treatment
- Acute and other residential treatment programs
- Clinically managed detoxification services
- Crisis stabilization
- Intensive Outpatient Programs (IOP)
- In-home Therapy services

To obtain services, call Beacon at 1-800-414-2820 (TTY 781-994-7660). You may also contact your PCP for help. You or your Behavioral Health Provider must get prior Authorization from Beacon for these services except for SOAP, community based detoxification, addiction day treatment program for pregnant women.

Behavioral Health Services (Inpatient)

Services may be provided in a general hospital licensed to provide such services; in a facility under the direction and supervision of the Department of Mental Health; in a private mental hospital licensed by the Department of Mental Health; or in a substance use facility licensed by the Department of Public Health. Inpatient services are a 24-hour service, delivered in a licensed hospital setting for mental health or Substance Use treatment.

To obtain services, call Beacon at 800-414-2820 (TTY 781-994-7660). You may also contact your PCP or ESP for assistance. You or your Behavioral Health Provider must get prior Authorization from Beacon for inpatient mental health services. Inpatient substance use services do not require prior Authorization. Biologically-based inpatient services are provided without annual, lifetime or day limitations.

Federal and State Mental Health Parity laws

Federal and state laws require that all Managed Care Organizations, including NHP, provide mental health and substance use services to members in the same way they provide medical/ surgical health services. This is what is referred to as "mental health parity." Mental health parity laws are important because, in the past, patients who require mental health and substance use treatment may have faced higher Deductibles, office visit limits and other treatment limitations in comparison to patients who require medical/ surgical treatments. The federal and state parity laws help limit these differences. The federal law is known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. Below is information regarding your rights and NHP's obligations under the mental health parity laws as well as information on how to submit a formal Complaint if you believe that NHP has not complied with these laws.

Your Rights and NHP's Obligations According to the Mental Health Parity Laws

- NHP must provide you with the same level of Benefits for mental health and substance use problems you have as for other medical/surgical problems you may have.
- NHP must have similar prior Authorization requirements and treatment limitations for mental health and substance use services as we do for medical/surgical services.

- Upon your or your Provider's request, NHP must provide you or your Provider with a copy of the medical necessity criteria used by NHP for prior Authorization.
- Within a reasonable time frame, NHP must provide you with a written notice regarding any denial of Authorization for mental or substance use services. See Section 17: Utilization Review and Quality Assurance for more information.
- You have the right to receive a second medical opinion on a mental health or substance use problem when you are given a diagnosis or treatment option. Also remember that you can access outpatient mental health and substance use services from a Beacon Behavioral Health Provider without obtaining a Referral from your PCP.

Submitting a Complaint About a Mental Health Parity Issue

If you believe that NHP has not complied with federal or state mental health parity laws, you may submit a Complaint to NHP and/or to the Massachusetts Division of Insurance's Consumer Services Section.

Submitting a Complaint to NHP

To submit a Complaint about a mental health parity issue to NHP, follow the instructions shown in Section 15: Complaint and Grievance Process.

Submitting a Complaint to the Massachusetts Department of Insurance

Complaints alleging a Carrier's non-compliance with the mental health parity laws may be submitted verbally or in writing to the Division's Consumer Services Section for review. A written submission may be made using the Division's Insurance Complaint Form. A copy of the form may be requested by telephone or by mail, and the form can also be found on the Division's webpage at: http://www.mass.gov/ocabr/ consumer/insurance/file-a-Complaint/fi ling- aComplaint.html

Consumer Complaints regarding alleged non-compliance with the mental health parity laws may also be submitted by telephone to the Division's Consumer Services Section by calling (877) 563-4467 or (617) 521-7794. All Complaints that are initially made verbally by telephone must be following up by a written submission to the Consumer Services Section, which must include but is not limited to the following information requested on the Insurance Complaint Form:

- The complainant's name and address
- The nature of the Complaint The complainant's signature authorizing the release of any information regarding the Complaint to help the Division with its review of the Complaint

NHP and the Division of Insurance will attempt to resolve all consumer Complaints regarding non-compliance with the mental health parity laws in a timely fashion.

Mental Health/Substance Use Summary of Copayments

Member cost: *$20 per Office Visit for outpatient Mental/Substance Use including detoxification rehabilitation*

$0 Copayment Office Visit for Medication Assisted Treatment (MAT)

$0 Copayment for the following generic drugs for Medication Assisted Treatment: generic buprenorphine-naloxone, naloxone, and naltrexone

$0 Copayment for Inpatient Care Mental Health or Substance Use including detoxification

Development of Clinical Guidelines and Utilization Review Criteria

Behavioral Health Clinical guidelines and Utilization Review criteria are developed with input from practicing physicians and Beacon in accordance with standards adopted by national accreditation organizations. Guidelines are evidence-based, wherever possible, are applied in a manner that considers the individual's Behavioral Health needs, and are otherwise compliant with applicable state and federal law.

Section 9.

Benefit Exclusions and Limitations

NHP does not cover the following services or supplies.

Acupuncture

No Benefits are provided for acupuncture.

Ambulance

No benefits are provided for ambulance costs to transport you to a facility of your choice or to return you to the United States from another Country, also referred to as repatriation or medical evacuation.

Benefits from Other Sources

Benefits from other sources are Health Care Services and supplies to treat an illness or injury for which you have the right to Benefits under government programs. These include:

- Veterans Administration for an illness or injury connected to military service.
- Programs set up by other local, state, federal or foreign laws or regulations that provide or pay for Health Care Services and supplies or that require care or treatment to be furnished in a public facility. No Benefits are provided if you could have received government Benefits by applying for them on time.
- Services for which payment is required to be made by a Workers' Compensation plan.
- Employers under state or federal laws are also Benefits from other sources.

Biofeedback

No Benefits are provided for biofeedback.

Blood and Related Fees

Blood or blood products except as specified in this handbook under "Section 7: Your NHP Benefits."

Chiropractic Care

No Benefits are provided for chiropractic care.

Cosmetic Services and Procedures

No Benefits are provided for Cosmetic Services that are performed solely for the purpose of making you look better whether or not these services are meant to make you feel better about yourself or treat a mental condition. For example, Surgery to treat acne lesions or remove tattoos and medications for cosmetic purposes to treat hair loss or wrinkles. Reconstructive Surgery is covered, Please see "Section 7: Your NHP Covered Health Care Services" for details.

Custodial Care

No Benefits are provided for custodial or rest care: this is care given to help a person in the activities of daily living and does not require day- to-day attention by medically-trained persons.

Dental Care

No Benefits are provided for routine dental care.

Dentures

No Benefits are provided for dentures.

Diet Foods

No Benefits are provided for the purchase of special foods to support any type of diet, except for those nutritional supplements/formulas listed as a Covered Health Care Service in this handbook.

Educational Testing and Evaluations

No Benefits are provided for educational services or testing unless they are covered under the Early Intervention Services and Outpatient Mental Health and Substance Use Benefit. No Benefits are provided for educational services whose sole intent is to enhance educational achievement (e.g., subject achievement testing) or to resolve problems regarding school performance.

Exams Required by a Third Party

No Benefits are provided for physical, psychiatric, and psychological examinations or testing required by a third party. This includes but is not limited to employment; insurance; licensing and court- or school-ordered exams and drug tests that are not Medically Necessary or are considered evaluations for work performance.

Experimental Services and Procedures

The Benefits described in this Member Handbook are provided only when covered services are furnished in accordance with NHP's medical technology assessment guidelines. No Benefits are provided for health care charges that are received for or related to care that NHP considers experimental services or procedures. The fact that a treatment is offered as a last resort does not mean that Benefits will be provided for it. There are three exceptions to this exclusion. As required by law, NHP does provide Benefits for it.

There are three exceptions to this exclusion. As required by law, NHP does provide Benefits for:

- One or more stem cell (bone marrow) transplants for a member who has been diagnosed with breast cancer that has spread. The member must meet the eligibility standards that have been set by the Massachusetts Department of Public Health;
- Certain drugs used on an off-label basis.
- Examples are drugs used to treat cancer and drugs used to treat HIV/AIDS.
- Coverage of patient care services provided during a qualified clinical trial intended to treat cancer.

Eyewear/Laser Eyesight Correction

No Benefits are provided for eyeglasses and contact lenses. Benefits are also not provided for eye Surgery to treat conditions which can be corrected by means other than Surgery. An example of eye Surgery that is excluded is laser Surgery for conditions such as near-sighted vision.

There is an exception to this exclusion. NHP does provide Benefits for contact lenses when Medically Necessary for certain eye conditions such as use for post-cataract Surgery and the treatment of keratoconus.

Foot Care

No Benefits are provided for routine foot care services such as trimming of corns, trimming of nails and other hygienic care, except when your care is Medically Necessary due to systemic circulatory diseases such as diabetes.

Long-term Care

No Benefits are provided for long-term care.

Massage Therapy

No Benefits are provided for Massage Therapy.

Other Non-Covered Services

No Benefits are provided for any service or supply that is not described as a Covered Benefit in this Member Handbook. Including but not limited to:

- Any service or supply that is not
- Medically Necessary
- All institutional charges over the semi- private room rate, except when a private room is Medically Necessary
- A Provider's charge for shipping and handling or taxes
- Medications, devices, treatments and procedures that have not been demonstrated to be medically effective
- Routine Care, including routine prenatal care, when the Member is traveling outside the NHP Service Area
- Services for which there would be no charge in the absence of insurance
- Special equipment needed for sports or job purposes.
- There is no coverage for delivery of a baby outside the NHP Service Area within thirty (30) days of the expected delivery date, or after the Member has been told that she is at risk for early delivery.
- Work rehabilitation.

Out-of-Network Providers

No Benefits are provided for any service that is provided to, arranged by, or approved by a Provider that is not Member's PCP or an NHP Provider. Also, no Benefits are provided for Medications or supplies prescribed by Providers who are not an NHP authorized provider, except as covered outside the NHP Service Area.

Personal Comfort Items

No Benefits are provided for items or services that are furnished for your personal comfort or for the convenience of your family. Examples of these types of items or services are: phones, radios, TVs and personal care services. The following items are generally deemed convenience items:

- Air conditioners
- Air purifiers
- Chair lifts
- Dehumidifiers
- Dentures
- Elevators
- "Spare" or "back-up" equipment.
- Bath/bathing equipment such as aqua massagers and turbo jets.
- Whirlpool equipment generally used for soothing or comfort measures.
- Home type bed baths requiring installation (such as Schmidt or Century Bed Bath).
- Non-medical equipment otherwise available to the member that does not serve a primary medical purpose.
- Bed lifters not primarily medical in nature.
- Beds and mattresses, non-hospital type (e.g., Beautyrest or Craft-matic brand adjustable beds)
- Full, queen and king size hospital Beds
- Cushions, pads and pillows except those described as covered
- Pulse tachometers

Private-Duty Nursing

No Benefits are provided for private-duty nursing.

Reversal of Voluntary Sterilization

No Benefits are provided for the reversal of voluntary sterilization.

Self-Monitoring Devices Limitation

No Benefits are provided for self-monitoring devices that are used in the absence of serious medical conditions. For example, a Personal Emergency Response System is not covered. Coverage is provided for:

- Blood glucose monitoring devises used by members with insulin-dependent, insulin-using, gestational or non-insulin dependent diabetes
- Certain devices that NHP decides would give a Member having particular symptoms the ability to detect or stop the onset of a sudden life-threatening condition
- Peak flow meters used in the monitoring of asthma control

Section 10.

When You Have Other Coverage

This section explains how Benefits under this policy will be coordinated with other insurance Benefits available to pay for health services that a member has received. Benefits are coordinated among insurance Carriers so that only one payment is made for a 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.

Coordination of Benefits

Benefits under this Evidence of Coverage will be coordinated to the extent permitted by law with other health Benefits including but not limited to homeowner's insurance, motor vehicle insurance, group and/or non-group health insurance, Hospital indemnity Benefits that exceed $100 per day, and governmental Benefits.

Coordination of Benefits will be based upon the Massachusetts Regulation for a service that is covered at least in part by any of the plans involved. NHP reimbursement shall not exceed the maximum allowable under the Plan. (Unless otherwise required by law, coverage under this policy by NHP will be secondary when another plan, including without limitation, medical payment coverage under an automobile or home insurance policy, provides you with coverage for Health Care Services.)

Primary vs. Secondary Coverage

When a Member is covered by two or more health Benefit plans, one plan will be "primary" and the other plan (or plans) will be "secondary." The Benefits of the primary plan are determined before those of the secondary plan(s) and without considering the Benefits of the secondary plan(s). The Benefits of the 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:

Dependent/Non-dependent

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

A Dependent Child Whose Parents/Guardians are Not Separated or Divorced

The order of Benefits is determined as follows:

- The Benefits of the plan of the parent/guardian whose birthday falls earlier in a year are determined before those of the plan of the parent or guardian whose birthday falls later in that year. If both parents or guardians have the same birthday, the plan covering the parent or guardian for the longer time is primary.
- When the other plan does not have the same rules of priority as those listed above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of Benefits, the rule of the other plan will determine order of Benefits.

A Dependent Child Whose Parents are Separated or Divorced

Unless a court order, of which NHP 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:

- First, the plan of the parent with custody of the child.
- Then, the plan of the spouse of the parent with custody of the child
- Finally, the plan of the parent not having custody of the child

Active/Inactive Employee

The Benefits of the plan that covers the person as an active employee are determined before those of the plan that covers the person as a laid-off or retired employee.

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 a Member is 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.

Provider Payment when NHP Coverage is Secondary

When a Member's NHP coverage is secondary to a Member's coverage under another health Benefit plan, NHP may suspend payment to a Provider of

services until the Provider has properly submitted a Claim to the primary plan and the Claim has been processed and paid, in whole or in part, or denied by the primary plan. NHP may recover any payments made for services in excess of NHP's liability as the secondary plan, either before or after payment by the primary plan.

Worker's Compensation/Government Programs

If NHP has information indicating that services provided to a Member are covered under Worker's Compensation, employer's liability, or another program of similar purpose, or by a federal, state or other government agency, NHP may suspend payment for such services until a determination is made whether payment will be made by such program. If NHP provides or pays for services for an illness or injury covered under Worker's Compensation, employer's liability, or another program of similar purpose, or by a federal, state or other government agency, NHP 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.

Subrogation

If you are injured by any act or omission of another person, the coverage under this contract will be subrogated. This means that NHP may use your right to recover money from the person(s) who caused the injury or from any insurance company or other party. If you recover money, you must reimburse NHP up to the amount of the payments that it has made. This is true even if you do not recover the total amount of your Claim against the other person(s). This is also true if the payment you receive is described as payment for other than health care expenses. The amount you must reimburse NHP will not be reduced by any attorney's fees or expenses you incur.

You must give NHP information and help. This means you must complete and sign all necessary documents to help NHP get this money back.

This also means that you must give NHP notice before settling any Claim arising out of injuries you sustained by an act or omission of another person(s) for which NHP provide coverage. You must not do anything that might limit NHP's right to full reimbursement. The subrogation and recovery provisions in this Evidence of Coverage apply whether or not the Member recovering money is a minor.

To enforce its Subrogation rights under this policy, NHP will have the right to take legal action, with or without the Member's consent, against any party to secure recovery of the value of services provided or paid for by the Plan for which such party is, or may be, liable.

Member Cooperation

As a Member of NHP, you agree to cooperate with NHP in exercising its rights of Subrogation and Coordination of Benefits under the Evidence of Coverage. Such cooperation will include, but not be limited to:

- Providing all information and documents requested by NHP.
- Executing any instruments deemed necessary by NHP to protect its rights.
- Promptly assigning NHP any monies received for services provided or paid for by NHP.
- Promptly notify NHP of any instances that may give rise to NHP's rights.

The Member further agrees to do nothing to prejudice or interfere with NHP's rights to Subrogation or Coordination of Benefits. Failure of the Member to perform the obligations stated in this section shall render the Member liable to NHP for any expenses NHP may incur, including reasonable attorneys' fees, in enforcing its rights under this Plan.

Nothing in this Member Handbook may be interpreted to limit NHP's right to use any means provided by law to enforce its rights to Subrogation or Coordination of Benefits under this plan.

Members Eligible for Medicare

When you receive Covered Benefits that are eligible for coverage by Medicare as the primary payer, the Claim must be submitted to Medicare before payment by NHP. The Plan will be liable for any amount eligible for coverage that is not paid by Medicare. You shall take such action as is required to assure payment by Medicare. If you are eligible for Medicare by reason of End Stage Renal Disease, the Plan will be the primary payor for Covered Benefits during the "coordination period" specified by federal regulations at 42 CFR Section 411.62. Thereafter, Medicare will be the primary payor. When Medicare is primary (or would be primary if you were timely enrolled) the Plan will pay for services only to the extent payments would exceed what would be payable by Medicare. When the plan provides Benefits to a Member for which the Member is eligible under Medicare, the Plan shall be entitled to reimbursement from Medicare for such services. The Member shall take such action as is required to assure this reimbursement.

Please note: Retirees who are eligible for Medicare Part A for free must enroll in Part B, and must enroll in a GIC Medicare plan in order to continue coverage through the GIC.

Section 11.

Care Management Programs

If you have a complex health concern, NHP has care managers who can support you and your health care Provider during treatment. Our care managers are nursing and therapy professionals (physical, respiratory, etc.) who have expertise helping Members who have a range of health care needs. Care management can be provided for:

- Diabetes
- Tobacco cessation (help to stop smoking)
- Asthma
- Behavioral Health (mental health and substance use)
- Complex care needs
- Injuries requiring rehabilitation
- Organ transplant patients
- Chronic illnesses

Members may join any of the care management programs listed below. For more information on these or other programs:

- Call NHP's GIC Customer Service at 866-567-9175 (TTY 711).
- Visit NHP's website at www.nhp.org.
- Call one of our Care Managers toll-free at 800-432-9449.

Asthma Management Program

NHP's Asthma Program helps you manage your asthma by making sure you get all the care you need. An Asthma Care Manager will work with you and your health care Provider on a treatment plan that works for you.

A respiratory therapist can also visit you at home to help you learn how to use your medication and help you figure out what could be triggering asthma episodes. You can also get books, videos and a computer game that help children understand asthma.

Behavioral Health Care Program

NHP provides care for Members who may have mental health and substance use concerns. NHP's Behavioral Health Care Management program is managed by Beacon. They can help find a counselor near you, make recommendations and explain treatment options. You do not need a Referral from your Doctor for these services. For more information about Behavioral Health Benefits:

- Call Beacon Health Options at 800-414-2820 (TTY: 781-994-7660).
- Visit Beacon's website at www.beaconhealthstrategies.com.
- Call NHP's GIC Customer Service at 866-567-9175 (TTY 711).
- Visit the NHP website at www.nhp.org.

Cardiovascular Disease (CVD) Program

NHP offers a CVD Program to all NHP members. Members with documented CVD are potentially eligible for this program to help participants with condition management and reduction of Secondary Cardiovascular risk factors through education, coaching and lifestyle changes. For more information on the CVD program, please call NHP's GIC Customer Service.

Care Partnership Program

If you have complex care needs or the potential for complex care needs, care managers work with you on developing health and wellness action plans, coaching and education, and work with your Providers to coordinate your health care needs.

Congestive Heart Failure (CHF) Program

If you have Congestive Heart Failure, you may benefit from the extra care and education that our CHF Care Management Program provides. CHF care managers' work with Network providers and reach out to Members considered to be at-risk for heart failure-related complications by providing education and support.

Diabetes Management Program

If you have diabetes you may benefit from the extra care and education our Diabetes Care Management Program provides. Diabetes care managers reach out to Members considered to be at-risk for diabetes-related complications by providing education and support.

For You Two Prenatal Program

If you are pregnant, NHP's For You Two program provides you with information about pregnancy, plus educational material and extra support for moms-to-be.

The For You Two program is free and offers you:

- Help from an NHP care manager
- Rental or purchase of an electric breast pump
- A home nurse visit after delivery
- Access to NHP's Tobacco Treatment Specialist
- Access to mental health or substance use services
- Immunization information, schedules and reminders

Childbirth education classes are available to you and your partner or support person free of charge at many Primary Care Sites and hospitals. Speak to the Provider caring for you during your pregnancy or the facility where you plan to deliver about enrolling. If they do not offer a childbirth education program, NHP will reimburse you for the cost of these classes up to $130 per pregnancy. You must pay the full cost of the childbirth course. After you complete the course you may file a Claim to NHP for reimbursement.

For more information, call NHP's GIC Customer Service at 866-567-9175 (TTY 711).

Pediatric Care Management

NHP's Pediatric Care Management program focuses on Members under age 19 that may have special health care needs. As a service to parents, this program coordinates a child's medical and Behavioral Health care and other needs. The program also links families to special resources and other programs that help children with special health care needs.

NHP can also connect you to our Parent Consultant, the parent of a special needs child who can provide emotional support, as well as information about support groups, special education and community resources.

Rare Condition Programs

There are a number of conditions that are not commonly experienced by our members but can benefit from the structure of a Disease Management approach. For these, NHP has engaged AccordantCare™ to provide rare disease management services to our members. Our Care Managers work closely with AccordantCare™ to ensure the most appropriate and timely support is provided to our members for these conditions. For a list of rare conditions in the program, visit www.nhp.org/Member/programs.

Social Care Management

NHP has a team of Social Care Managers who have experience helping Members access community-based services and programs.

A Social Care Manager can help you determine the types of programs you and your family may be able to access, such as:

- Public assistance (cash Benefits)
- Housing services
- Food programs
- Utilities assistance (gas, electric, or phone service)
- Services for people with disabilities
- Making appointments and finding transportation

The Quit for Life Tobacco Cessation Program

NHP provides support for Members trying to quit tobacco. Research shows that a combination of counseling and use of tobacco cessation medications doubles your chances of quitting successfully.

A Certified Tobacco Treatment Specialist (CTTS) can help you create a quit plan, discuss treatment options, choose a quit day, deal with cravings and live with other tobacco users in your life who are not ready to quit. The CTTS is available to call your Provider with you to discuss obtaining a prescription for tobacco cessation medication. NHP's pharmacy benefit covers certain over the counter and prescription tobacco cessation medications at $0 cost with a prescription from your provider. The program also includes free educational materials. Coverage is up to 300 minutes of counseling per Benefit year, including telephonic counseling.

For more information and help quitting tobacco:

NHP Certified Tobacco Treatment Specialist
857-282-3096

quitsmoking@nhp.org

Massachusetts Quitline
800-TRY-TO-STOP

Section 12.

Member Rights and Responsibilities

Your Rights as an NHP Member

As a valued Member of NHP, you have the right to:

- Receive information about NHP, our services, our providers and practitioners, your covered Benefits, and your rights and responsibilities as a Member of NHP
- Receive documents in alternative formats and/or oral interpretation services free of charge for any materials in any language
- Have your questions and concerns answered completely and courteously
- Be treated with respect and with consideration for your dignity
- Have privacy during treatment and expect confidentiality of all records and communications
- Discuss and receive information regarding your treatment options, regardless of cost or Benefit coverage, with your Provider in a way which is understood by you
- Be included in all decisions about your health care, including the right to refuse treatment
- Change your PCP
- Access Emergency care 24 hours/day, seven days a week
- Access an easy process to voice your concerns, and expect follow-up by NHP
- File a Complaint or Appeal if you have had an unsatisfactory experience with NHP or with any of our In-network Providers or if you disagree with certain decisions made by NHP
- Make recommendations regarding NHP's Member rights and responsibilities
- Create and apply an Advance Directive, such as a will or health care proxy, if you are over 18 years of age
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- Freely apply your rights without negatively affecting the way NHP and/or your Provider treats you
- Ask for and receive a copy of your medical record and request that it be changed or corrected, as explained in the Notice of Privacy Practices
- Receive the Covered Health Care Services you are eligible for as outlined in the handbook

Your Responsibilities as an NHP Member

As a Member of NHP, you also have responsibilities. It is your responsibility to:

- Choose a PCP, the Provider responsible for your care
- Call your PCP when you need health care.
- Tell any health care Providers that are treating you that you are an NHP Member
- Give complete and accurate health information that NHP or your Provider needs in order to provide care
- Understand the role of your PCP in providing your care and arranging other medical services that you may need
- To the degree possible, understand your health problems and take part in making decisions about your health care and in developing treatment goals with your Provider
- Follow the plans and instructions agreed to by you and your Provider.
- Understand your Benefits—what's covered and what's not covered
- Call your PCP within forty-eight (48) hours of any Emergency or out-of-area treatment. If you experienced a Behavioral Health (mental health and substance use) Emergency you should contact your Behavioral Health Provider, if you have one
- Notify NHP and your employer of any changes in personal information such as address, telephone, marriage, additions to the family, eligibility of other health insurance coverage, etc.
- Understand that you may be responsible for payment of services you receive that are not included in the Covered Services list for your coverage type.

Reporting Health Care Fraud

If you know of anyone trying to commit health care fraud, please call our confidential Compliance Helpline at **844-556-2925**. You do not need to identify yourself.

Examples of health care fraud include:

- Receiving bills for Health Care Services you never received
- Individuals loaning their health insurance ID card to others for the purpose of receiving Health Care Services or prescription drugs
- Being asked to provide false or misleading health care information

Member Satisfaction

Our Customer Service Representatives want you to get the most from your NHP Membership. Call us if you:

- Have any questions about your NHP Benefits
- Need help choosing a PCP
- Receive a bill from a Provider, Primary Care Site, or hospital
- Lose your NHP Member Card
- Want to file a Grievance or make a Complaint

Please contact the GIC at 617-727-2310 if you:

- Move/relocate
- Get a new telephone number
- Have any changes to your policy (e.g., marriage, new baby, etc.)

If You Receive a Bill in the Mail or If You Paid for a Covered Service

NHP Providers should not bill you for any service included in the description of Covered Health Care Services that exceeds Deductibles, Copayments or Coinsurance specified in your Schedule of Benefits. Your Explanation of Benefits, a monthly statement that NHP mails you, shows what NHP has paid the Provider and what your cost-sharing obligations to the Provider are for Covered Services. If you believe you have overpaid or receive a bill from a NHP Provider in error for any service included on the Covered Health Care Services list, you should contact NHP's GIC Customer Service at 866-567-9175. If you need Emergency or Urgent Care while traveling abroad or out-of-state, NHP will pay the Provider directly. Ask the Provider to contact NHP to discuss payment if the Provider asks you for money.

If you do pay for Emergency or Urgent Care while traveling abroad or out-of- state, please send a copy of the bill and proper receipts to NHP at:

Neighborhood Health Plan
Attn: Customer Service
399 Revolution Drive, Suite 810
Somerville, MA 02145

Be sure to include the following information:

- Member's full name
- Member's date of birth
- Member's NHP Member identification number
- Date the Health Care Service was provided
- A brief description of the illness or injury

For pharmacy items, you must include a dated drug store receipt stating the name of the drug or medical supply, the prescription number, and the amount paid for the item

Limits on Claims

NHP will pay or reimburse you only for services that are Emergency or Urgent Care Benefits. You must send any bills or receipts to NHP within twelve (12) months of the Date of Service. NHP is not required to pay bills or reimburse you for Claims received later than twelve (12) months after the Date of Service. NHP will pay or reimburse you only for Covered Health Care Services that are obtained in accordance with NHP policies.

Section 13.

Financial Obligations

As part of your contract, you will be asked to pay when receiving certain covered health services.

Deductibles—This plan requires you to pay a Deductible. Your Schedule of Benefits indicates what your Deductible amount is. A Deductible is a specific annual dollar amount you must pay each Benefit year for certain services. You have a Deductible for medical expenses. Once you meet your Deductible, you may still be responsible for Copays and any applicable Coinsurance (see below for more on copays and Coinsurance). If you have an individual membership, you must pay the individual Deductible each year. A family Deductible is met when the combined Deductible payments for any covered family members adds up to the total family Deductible amount. The most each Member can contribute towards the family Deductible per Benefit year is equal to the individual Deductible amount.

Please note that not all services may apply to a Deductible. Your Schedule of Benefits tells your deductible amounts and which services apply to the deductible. Your plan includes a benefit period Deductible for individuals and family members. The benefit period begins on July 1 and ends on June 30th of the following year and cost sharing changes occurring on July 1st.

Copayments and Coinsurance—In some cases, you will be asked to pay a Copay when receiving a covered health care Benefit, such as a visit to the doctor, or a prescription. Copays are fixed dollar amounts that are due at the time the service is received or when billed by the Provider. Your Schedule of Benefits identifies what your Copay should be for various health care Benefits. Some plans also provide coverage with Coinsurance. If your coverage requires payment of Coinsurance, the applicable Coinsurance percentages are listed in your Schedule of Benefits. After you have met any applicable Deductible amount, you may be responsible for a specified percentage of the cost of a covered health care Benefit you receive, and NHP will be responsible for the remainder of the cost.

Your plan includes Coinsurance for Durable Medical Equipment (DME). Durable Medical Equipment is subject to the benefit period Deductible and then 20 percent Coinsurance of the purchase price or rental cost of the DME service.

Out-of-Pocket Maximum—Your Schedule of Benefits indicates what your Out-of-Pocket Maxi- mum amount is. The Out-of-Pocket Maximum represents the most you are required to pay out-of-pocket, including Deductible, Copayment and Coinsurance amounts.

In order to ensure that you are not held responsible for amounts in excess of your Copayments, Coinsurance, Deductible amounts or Out-of-Pocket Maximum, your Health Care Services (except as specified in this handbook) must be provided by an NHP Network Provider; arranged by your PCP; authorized by NHP, if prior Authorization is required; and services received during your active enrollment with NHP. If you fail to meet these requirements you may have to pay for the total cost of the service provided to you.

When seeing a NHP Network Provider you should never be asked to pay more than your Copayments, Coinsurance, or Deductible amounts stated in your Schedule of Benefits. If you receive a bill from a NHP Network Provider that is more than these allowed amounts please contact the NHP's GIC Customer Service. If your Plan has a Deductible, you will receive a monthly Explanation of Benefits (EOB) in the mail from NHP which indicates what a Provider has billed, what NHP has paid, and what you are responsible for paying (i.e., for Deductible, Copayments and Coinsurance) based on Claims recently received by NHP. Please retain all EOBs for your records and contact NHP's GIC Customer Service if you have any questions about the information shown in the EOB.

Medical Cost Estimator

NHP can help you estimate your cost-sharing obligations before you receive a Covered Service from an In-Network Provider. To get an estimate, log into MyNHP.org and under the 'My Coverage" tab, select the link "Request Cost Estimate for Medical Services". The tool will allow you to select the name of your doctor or facility as well as the medical service you want to estimate. A real time estimate will be provided to you for the service specific to the site and/or provider you selected.

If you are unable to request it on-line then please call the NHP GIC Customer Service number on the back of your Member ID card, or for the hearing impaired, 711.

If you request an estimate for a medical procedure that is not located in the tool, then, complete the form provided and click submit to obtain the cost. You will receive a response to the submitted form within 48 hours.

The information provided is an estimate based on the information supplied to NHP at the time of the request. It represents best efforts to assist members in

anticipating cost-sharing prior to services being rendered and/or facilitating a dialogue between members and providers as to financial responsibilities and treatment options. This estimate does not guarantee coverage and/ or pre-approval. The estimated amount may change due to several factors. Including but not limited to: changes to your plan design; additional Claims received for processing subsequent to this estimate being provided; other services rendered in conjunction with these procedures; and changes to a Provider's contract with NHP.

Section 14.

Notices

Confidentiality

NHP takes our obligation to protect your personal and health information seriously. To help in maintaining your privacy, we have instituted the following practices:

- NHP employees do not discuss your personal information in public areas. Electronic information is kept secure through the use of passwords, automatic screen savers and limiting access to only those employees with a "need to know."
- Written information is kept secure by storing it in locked file cabinets, enforcing "clean-desk" practices and using secured shredding bins for its destruction.
- All employees, as part of their initial orientation, receive training on our confidentiality and privacy practices. In addition, as part of every employee's annual performance appraisal, they are required to sign a statement affirming that they have reviewed and agree to abide by NHP's confidentiality policy.
- All Providers and other entities with whom we need to share information are required to sign agreements in which they agree to maintain confidentiality.
- NHP only collects information about you that we need to have in order to provide you with the services you have agreed to receive by enrolling in NHP or as otherwise required by law.

To comply with state law, NHP takes special steps to protect any information about mental health or substance use, HIV status, sexually transmitted diseases, pregnancy or termination of pregnancy.

NHP Notice of Privacy Practices

This section describes how health information about you may be used and disclosed, and how you can access this information. Please read it carefully. NHP provides health insurance coverage to you. Because you get health Benefits from NHP, we have personal health information about you. By law, NHP must protect the privacy of your health information.

This section explains:

- When NHP may use and share your health information.
- What your rights are regarding your health information.

NHP May Use or Share Your Health Information:

- When the U.S. Department of Health and Human Services needs it to make sure your privacy is protected.
- When required by law or a law enforcement agency.
- For payment activities, such as checking if you are eligible for health Benefits, and paying your health care Providers for services you get.
- To operate programs, such as evaluating the quality of Health Care Services you get, providing care management and disease management and performing studies to reduce health care costs.
- With your health care Providers to coordinate your treatment and the services you get.
- With health-oversight agencies, such as the federal Centers for Medicare and Medicaid Services, and for oversight activities authorized by law, including fraud and abuse investigations.
- For research projects that meet privacy requirements.
- With government agencies that give you Benefits or services.
- With plan sponsors of Employer Group health plans, but only if they agree to protect that information;
- To prevent or respond to an immediate and serious health or safety Emergency.
- To remind you of appointments, Benefits, treatment options or other health-related choices you have.
- With entities that provide services or perform functions on behalf of NHP (Business Associates), provided that they have agreed to safeguard your information.

Please also note:

- When a federal or state privacy law provides for stricter safeguards of your protected health information (PHI), NHP will follow the stricter law.
- Except as described above, NHP cannot use or share your health information with anyone without your written permission. You may cancel your permission at any time, as long as you tell us in writing.

- We cannot take back any health information we used or shared when we had your permission.
- For purposes of underwriting, NHP is prohibited from using or disclosing any genetic information.
- NHP does not use your health information for any marketing purposes and will not sell your health information to anyone.

You Have the Right To:

- See and get a copy of your health information that is contained in a "designated record set." You must ask for this in writing. To the extent your information is held in an electronic health record, you may be able to receive the information in electronic form. NHP may charge you to cover certain costs, such as copying and postage. In some cases, we may deny your request to see and get a copy of your health information.
- Ask NHP to change your health information that is in a "designated record set" if you think it is wrong or incomplete. You must tell us in writing which health information you want us to change, and why. If we deny your request, you may file a statement of disagreement with us that will be included in any future disclosures of the disputed information.
- Ask NHP to limit its use or sharing of your health information. You must ask for this in writing. NHP may not be able to grant this request.
- Ask NHP to get in touch with you in some other way, if by contacting you at the address or telephone number we have on file; you believe you would be harmed.
- Get a list of when and with whom NHP has shared your health information. You must ask for this in writing.
- Be notified in the event that we or one of our Business Associates discovers a breach of your unsecured PHI.
- Get a paper copy of this notice at any time.

These rights may not apply in certain situations. By law, NHP must give you notice explaining that we protect your health information, and that we must follow the terms of this notice. This notice will remain in effect until we change it. This notice replaces any other information you have previously received from NHP about the privacy of your health information. NHP can change how we use and share your health information. If NHP does make important changes, we will send you a new notice and post an updated notice on our website. That new notice will apply to all of the health information that NHP has about you. NHP takes your privacy very seriously.

If you would like to exercise any of the rights we describe, or if you feel that NHP has violated your privacy rights, contact NHP's Privacy Officer in writing at the following address:

Neighborhood Health Plan
Privacy Officer
399 Revolution Drive, Suite 810
Somerville, MA 02145

Filing a Complaint or exercising your rights will not affect your Benefits. You may also file a Complaint with the U.S. Secretary of Health and Human Services at:

The U.S. Department of Health and
Human Services
200 Independence Avenue,
SW Washington, DC 20201

Telephone: 202-619-0257
Toll Free: 877-696-6775

NHP will not retaliate against you if you file a Complaint either with NHP or the U.S. Secretary of Health and Human Services. For more information, or if you need help understanding this notice, call NHP's GIC Customer Service.

Group Insurance Commission Notices

NOTICE OF GROUP INSURANCE COMMISSION PRIVACY PRACTICES

Effective September 3, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the GIC must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the group Insurance Commission. Under federal law, your health information (known as "protected health information" or "PHI") includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may

receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at www.mass.gov/gic.

Required and Permitted Uses and Disclosures

We use and disclose protected health information ("PHI") in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make without your authorization:

Payment Activities: The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

Health Care Operations: The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

To provide you Information on health-related programs or products: Such information may include alternative medical treatments or programs or about health-related products and services, subject to limits imposed by law as of September 23, 2013

Other Permitted Uses and Disclosures: The GIC may use and share PHI as follows:

- To resolve complaints or inquiries made by you or on your behalf (such as appeals);
- To enable business associates that perform functions on our behalf or provide services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. Our business associates are also directly subject to federal privacy laws;
- For data breach notification purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access or disclosure of your health information;
- To verify agency and plan performance (such as audits);
- To communicate with you about your GIC-sponsored benefits (such as your annual benefits statement);
- For judicial and administrative proceedings (such as in response to a court order);
- For research studies that meet all privacy requirements; and
- To tell you about new or changed benefits and services or health care choices.

Required Disclosures: The GIC must use and share your PHI when requested by you or someone who has the legal right to make such a request on your behalf (your Personal representative), when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

Organizations That Assist Us: In connection with payment and health care operations, we may share your PHI with our third party "Business Associates" that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI and also have direct responsibility to protect your PHI imposed by federal law.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based on your permission.

Your Rights

You have the right to:

- Ask to see and get a copy of your PHI that the GIC maintains. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.
- Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. You must ask for this by in writing, along with a reason for your request. If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.
- Get a listing of those with whom the GIC shares your PHI. You must ask for this in writing. The list

will not include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research;

- Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. You must ask for this in writing. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.
- Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. You must tell us in writing that you are in danger, and where to send communications.
- Receive notification of any breach of your unsecured PHI.
- Receive a separate paper copy of this notice upon request. (An electronic version of this notice is on our website at www. mass.gov/gic.)

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call **617-727-2310**, extension 1 or TTY for the deaf and hard of hearing at 711.

Important Notice from the Group Insurance Commission (GIC) about your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with NHP Prime HMO for GIC members and your options under Medicare's prescription drug coverage. This information can help you decide whether or not to join a non-GIC Medicare drug plan.

If you are considering joining a non-GIC plan, you should compare your current coverage, particularly which drugs are covered, and at what cost with that of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage can be found at the end of this notice.

For most people, the drug coverage that you currently have through your GIC health plan is a better value than the non-GIC Medicare Part D drug plans.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available to everyone with Medicare in 2006. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly Premium.
- The GIC has determined that the prescription drug coverage offered by your plan is, on average for all participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Part D drug plan.

When Can you Join a Medicare Part D Drug Plan?

You can join a non-GIC Medicare drug plan when you first become eligible for Medicare and each subsequent year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period to join a non-GIC Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join a Non-GIC Medicare Drug Plan?

If you enroll in another Medicare prescription drug plan or a Medicare Advantage plan with or without prescription drug coverage you will be disenrolled from the GIC-sponsored NHP plan. If you are disenrolled from NHP, you will lose your GIC-sponsored medical, prescription drug, and behavioral health coverage.

If you are the insured and decide to join a non-GIC

Medicare drug plan, both you and your covered spouse/dependents will lose your GIC medical, prescription drug, and behavioral health coverage.

If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available online at www.socialsecurity.gov, or by phone at 1-**800-772-1213** (TTY: 1-800-325-0778).

When will you Pay a Higher Premium (penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with a GIC plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary Premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information about This Notice or your Current prescription drug Coverage

Contact the GIC at (**617) 727-2310**, ext. 1.

NOTE: You will receive this notice each year, and if this coverage through the Group Insurance Commission changes. You may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug Coverage

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for the telephone number) for personalized help.
- Call 1-**800-Medicare** (1-800-633-4227).
- TTY users should call 1-877-486-2048

If you have limited income and assets, extra help paying for Medicare prescription drug coverage is available. For information about the Extra Help program, visit Social Security online at www.socialsecurity.gov, or call 1-**800-772-1213** (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The GIC has more generous guidelines for benefit coverage that apply to persons subject to USERRA, as set forth below:

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents while in the military.
- Service members who elect to continue their GIC health coverage are required to pay the employee's share for such coverage.
- Even if you don't elect to continue coverage during your military service, you have the right to be reinstated to GIC health coverage when you are reemployed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

  The U.S. Department of Labor, Veterans Employment and Training Service (VETS) are authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-**866-4-USA-DOL** or visit its website at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information about your GIC coverage, please call the Group Insurance Commission at (**617) 727-2310**, ext. 1.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP program. If you or your children are not eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your State if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA** (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2017. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: http://www.myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/
State Relay 711

FLORIDA – Medicaid
Website:
https://www.flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
Phone: 1-404-656-4507

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid
Website:
http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003 | TTY Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website:
http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: http://www.mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website:
http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx
Phone: 1-855-632-7633

NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/
Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website:
http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website:
http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website:
http://www.nyhealth.gov/health_care/medicaid/
Phone: 800-541-2831

NORTH CAROLINA – Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website:
http://www.oregon.gov/oha/healthplan/Pages/splash.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website:
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid Website:
http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid Website:
http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/

CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP Medicaid
Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website:
http://www.dhhr.wv.gov/bms/Pages/default.aspx
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid
Website:
https://www.dhs.wisconsin.gov/publications/p1/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other States have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor

Employee Benefits Security Administration | www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

or

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

877-267-2323, Menu Option 4, Ext. 61565

Section 15.

Complaint and Grievance Process

NHP tries to meet and go beyond what our Members expect of us. If an NHP experience did not meet with your expectations, we want to know about it so we can understand your needs and provide better service.

Complaints

Members have the right to voice concerns and file Complaints. If you file a Complaint, NHP staff will be courteous and professional, and all information about the Complaint will be kept confidential. Filing a Complaint will not affect your NHP coverage in a negative way.

To file a Complaint, call, write, or fax the NHP:

NHP's GIC Customer Service
866-567-9175 (TTY 711)
Monday–Friday, 8 a.m.–6 p.m.
Thursday 8 a.m.– 8 p.m.

Neighborhood Health Plan
Attn: Customer Service
399 Revolution Drive, Suite 810
Somerville, MA 02145
Fax: 617-526-1985

How the Complaint Process Works

A Customer Service Representative will ask for information about the Complaint, and, if possible, solve the problem over the telephone at the time of your call. If the Customer Service Representative cannot resolve the situation to your satisfaction at the time of your call, we will make every effort to resolve your Complaint within three (3) business days (called the "Internal Inquiry Period"). If we are unable to satisfactorily resolve your Complaint within three (3) business days, we will, at your request, continue to investigate and resolve the matter through our internal Grievance process.

Grievances

If you are not satisfied with the way NHP responded to your Complaint or with any decision made by NHP about your health care or service, you have the right to file a Grievance. A Grievance is a request that NHP reconsider a decision or investigate a Complaint regarding the quality of care or services that you have received or any aspect of NHP's administrative operations. If your Grievance is about a decision NHP has made to deny coverage of health care or services, you must file your Grievance within 180 calendar days of your being notified of the decision. Filing a Grievance will not affect your NHP coverage in a negative way. The time period for NHP to resolve your Grievance will begin either on the day after the Internal Inquiry Period, or at any time during the Internal Inquiry Period if you notify NHP that you are not satisfied with the response thus far to your inquiry. Time limits may only be waived or extended by mutual written agreement between you or an Authorized Representative and NHP. Any such agreement shall state the additional time limits, which shall not exceed fifteen (15) business days from the date of the agreement.

You may designate an Authorized Representative (a friend, relative, health care Provider, etc.) to act as your representative during the Grievance process. The Authorized Representative has the same rights and responsibilities as the Member.

Frequently Asked Questions About The Grievance Process

How Do I File a Grievance?

You may file a Grievance by telephone, in person, by mail or by fax.

NHP will send you a written acknowledgement of receipt of your Grievance within one (1) business day. If you telephone us or stop by in person, your Grievance will be transcribed by NHP and a copy forwarded to you or your Authorized Representative within twenty-four (24) hours (except where this time limit is waived or extended by mutual written agreement between you or your Authorized Representative and NHP). We request that you read, sign and return to NHP this written transcription of your oral Complaint. This helps to ensure that we fully understand the nature of your Complaint. You may contact NHP in writing or by phone to initiate the Grievance process. (See address, telephone, and fax number above in "Complaints.")

How Do I Designate an Authorized Representative?

An Authorized Representative is anyone you choose to act on your behalf in filing a Grievance with NHP. An Authorized Representative can by a family Member, a friend, a Provider or anyone else you choose. Your Authorized Representative will have the same rights as you do in filing your Grievance. If you wish to choose an Authorized Representative you must sign and return a Designation of Authorized Representative Form to NHP. To obtain this form, please contact the NHP's GIC Customer Service.

What if My Grievance is About My Health Care or Services?

If your Grievance pertains to a decision NHP has made about your health care or services, you or your Authorized Representative may be asked to sign and return a release of medical information to NHP. After receipt of all necessary releases, your medical information will be requested by NHP. You or your Authorized Representative will have access to any medical information and records relevant to the Grievance which are in the possession of NHP. If we requested that you provide us with a signed authorization and you (or your Authorized Representative) do not provide the signed authorization within thirty (30) calendar days of the receipt of the Grievance, NHP, may issue a resolution of the Grievance without review of some or all of the medical records.

What if My Grievance Is About a Behavioral Health Care Service?

NHP has delegated the management of Grievances involving Behavioral Health or Substance Use services to Beacon. To initiate a Grievance with Beacon you may contact them in writing or by phone.

Beacon Health Options
500 Unicorn Park Drive
Woburn, MA 01801

Appeals Coordinator
800-414-2120
(TTY 781-994-7660)

If you prefer, you can request that NHP, instead of Beacon, review your Grievance regarding a Behavioral Health or Substance Use service.

What if Resolution of My Grievance Does Not Require Review of My Medical Records?

If resolution of your Grievance does not require review of your medical records, the Grievance resolution process will begin on the day immediately after the Internal Inquiry Period or sooner if you notify NHP that you are not satisfied with NHP's response during the Internal Inquiry Period.

Who Will Review My Grievance?

Grievances are reviewed by an individual or individuals who are knowledgeable about the matters at issue in the Grievance. Grievances of Adverse Determinations will be reviewed by an individual or individuals that did not participate in any of the prior decisions regarding the matter of the Grievance.

These individuals are actively practicing health care professionals in the same or similar specialty that typically treat the medical condition, perform the procedure, or provide the same treatment that is the subject of the Grievance.

How Will the Decision on My Grievance Be Explained?

When NHP sends you a written decision on your Grievance, we will include complete identification of the specific information considered and an explanation of the basis for the decision. In the case of a Grievance that involves an Adverse Determination, the written resolution will include a substantive clinical justification that is consistent with generally accepted principles of professional medical practice, and will, at a minimum:

- State the date of service, treating Provider, diagnosis and treatment codes and their meanings.
- Identify the specific information upon which the Adverse Determination was based.
- Discuss the presenting symptoms or condition, diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant medical review criteria.
- Specify alternative treatment options covered by NHP, if any.
- Reference and include applicable clinical practice guidelines and review criteria.
- Notify you (or your Authorized Representative) of the procedures for requesting external review, including an expedited review and the opportunity to request continuation of services.

When Will I Hear from NHP About My Grievance?

NHP will contact you in writing within thirty (30) calendar days with the outcome of your Grievance review, unless you and NHP agreed to an extension.

Continuation of Services During the Grievance Process

If the subject matter of the Grievance involves the termination of ongoing services, the disputed coverage or treatment will remain in effect, without liability to you, until you or the your Authorized Representative have been informed of NHP's decision provided that you have filed your Grievance on a timely basis. This continuation of coverage or treatment applies only to those services which, at the time of their initiation, were approved by NHP and which were not terminated pursuant to an exhaustion of your Benefit coverage.

Reconsideration

NHP may offer you (or your Authorized Representative) the opportunity for reconsideration of a Final Adverse Determination where relevant medical information was:

- Received too late to review within the thirty (30) calendar-day time limit; or
- Not received, but is expected to become available within a reasonable time period following the written resolution; or
- For other good cause offered by you or your Authorized Representative

If you choose to request reconsideration, NHP must agree in writing to a new time period for review, but in no event greater than thirty (30) calendar days from the agreement to reconsider the Grievance. The time period for requesting external review begins the date of resolution of the reconsidered Grievance.

Expedited Grievance Review for Special Circumstances

If you or your health care Provider believe your health, life, or ability to regain maximum functioning may be put at risk by waiting thirty (30) calendar days, you or your Doctor can request an expedited Grievance review.

An expedited Grievance will be reviewed and resolved as soon as possible consistent with the medical exigencies involved but in no event later than 72 hours. You have the right to apply for expedited external review at the same time you apply for an expedited internal review.

NHP will provide an automatic reversal of the denial for services or durable medical equipment, pending the outcome of the expedited internal appeal, within 48 hours of receiving written certification by the Member's physician which states the service or durable medical equipment is: (1) Medically Necessary; (2) that a denial of coverage would create substantial risk or serious harm; (3) and that the risk of such harm is so immediate that services or durable medical equipment should not await the outcome of the normal appeal process. For durable medical equipment, the treating physician must further certify as to the specific, immediate and severe harm that will result to the Member if such equipment is not provided within 48 hours.

Expedited Grievance Review for Persons Who are Hospitalized

A Grievance made while a Member is hospitalized will be resolved as expeditiously as possible, taking into consideration the medical and safety needs of the Member.

A written resolution will be provided before the Member's discharge from the hospital. During a Member's hospitalization, and only during hospitalization, a health care professional or a representative of the hospital may act as the Member's Authorized Representative without written authorization by the Member.

Expedited Grievance Review for Persons with Terminal Illness

When a Grievance is submitted by an insured with a terminal illness, or Authorized Representative, resolution will be provided to the insured or Authorized Representative within five (5) business days from the receipt of the Grievance except for grievances regarding urgently needed services, which will be resolved within seventy- two (72) hours. If the Expedited Review process affirms the denial of coverage or treatment to an insured with a terminal illness, NHP will provide the insured or the insured's Authorized Representative, within five (5) business days of the decision:

- A statement, setting forth the specific medical and scientific reasons for denying coverage or treatment
- A description of alternative treatment, services or supplies covered or provided by NHP, if any

If the Expedited Review process affirms the denial of coverage or treatment to an insured with a terminal illness, NHP will allow the insured, or the insured's Authorized Representative, to request a conference. The conference will be scheduled within ten (10) days of receiving a request from an insured; provided however that the conference shall be held within five (5) business days of the request if the treating physician determines, after consultation with NHP's medical director or his designee, and based on standard medical practice, that the effectiveness of either the proposed treatment, services or supplies covered by NHP, would be materially reduced if not provided at the earliest possible date.

At the conference, NHP will permit attendance of the insured, the Authorized Representatives of the insured, or both, as well as the insured's treating health care professional or other providers.

A representative of NHP, who has authority to determine the disposition of the Grievance, will conduct the review.

NHP's Obligation to Timely Resolution of Grievances

If NHP does not act upon your Grievance within the prescribed time frames or the agreed upon ex- tended time frame, the Grievance will be decided in your favor. Any extension deemed necessary to complete the review of your Grievance must be authorized by mutual written agreement between you or your Authorized Representative and NHP.

Independent External review

If you are not satisfied with the final outcome of the Grievance review you receive, you have the right to apply for an independent external review with the Massachusetts Health Policy Commission's Office of Patient Protection (OPP). The Office of Patient Protection provides an independent review of grievances not resolved at the health plan (NHP) level to your satisfaction. The External Review Organization will review the Grievance to determine if the service or treatment in question is Medically Necessary and a Covered Benefit. The decisions of the External Review Organization are final and binding. You will not be required to pay more than $75.00 in fees for external review requests per plan year, regardless of the number of external review requests submitted.

You may contact the Office of Patient Protection at any time by phone at 800-436-7757, by fax at 1-617-624-5046, or online at www.mass.gov/hpc/opp. You, or your Authorized Representative, are responsible to activate the External Review Process. To activate the review:

- Complete and submit the required application to the Health Policy Commission within four (4) months of the receipt of NHP's Final Grievance decision.
- Submit applicable filing fees ($25.00) to the Health Policy Commission (The OPP may waive the fee in cases of extreme financial hardship).

For non-expedited reviews, a final decision will be issued within forty-five (45) calendar days from the receipt of the appeal at the OPP. A final decision will be issued within seventy-two (72) hours of receiving the request for expedited external review.

The OPP shall screen all requests for external reviews to determine if they:

- Comply with the requirements of 958 CMR 3.404.
- Do not involve a service or Benefit that has been explicitly excluded from coverage by NHP in the Member Handbook or Schedule of Benefits.
- Result from NHP's issuance of a final decision of a Grievance, provided that NHP did not fail to comply with the timeframe for resolving the Grievance.
- Result from NHP's issuance of a final decision of a Grievance provided, however, that no final Adverse Determination is necessary where NHP has failed to comply with timelines for the internal Grievance process, NHP has waived the internal Grievance process in writing, or if the insured or his or her Authorized Representative is requesting an expedited external review at the same time that the insured is requesting an expedited internal review.

If the external review agency overturns NHP's decision in whole or in part, NHP shall issue a written notice to the Member within five (5) business days of receipt of the written decision from the OPP.

Such notice shall:

- Acknowledge the decision of the OPP.
- Advise the Member of any additional procedures for obtaining the requested coverage or services.
- Advise the Member of the date by which the payment will be made or the Authorization for services will be issued by NHP.
- Advise the Member of the name and phone number of the person at NHP who will assist the Member with final resolution of the Grievance.

You may contact the Office of Patient Protection at any time by phone at 80 0 - 436 -7757, by fax at 617-624 -50 4 6, or online at www.mass.gov/hpc /opp.

Expedited External review and Continuation of Coverage

You or your Authorized Representative may request to have your request for review processed as an expedited external review. You have the right to apply for independent expedited external review at the same time a request for an internal expedited review is requested.

Any request for an expedited external review must contain a certification, in writing, from your physician, that delays in the providing or continuation of Health Care Services that are the subject of a Final Adverse Determination would pose a serious and immediate

threat to your health. If the subject matter of the external review involves the termination of ongoing services, you may apply to the external review panel to seek continuation of coverage for the terminated service during the period the review is pending.

Any such request must be made by the end of the second business day following receipt of the Final Adverse Determination.

The review panel may order the continuation of coverage or treatment where it determines that substantial harm to your health may result in the absence of such continuation or for such other good cause, as the review panel shall determine. Any such continuation of coverage will be at NHP's expense regardless of the final external review determination.

For more information about your Grievance rights as a resident of the Commonwealth of Massachusetts, contact the Massachusetts Office of Patient Protection. You can contact the Office of Patient Protection (OPP) at any time by telephone at **800-436-7757**, by fax at 617-624-5046, or online at www.mass.gov/hpc/opp.

Section 16.

Utilization Management and Quality Assurance

Utilization Management (UM)

The mission of the Utilization Review (UR) program at NHP is to ensure the best health care to its Members. NHP does this through a multidisciplinary team approach to advocate for highest standards of patient health, education and safety. Our commitment to providing quality care is consistently combined with our goal to promote proper resource use.

The UR program promotes the continuity of patient care and helping with patient service to ensure a smooth transition for Members as they obtain the appropriate level and intensity of services, across the continuum of health care. This program ensures a smooth transition as Members get the best and most appropriate level of services across the spectrum of health care. This program continually evaluates the needs of NHP's Members and promotes improvements to the program and to the care delivery system.

NHP recognizes that under-use of medically appropriate services can harm our Members' health and wellness. For this reason, NHP promotes appropriate use of services. NHP's UR decisions are based only on appropriateness of care and service and existence of coverage. NHP does not specifically reward practitioners or other individuals conducting Utilization Review for issuing denials of coverage or service, nor does NHP provide financial rewards to UR decision makers to encourage decisions that cause underutilization.

Adverse Determinations

Decisions made by NHP or a designated Utilization Review organization to deny, reduce, modify, or terminate an admission, continued Inpatient stay, or the availability of any other services, for failure to meet the requirements for coverage based on Medical Necessity, appropriateness of health care setting and level of care or effective- ness are considered Adverse Determinations.

Written notice of Adverse Determinations will include a substantive clinical justification that is consistent with generally accepted principles of professional medical practice, and will, at a minimum:

- Identify the specific information upon which the Adverse Determination was based.
- Discuss the presenting symptoms or condition, diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant medical review standards.
- Specify other treatment options covered by NHP, if any.
- Reference and include suitable applicable clinical practice guidelines and review standards.
- Notify you (or your Authorized Representative) of our internal grievance process and the procedures for requesting external review.

NHP engages in prospective review, concurrent review with discharge planning and case management of Health Care Services as part of its Utilization Review Program.

Initial Determination

Also known as Prospective Review or Prior Authorization

Prior Authorization is required on certain services to ensure the efficient and appropriate use of covered Health Care Services. Prior Authorization is obtained by the Provider before you receive the service. Decisions are made by NHP or a designated Utilization Review Organization within two (2) working days of obtaining all required information. This includes any necessary evaluations and/or second opinions. Providers are notified of the decision within twenty-four (24) hours. Both Providers and Members are sent written notice of prospective approvals within two (2) working days of the initial notification and within one (1) working day for prospective denials.

Concurrent review

Decisions are made within one (1) working day of getting all required information, including any required evaluations and/or second opinions. Providers are told of the decision within twenty four (24) hours. Both Providers and Members are sent written notice (including number of extended days or visits, next review date, total number of days or visits approved, and date of service initiation) of concurrent approvals and denials within one (1) working day of the initial notice.

Services subject to concurrent review are continued without liability to the Member until the Member has been told of the decision.

Reconsideration

NHP offers a treating Provider a chance to seek reassessment of an Adverse Determination from a

clinical peer reviewer in any case involving a prospective or concurrent review. The treating Provider is informed of this chance within the written denial letter. The reconsideration process will occur within one working day of the Provider's request and will be conducted between the Provider and an NHP clinical peer reviewer. If the reassessment does not reverse the Adverse Determination, the Member or Provider, on behalf of the Member, may pursue NHP's Grievance process. The reconsideration process is not a prerequisite to NHP's Grievance process or an expedited appeal. Members can call the NHP's GIC Customer Service to find the status or outcome of Utilization Review decisions.

Case Management

Case Management is for timely coordination of quality Health Care Services to meet a person's specific health care needs while making it easier to get care across agencies and organizations (home health, skilled nursing, hospitals are examples) and creating cost effective choices for catastrophic, chronically ill or injured Members on a case by case basis.

Examples where case management may be helpful include organ transplants, asthma, diabetes or major traumatic injury such as burns.

For Behavioral Health or Substance Use services, NHP has delegated Utilization Review to Beacon and Pharmacy to NHP's Pharmacy Vendor.

Quality assurance program

NHP is committed to improving the health of its Members by providing the highest quality health care through the design, use and continuous improvement of the most appropriate and effective delivery systems. The scope of NHP's Quality Assurance Program includes:

- Member satisfaction
- Access to care and services
- Continuity of care
- Provider credentialing
- Preventive health services
- Patient safety
- Health care outcomes

If you are concerned about the quality of care you have received by an NHP Network Provider or the Service provided by NHP, please contact the NHP Quality Services Department at 800-433-5556.

Development of Clinical Guidelines and Utilization Review Criteria

Clinical guidelines and Utilization Review criteria at NHP are developed with input from practicing physicians in NHP's Network and comply with standards of national accreditation organizations.

NHP guidelines are evidence based, when possible, and are applied in a way that considers the person's health care needs, and otherwise compliant with applicable state and federal law.

NHP guidelines are reviewed twice a year or more often as new drugs, treatments, and technologies become generally accepted medical practice.

Evaluation of New Technology

NHP strives to ensure that our Members have access to safe and effective medical care. With the rapid progress of technology and medicine, NHP has a process to evaluate new technology on a case-by-case basis as well as on a Benefit level.

Decisions to approve the use of a new technology are based on the highest Benefit and lowest risk to the Member.

NHP reviews and assesses new and emerging technologies, including diagnostics, surgical procedures, medical therapies, equipment and medicines to determine their safety and effectiveness. NHP uses information gathered from varied sources including peer reviewed scientific literature, policy statements from professional medical organizations, national consensus guidelines, FDA reviews, and internal and external experts in its evaluation efforts. Additionally, NHP may analyze market trends and legal and ethical issues in its evaluations as appropriate. Technologies are selected for review based on actual or potential demand.

The Chief Medical Officer or Medical Director is responsible for making medical necessity decisions on urgent requests for new technologies that have not been assessed and approved through NHP's technology assessment process. In making this decision, the Chief Medical Officer or Medical Director reviews any available literature and consults with internal and external experts as needed.

New technologies are incorporated into the NHP Benefit structure based upon the strength of the safety and efficacy evidence, market analysis and the relevance to the NHP Membership.

Access and Utilization

Members can reach NHP to find out about the Utilization Review (UR) process and Authorization requests and decisions from 8:30 a.m. – 5:30 p.m., Monday–Friday. You may call at 1-866-567-9175 or TTY 711, or fax at 617-586-1700. For after hour UR issues, you may leave a message or fax; these lines are available 24/7. All requests and messages left after hours will be retrieved the next business day.

Section 17.

Glossary

Adverse Determination

A determination, based upon a review of information provided, by NHP or its designated Utilization Review Organization, to deny, reduce, modify, or terminate an admission, continued Inpatient stay, or the availability of any other services, for failure to meet the requirements for coverage based on Medical Necessity, appropriateness of health care setting and level of care or effectiveness including a determination that a requested or recommended Health Care Service or treatment is experimental or investigational.

Applied Behavior analysis (ABA)

The design, implementation and evaluation of environment modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Authorization

An Authorization is a special approval by NHP for payment of certain services.

Authorized Representative

Any Enrollee's guardian, conservator, power of attorney, health care agent, family Member or other person authorized by the Enrollee that NHP can document has been authorized by the Member in writing to act on the Member's behalf with respect to a Complaint or Grievance.

Autism Services Provider/Networks

A person, entity or group that provides treatment of Autism Spectrum Disorders. This includes: board certified behavior analysts; psychiatrists and psychologists; licensed or certified speech therapists; occupational therapists; physical therapists, social workers, and pharmacies.

Beacon Health Options (Beacon)

The organization contracted by NHP to work in collaboration with the NHP Behavioral Health Department to administer NHP's Mental Health Program.

Behavioral Health Treatment

Mental health and substance use treatment.

Behavioral Health Manager

A company organized under the law of the Commonwealth, or organized under the laws of another state and qualified to do business in the Commonwealth that has entered into a contractual arrangement with a carrier to provide or arrange for the provision of behavioral, substance use disorder, and mental health services to voluntarily enrolled Member of the carrier.

Beacon Health Options is NHP's delegated Behavioral Health Manager.

Benefit

A specific area of plan coverage, such as outpatient visits, hospitalization and so forth that make up the range of medical services available to members. Also, a contractual agreement, specified in an Evidence of Coverage, determining Covered Services provided by insurers to Members.

Benefit Period

The annual cycle in which your health insurance plan operates. The Group Insurance Commission cycle is from July 1st to June 30th with potential benefit changes occurring on July 1st.

Board Certified Behavior Analyst

A behavior analyst credentialed by the behavior analyst certification board as a board certified behavior analyst.

Centered Care Program

NHP has partnered with the GIC to launch Centered

Care, a program for members to get personalized care from providers that meet certain high standards for quality and efficiency. The program offers members enhanced services such as care coordination with Specialists, expanded hours, easy access to Urgent Care, helpful reminders about necessary tests, checkups, and more. Qualified Centered Care

providers are marked with the Centered Care logo in the NHP 'Find a Doctor' online tool.

Claim

An invoice from a Provider that describes the services that have been provided for a Member.

Coinsurance

A percentage of the medical or pharmacy cost that the Member is financially responsible for instead of a fixed dollar amount.

Complaint

Any matter concerning an Adverse Determination made by, or on behalf of, a Member to NHP or one of NHP's Utilization Review designees that is not explained or resolved to the Member's satisfaction within three business days of the Inquiry.

Copayment

A fixed amount paid by an NHP Member for applicable services or for prescription medications at the time they are provided. A Covered Service may require other Member cost-sharing (such as Deductible and/or Coinsurance) before or after a Copayment is required.

Cost Sharing

The general term that refers to the share of costs for services covered by a plan or health insurance that you must pay out of your own pocket (sometimes called "out-of-pocket costs").

Some examples of types of cost sharing include copayments, deductibles, and coinsurance. Other costs, including your premiums, penalties you may have to pay or the cost of care not covered by a plan or policy are usually not considered cost sharing.

Coverage Date

The date medical coverage becomes effective for a NHP Member.

Covered Benefits/Covered Services

The services and supplies covered by NHP described in this handbook.

Day

A calendar Day (unless business day specified).

Deductible

The amount you are required to pay to Providers for covered Health Care Services before NHP begins to pay for these services. Please refer to your Schedule of Benefits to determine if your plan has a Deductible.

Diagnosis of Autism Spectrum Disorders

Medically necessary assessments, evaluations including neuropsychological evaluations, genetic testing or other tests to diagnose whether an individual has one of the Autism Spectrum Disorders.

Disenrollment

The process by which a Member's NHP coverage ends.

Diversionary Behavioral Health Services

Diversionary Behavioral Health Services include: Partial Hospitalization Programs (PHP); Structured Outpatient Addiction Programs (SOAP); and Community Support Services (CSP). PHPs have structured intensive therapeutic services for up to six hours a day, and CSPs offer outreach and support to assist a Member/Family in accessing their mental health or substance use treatment in the community. Structured Outpatient Addiction Programs (SOAPs) provide short-term, clinically-intensive structured day and/or evening addiction treatment services, usually provided in half- or full-day units, up to six or seven days per week. This program is designed to enhance continuity for Members being discharged from Level III or Level IV detoxification programs as they return to their homes and communities.

Effective Date

The date on which an individual becomes a Member of NHP and is eligible for Covered Benefits.

Eligible Individuals

Eligible Individuals are individuals who have permanent residence in the NHP Service Area or are employees of a sole proprietorship, firm, corporation, partnership or association actively engaged in a business that is based within the NHP Service Area. See "Section 2: Eligibility and Enrollment" for what qualifies an Individual as eligible.

Emergency

A medical condition, whether physical, behavioral, related to substance use disorder, or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention, could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of the Member or another person in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any body organ or part. With respect to a pregnant woman who is having contractions, an Emergency also includes having an inadequate amount of time to affect a safe transfer to another hospital before delivery or a threat to the health or safety of the Member or her unborn child. For further information refer to section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

Employer Group

The Group Insurance Commission, the state agency with which NHP enters into an Agreement to provide health care Coverage for the GIC's eligible members and their Dependents.

Enrollee

An Eligible Individual or subscriber enrolled in a health insurance plan offered by a contracted MCO (such as NHP), either by choice of the Eligible Individual or through an Employer Group.

Enrollment

The process by which NHP registers Eligible Individuals and Employees for Membership.

Enrollment Date

The first day on which NHP is responsible for providing Covered Services to a Member.

Essential Community provider

An Essential Community Provider (ECP) is a health care Provider that serves high-risk, special needs and underserved individuals.

Evidence of Coverage

The legal document, made up of this Member Handbook and your Schedule of Benefits that sets forth the services covered by NHP, the exclusions from coverage, and the conditions of coverage for Members.

Explanation of Benefits (EOB)

An Explanation of Benefits (EOB) is a statement sent by NHP to members who are enrolled in a Plan with a Deductible which explains what medical treatments and/or services were paid for on their behalf. The EOB also contains information on Member cost-sharing amounts such as Deductible, copay and Coinsurance amounts. NHP mails these statements to members once a month.

Family Planning Services

Services directly related to the prevention of conception. Services include: birth control counseling, education about Family Planning, examination and treatment, laboratory examinations and tests, medically approved methods and procedures, pharmacy supplies and devices, sterilization, including tubal ligation and vasectomy. (Abortion is not a Family Planning Service.)

Final Adverse Determination

An Adverse Determination made after a Member has exhausted all remedies available through NHP's internal Grievance process.

Formulary

The schedule of prescription drugs approved for use which will be covered by the plan and dispensed through participating pharmacies.

Grievance

Any oral or written Complaint submitted to NHP or one of NHP's utilization management designees that has been initiated by a Member, or the Member's Authorized Representative, concerning any aspect or action of NHP relative to the Member, including, but not limited to, review of Adverse Determinations regarding scope of coverage, denial of services, rescission of coverage, quality of care, and administrative operations.

Group Insurance Commission Contract

The Contract between the Group Insurance Commission and NHP that sets forth the obligations of the GIC and the terms of NHP coverage for GIC insured's.

Habilitation Services

Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or outpatient settings.

Health Care Services

Services for the diagnosis, prevention, treatment, cure, or relief of a physical, behavioral, substance use disorder or mental health condition, illness, injury, or disease.

Hearing aid

A wearable aid or device, typically worn in the ear, which improves a Member's ability to hear sound. A Hearing Aid may include parts, attachments, accessories, and supplies. Hearing aid batteries are not part of the Hearing Aid.

Licensed Mental Health Professional

Includes a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed marriage and family therapist, a licensed mental health counselor or a licensed nurse mental health clinical Specialist.

Limited Service Clinic

These clinics offer basic services to treat non-life threatening illnesses or injury. They are usually staffed by certified nurse practitioners or physician assistants.

In-Network Provider

A Provider contracted with NHP to provide services to members. All Covered Services except Emergency Services must be with In-network Providers.

Inpatient

Care in a hospital that requires admission and at least one overnight stay. An overnight stay in an observation bed is considered outpatient.

Inquiry

Any communication by or on behalf of a Member to NHP that has not been the subject of an Adverse Determination and that requests redress of an action, omission or policy of NHP.

Managed Care

A system of health care delivery that is provided and coordinated by a PCP. The goal is a system that delivers value by providing access to quality, cost-effective health care.

Managed Care Organization (MCO)

A carrier subject to M.G.L. c. 176O (this is Health Insurance Consumer Protections).

Medically Necessary Services

Medically Necessary or Medical Necessity describes Health Care Services that are consistent with generally accepted principles of professional medical practice as determined by whether: (a) the service is the most appropriate available supply or level of service for the Member in question considering potential Benefits and harms to the individual; (b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or (c) for services and interventions not in widespread use, is based on scientific evidence.

Member

Any Individual actively enrolled in NHP.

Member Financial Responsibility

The Member's financial responsibility, if any, for any Premiums, Coinsurance, Copayments, or Deductibles.

Member ID Card

The card that identifies an individual as a Member of NHP. The Member Card includes the Member's identification number, Copayments and other information about the Member's coverage. The Member ID Card must be shown to Providers prior to receipt of services.

Neighborhood Health Plan (NHP)

A Massachusetts licensed, not-for-profit Health Maintenance Organization (HMO) founded in 1986 by the Massachusetts League of Community Health Centers and the Greater Boston Forum for Health Action. NHP's mission is to provide accessible health care delivery systems, which are Member-focused, quality-driven, and culturally responsive to our Members' needs.

NHP Provider

A Provider who, under contract with NHP or a delegated entity, has agreed to provide Health Care Services to insured's with an expectation of receiving payment, other than Coinsurance, Copayments or Deductibles, directly or indirectly from NHP.

NHP Treating Provider

See "NHP Provider."

Network

The group of Providers contracted by NHP to provide Health Care Services to Members.

Nondiscriminatory Basis Coverage

NHP's coverage policies do not contain any annual or lifetime dollar or unit of service limitations imposed on coverage for care provided by Nurse Practitioners that are less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the same services by other Providers.

Nurse Practitioner

A registered nurse who holds authorization in advance nursing practice as a Nurse Practitioner under M.G.L. c. 112, 80B and regulations promulgated thereunder.

Out-of-Network Provider

A Provider not contracted with NHP to provide services to Members. Services with out-of-Network Providers are not covered unless authorized by NHP before you have the service or in an Emergency or Urgent situation.

Out-of-Pocket Maximum

Maximum amount of money that a member must pay on his own during a Benefit period before NHP will pay 100% of the allowed amount. The limit does not include your Premium or a service your plan does not cover.

Premium

The amount of money paid to NHP on the subscriber's behalf by an employer to cover the cost of health insurance.

Physician Assistant

A health care professional who meets the requirements for registration as set forth in M.G.L. c. 112 § 9I and who may provide medical services appropriate to his or her training, experience and skills and under the supervision of a registered physician.

Preventive Care

Care such as annual physical exams, immunizations, mammograms and other screening tests which are generally provided by your PCP.

Primary Care Provider (PCP)

A health care professional qualified to provide general care for common health care problems who: supervises, coordinates, prescribes, or otherwise provides or proposes Health Care Services; initiates Referrals for Specialist care; and maintains continuity of care within the scope of practice.

Primary Care Site

The locations where PCPs provide care to NHP Members. A Primary Care Site may be a health center, an outpatient department of a hospital, or a physician group practice.

Provider

A health care professional or facility licensed as required by state law. Providers include doctors, hospitals, laboratories, pharmacies, skilled nursing facilities, Nurse Practitioners, registered nurses, Physician Assistants, psychiatrists, social workers, licensed mental health counselors, licensed marriage and family therapists, clinical Specialists in psychiatric and mental health nursing, and others. NHP will only cover services of a Provider if those services are Covered Benefits and within the scope of the Provider's license.

Provider Directory

A list of NHP's In-network medical facilities and professionals, including PCPs, Specialists, hospitals, and Urgent Care centers. The GIC NHP Provider Directory is available online at www. nhp.org (select "Find a Doctor").

A Directory of Behavioral Health providers can be found at www.beacon healthstrategies.com (select "Locate a Provider").

Referral

A recommendation by a PCP for a Member to receive medical services from another Provider. In most cases, NHP requires Referrals for Specialist services provided by In-network NHP Providers. Please see "Section 4: Accessing Care" for more information.

Rehabilitation Services

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric Rehabilitation Services in a variety of Inpatient and/or outpatient settings.

Service Area

The geographical area where NHP has developed a Network of Providers to provide adequate access to Covered Services. The NHP Service Area includes most communities in Massachusetts, see Section 2 for details.

Specialist

A Provider who is trained and certified by the state of Massachusetts to provide specialty services. Examples include but are not limited to cardiologists, obstetricians and dermatologists.

Schedule of Benefits

The Schedule of Benefits is a general description of your NHP coverage. It also lists the Deductible, Copayment, Coinsurance, and Out-of-Pocket Maximum amounts, where applicable, on services your policy covers. The Schedule of Benefits is not the same as the Member ID Card (see Member ID Card).

Tier (or Provider Tiering)

The level of Copayment structure assigned to a select Specialists, including Allergist/Immunologist, Cardiology, Dermatologist, Endocrinology, ENT/Otolaryngology, Gastroenterologist, General Surgeon, Hematologist & Oncologist, Nephrologist, Neurologist,- OB/GYN, , Ophthalmologist, Orthopedic Surgeon, Podiatrist, Pulmonology, Rheumatologist and Urologist. The Tier assignment is based upon the Provider's combined quality/and/or cost-efficiency scores as derived from the GIC's Clinical Performance Improvement (CPI) Initiative data.

There are three levels, including:

*** Tier 1 (excellent)

** Tier 2 (good)

* Tier 3 (standard)

(ID) Insufficient Data

Select Specialists with the highest combined quality and/or cost-effectiveness scores are assigned to ***Tier 1 (excellent). Select Specialists with scores that fall within the middle range are assigned to Tier 2, and select Specialists with standard scores are assigned to *Tier 3 (standard). Specialists who have insufficient data for comparison are assigned to the **Tier 2 (good) copay level.

Treatment of Autism Spectrum Disorders

Includes the following care prescribed, provided or ordered for an individual diagnosed with one of the Autism Spectrum Disorders by a licensed physician or a licensed psychologist who determines the care to be medically necessary: habilitative or rehabilitative care; pharmacy care; psychiatric care; and therapeutic care.

Urgent Care

Care for an illness, injury or condition serious enough that a person would seek immediate care, but not so severe as to require Emergency room care. Urgent Care does not include Routine Care.

Utilization Review

A set of formal review techniques designed to monitor the use of—or evaluate the clinical necessity, appropriateness or efficiency of—Covered Health Care Services, procedures, or settings. Such review techniques may include, but are not limited to, ambulatory review, prospective review/prior Authorization, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

Utilization Review Organization

An entity that conducts Utilization Review under contract with or on behalf of a carrier, but does not include a carrier performing Utilization Review for its own health Benefit plans. A Behavioral Health manager is considered a Utilization Review Organization.

Workers Compensation

Insurance coverage maintained by employers under federal law to cover employees' injuries and illnesses under certain conditions.

NHP Customer Service

Whenever you have a question or concern about your NHP Membership or Benefits, our highly trained Customer Service Representatives are available to help you or **you can go online to nhp.org/Member and log in to mynhp.org—our secure Member portal.**

You can reach NHP's GIC Customer Service at **866-567-9175** (TTY 711) and a representative will assist you.

Our hours of operation are Monday–Friday 8:00 a.m.–6:00 p.m., and Thursday 8:00 a.m. –8:00 p.m.

nhp.org

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Neighborhood Health Plan™