Health New England

AMENDMENT 02-2019

This is an Amendment to your Health New England, Inc. Summary Plan Description (SPD). Please keep this Amendment with your SPD as it changes the terms of that SPD. Any language in the SPD that does not follow the terms of this Amendment no longer applies. This Amendment is effective July 1, 2019, unless noted below.

The SPD is amended as shown below.

Benefit, Program, or Requirement	Description
Sleep study limit removed	**Section 3 – Covered Benefits – Sleep Studies** The limit of two sleep studies per Calendar Year is removed. **Effective July 1, 2019**
Wigs (scalp hair prostheses)	**Section 3 – Covered Benefits – Other Services – Wigs (Scalp Hair Prostheses)** The following replaces the benefit description under "Wigs (Scalp Hair Prostheses)." HNE covers wigs (scalp hair prostheses) worn for hair loss due to the treatment of any form of cancer or leukemia. HNE covers one prosthesis per Calendar Year. Your Cost Sharing is shown in the Summary of Benefit Chart in Appendix A. Your cost will be less if you use a provider in the network of HNE's DME Benefit Manager, Northwood. A Northwood provider will submit a claim for you. Or, you can pay for a wig from any provider and submit a request to HNE Member Services for reimbursement. Requests for reimbursement must include: • Proof of payment • A written statement from our doctor that the wig is Medically Necessary. **Clarification**
Human leukocyte antigen testing limit removed	**Section 3 – Covered Benefits – Human Organ Transplants and Bone Marrow Transplants** The following is removed from the SPD. Human leukocyte antigen testing of histocompatibility locus antigen testing. This is covered for a Member when needed to establish the Member's bone marrow transplant donor suitability. HNE covers the costs of testing for A, B, or DR antigens, or any combination of those. A Member only needs to be tissue typed once during his or her lifetime. Tissue typing is similar to blood typing. Like blood type, tissue type does not change. Therefore, coverage is limited to one test per Member per lifetime. All other uses of HLA testing are covered when Medically Necessary. This service requires Prior Approval. The following is added to the SPD. Human leukocyte antigen testing of histocompatibility locus antigen. This is covered for a Member when needed to establish the Member's bone marrow transplant donor suitability. HNE covers the costs of testing for A, B, or DR antigens, or any combination of those. All other uses of HLA testing are covered when Medically Necessary. **Effective July 1, 2019**

Benefit, Program, or Requirement	Description
Transgender health services	**Section 3 – Covered Benefits** The following is added to the SPD. **Transgender Health Services** The Plan covers transgender health services in accordance with HNE's clinical guidelines. To receive a copy of HNE's guidelines for gender reassignment please call HNE Member Services at (800) 310-2835. You can also access the guidelines on our website at healthnewengland.org. Click on Members, under Member Resources click on Learn More, then click on "Behavioral Health/Medical Policies." Coverage includes: • behavioral health benefits • pharmaceutical coverage (e.g., for hormone replacement therapies) • coverage for medical visits or laboratory services • coverage for reconstructive surgical procedures related to sex reassignment • coverage of routine, chronic or urgent non-transition services Benefits for transgender health services are in addition to other benefits provided under the Plan. HNE does not consider transgender health services to be reconstructive surgery to correct a physical functional impairment or cosmetic services. Coverage for reconstructive surgery or cosmetic services is limited to the services described in the "Exclusions and Limitations" section of this SPD. **Clarification**
Suit therapy	**Section 4 – Exclusions and Limitations – Exclusions** The following is added to the list of services Health New England does not cover. • Suit therapy or the home use of a suit therapy device to treat any condition including, but not limited to, cerebral palsy or other neuromuscular conditions **Effective July 1, 2019**
Annual Notice	**WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998: ANNUAL NOTICE OF RIGHTS** If your Plan covers mastectomies, and if you are receiving benefits under the Plan in connection with a mastectomy, you have the right to receive coverage of: • Reconstruction of the breast on which the mastectomy was performed; • Surgery and reconstruction of the other breast to produce a symmetrical appearance; and • Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. The Plan provides coverage based on what you and your attending physician determine to be appropriate for you. If your Plan requires Deductibles, Coinsurance, or Copays for other benefits under the Plan, these requirements may apply to the above procedures to the same extent that they apply to other benefits.

Benefit, Program, or Requirement	Description
Notice of Privacy Practices	The Plan's Notice of Privacy Practices is located on Health New England's website. To view this notice, visit healthnewengland.org and click the Privacy & Disclaimer link at the bottom of the page. To request a paper copy of this notice, call Health New England's Member Services at (800) 791-7944. For TTY/TDD, call (800) 439-2370.