Member Handbook for the Commonwealth of Massachusetts

Health New England Group Medicare Supplement Plus

Commonwealth of Massachusetts
Group Insurance Commission

EFFECTIVE JULY 1, 2021

GICMEDSUPPLUS7.1.21

This health plan **meets Minimum Creditable Coverage standards** and **will satisfy** the individual mandate that you have health insurance. Please see inside this cover for additional information.

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information, call the Connector at (877) MA. ENROLL or visit the Connector website (mahealthconnector.org).

This health plan meets Minimum Creditable Coverage standards that are in effect January 1, 2021 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE IN EFFECT JANUARY 1, 2021. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

Welcome!

This handbook is for individuals who have retired from employment with the Commonwealth of Massachusetts or a Municipality or other entity participating in the Group Insurance Commission, and their Medicare dependents who are enrolled in Medicare Parts A and B. This handbook describes benefits for you and your retired dependents covered under Health New England Group Medicare Supplement Plus (the Plan). These benefits are provided through the Group Insurance Commission (GIC), the state agency responsible for the design and payment of all benefits for state, participating municipalities and other governmental entities' employees and retirees. This Plan is funded by the Commonwealth of Massachusetts and administered by HNE Advisory Services, Inc. (HNE).

HNE provides administrative services to the GIC including claims processing, customer service, prior approval reviews and case management. HNE Member Services is located at One Monarch Place, Suite 1500, Springfield, MA 01144.

This handbook is set up to help you find the information you need to know quickly and easily. The Table of Content lists each section and where it is located. You will find a shaded box at the beginning of each section. Words in this Handbook that begin with a capital letter may have a special meaning that is defined in the Definition section.

Health New England

Notice Informing Individuals of Nondiscrimination and Accessibility

Health New England complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health New England does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health New England:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Susan O'Connor, Vice President and General Counsel.

If you believe that Health New England has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Susan O'Connor, Vice President and General Counsel, One Monarch Place, Suite 1500, Springfield, MA 01104-1500, Phone: (888) 270-0189, TTY: 711, Fax: (413) 233-2685 or ComplaintsAppeals@hne.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Susan O'Connor, Vice President and General Counsel, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, (800) 368-1019, (800) 537-7697 (TDD). Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Multi-Language Services

We're here to help you. We can give you information in other formats and different languages. All translation services are free to members. If you have questions regarding this document, please call the toll-free member phone number listed on your health plan ID card, (TTY:711), Monday through Friday, 8:00 a.m. - 6:00 p.m.

BeHealthy Partnership members, this information is about your BeHealthy Partnership benefits. If you have questions, need this document translated, need someone to read this or other printed information to you, or want to learn more about any of our benefits or services, call the toll-free member phone number listed on your health plan ID card, (TTY: 711), Monday through Friday, 8:00 a.m. – 6:00 p.m. For questions about your Behavioral Health, call MBHP at: (800) 495-0086 (TTY: (617) 790-4130) 24 hours a day, 7 days a week, or visit www.masspartnership.com.

Medicare Advantage members, Health New England Medicare Advantage is an HMO and HMO-POS Plan with a Medicare contract. Enrollment in Health New England Medicare Advantage depends on contract renewal. If you have any questions regarding this document, please contact the toll-free member phone number listed on your health plan ID card, (TTY: 711).

Last Reviewed: 7/31/2019

English	You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. (TTY: 711)
Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. (TTY: 711)
Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. (TTY: 711)
Chinese	您有權免費以您使用的語言獲得幫助和訊息。如需口譯員，請撥打您的保健計劃 ID 卡上列出的免費會員電話號碼，按 0。(TTY: 711)
French Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. (TTY: 711)
Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. (TTY: 711).
Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия (телетайп: 711)
Arabic	يحق لك الحصول على المساعدة والمعلومات بلغتك مجانًا. لطلب مترجم، اتصل برقم هاتف العضو المجاني على بطاقة تعريف خطتك الصحية، ثم اضغط على 0. (TTY:711)
Mon-Khmer, Cambodian	អ្នកមានសិទ្ធិទ្ួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអ្ស់ថ្លៃ។ ដ ើមបីដសនើស ំអ្នកបកប្រប សូមទ្ូរស័ពទដៅដលខតតដេញថ្លៃសំរាប់សមាជិក ឬ លមានកត់ដៅកនុងប័ណ្ណ ID តំដរាងស ខភាពរបស់អ្នក រួេដ ើយ េ 0។ (TTY: 711)
French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. (ATS: 711).
Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti (TTY: 711).
Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. (TTY: 711).
Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. (TTY: 711).
Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
Gujarati	તમારી ભાષામાં વિના મૂલ્યે મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયાની વિનંતી કરવા માટે તમારા હેલ્થ પ્લાન ID કાર્ડ પર જણાવેલા ટોલ-ફ્રી નંબર પર કૉલ કરો અને 0 દબાવો. (TTY: 711).
Lao	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫ ຼືອແລະຂ ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບ ່ມີຄ່າໃຊ້ຈ່າຍ. ເພ ື່ອຂ ຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສ າລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. (TTY: 711).
Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. (TTY: 711).
Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. (TTY: 711).

TABLE OF CONTENTS

SECTION 1 – INTRODUCTION

WHAT'S IN THIS SECTION?

In this section we describe this book and how to use it. We also tell you about the Plan and how to get help from Medicare and from HNE's Member Services. Certain words in this book begin with a capital letter. They have a special meaning. We define these words in the "Definitions" section.

How to Use This Book

This document is called your "Handbook." In this Handbook, we talk about your benefits and the terms of your coverage with this Plan.

The Table of Contents lists each section of the Handbook. It also lists the main topics of information covered in that section. At the beginning of each section there is a shaded box, like the box at the top of this page. Each box lists some of the important things to know about that section. You can find more details below the shaded box.

In this Handbook certain words have a special meaning. You can find definitions of these words in Section 12.

Getting Help with Your Questions

This Plan works with your Medicare coverage. The Plan supplements your Medicare coverage. It also provides coverage for some services which are not covered under Medicare. If you have a question about Medicare benefits or claims, Medicare is your best source for information. If you have a question about this Plan's benefits or claims, you should contact HNE Member Services. We explain how to contact Medicare and Member Services.

Question About Medicare Benefits and Claims

Your Medicare handbook "Medicare and You" has answers to many of the questions you may have about your benefits under Medicare. You can get a copy of the handbook at most local Social Security offices. You can also go on the internet. The web address is: http://www.medicare.gov/publications/home.asp.

To get answers to your specific questions you can visit medicare.gov or call 1 (800) MEDICARE (800) 633-4227). The number for TTY service is (877) 486-2048.

HNE's Member Services representatives are available to help you Monday through Friday from 8:00 a.m. to 6:00 p.m. You can call (877) 443-3314. You can also visit healthnewengland.org/GIC.

WHAT'S IN THIS SECTION?

In this section we describe in general how this Plan works. We also tell you where to find more specific information about your Plan.

You are covered for Health Care Services for an Emergency Medical Condition.

How Your HNE Medicare Supplement Plus Plan Works

This Plan provides added coverage for persons enrolled in Medicare Part A and Part B. The Plan works with your Medicare coverage and:

- Pays the Medicare Deductible and Coinsurance amounts for Medicare Part A and Part B.
- Covers some services that Medicare does not cover at all.
- Pays for certain Medicare Covered Services after your Medicare benefits have been used up.

To use your Medicare benefits, you can get services from any healthcare Provider who is eligible for payment by Medicare. Medicare is the primary payer for Medicare Covered services. The Plan is the secondary payer for Medicare Covered services. This means that for Medicare Covered Services, your Provider will bill Medicare first, and then bill the Plan.

Some Covered Services are covered by this Plan, but are not covered by Medicare. When you use those benefits you do not have to use a Provider who is eligible for payment by Medicare. In this case the Provider or you may bill the Plan. See Section 6 for more information about reimbursement and claims procedures.

This plan provides coverage for Medicare Covered Services according to the rules of the Original Medicare Plan. Medicare may change the terms of your coverage. For example, Medicare may change the amounts of the Deductibles for Part A and Part B. If Medicare changes its coverage, we will automatically change this Handbook to match Medicare's changes.

The Plan also provides certain benefits that are mandated by Massachusetts state law. These benefits are shown in this Handbook. When Massachusetts law requires a change to these benefits, HNE will work with the GIC to communicate the change.

When changes to benefits occur, HNE will work with the GIC on updating this Handbook. If we make a benefit change, we will give you an Amendment that explains the change. Please keep any Amendments with this Handbook for easy reference.

Understanding Your Benefits

The Plan covers the services and supplies to treat illness and to treat injuries resulting from an Accident. The Plan provides benefits to treat an illness no differently than it provides benefits to treat an injury due to an Accident. This Plan has no limitations for pre-existing conditions.

Covered Services are described in Section 3 of this Handbook. Section 4 lists coverage limitations and exclusions. This Handbook does not fully explain Medicare's benefits.

Section 1 of this Handbook explains how you can get more information about your Medicare coverage.

Your Payment Responsibilities

You are responsible for:

- Copays and coinsurance indicated in the Charts of Benefits in Appendix A
- **Charges for services that go beyond the maximum benefit covered by Medicare and this Plan.** This applies to specific benefits that are limited by the number of visits or days or are limited to a fixed dollar amount of coverage. Benefit maximums are in the Chart of Benefits in Appendix A.
- **Some charges by Providers who do not accept assignment from Medicare.** This applies if you receive Medicare Covered Services from a Provider who does not accept Medicare assignment. If the Provider's charge is more than the Medicare approved amount, you are responsible for the difference in addition to any Deductible or Coinsurance.

HNE no longer routinely mails EOBs to members. EOBs are provided in electronic format on HNE's secure member portal at my.HealthNewEngland.org. You can print an EOB from the portal. Or, if you wish to have EOBs sent to you, you can log onto the portal and change your mailing preferences. You can also request paper copies of your EOBs by calling Member Services at the Member Services number listed below.

For more specific information about what you are responsible for paying, please read:

- The Chart of Benefits in Appendix A of this Handbook.
- Your Medicare handbook.

Identification Cards

When you enroll in the Plan you will get an identification card (ID card). You must show your Plan ID card along with your Medicare card to get services. Your ID card provides information such as:

- HNE's mailing address and telephone number
- Subscriber name
- ID number
- Type of plan
- Name and Member number of each person covered

Having an ID card does not guarantee coverage for services. To receive coverage for services, you must be enrolled with the Plan at the time of the service. If you let others use your ID card to get Covered Services to which they are not entitled, we may end your coverage. You should report the loss or theft of your ID card to HNE as soon as possible. Only use the most recent card HNE has provided to you.

How to Get Care in an Emergency

The Plan uses the definition of "Emergency" provided by Massachusetts law.

This is the definition:

> An emergency is a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the 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 395dd(e)(1)(B).

You are always covered for care you need for an Emergency Medical Condition. If you believe you need emergency care, you should seek care at once. This includes calling 911 or the local emergency number. No Member will be in any way discouraged from using 911 or any similar pre-hospital emergency medical system, or the local equivalent.

No Member will be denied coverage for medical and transportation expenses incurred because of any Emergency Medical Condition which meets the above conditions.

When an emergency occurs:

Seek medical care at once. Go to the nearest emergency room or dial "911."

WHAT'S IN THIS SECTION?

In this section we give you information about what the Plan covers. We tell you where to find more specific information about your Plan. We also describe any coverage limits or guidelines.

To be covered by the Plan, care must be:

- Listed as covered in this Handbook
- Medically Necessary
- Appropriate
- Supplied by Providers who are eligible to provide services that are covered by Medicare. Exceptions to this are stated in this Handbook.

Some care is ***not*** covered.

This section describes the benefits you have with the Plan. Some benefits are limited or excluded. Information about limited or excluded benefits is in Section 4 of this Handbook. For more information about your coverage with Medicare Part A and Part B, please read the most current version of your Medicare Handbook. You can also find more detailed information about Medicare benefits by visiting www.medicare.gov/coverage.

Ambulance Services — You Pay.....$0

After Medicare provides coverage, the Plan will cover Medicare approved services. Plan coverage is based on the Allowed Charge. Covered services are:

- Medicare approved ambulance transport to an emergency medical facility for treatment for an Accident or Emergency Medical Condition
- Other Medically Necessary ambulance transport approved by Medicare

Autism Spectrum Disorder Treatment — You Pay……$15/per visit

The Plan covers Medically Necessary services for the diagnosis and treatment of Autism Spectrum Disorder (ASD). The Plan uses the definition of ASD in the most recent edition of the Diagnostic and Statistical Manual of Mental Health Disorders. This includes:

- Autistic disorder
- Asperger's disorder
- Pervasive developmental disorders not otherwise specified

The Plan covers Medically Necessary services to diagnose ASD less the copayment per visit you are responsible to cover. This includes:

- Neuropsychological evaluations (Prior Approval required)

- Psychological care
- Therapeutic care when services provided by licensed or certified speech therapist
- Genetic testing (Prior Approval required)
- Other tests to diagnose ASD (some services may require Prior Approval)

Genetic testing Prior Approval process will be managed through eviCore. EviCore is the vendor that HNE also uses for Prior Approval of high cost imaging. Your provider will be able to access eviCore via web portal or telephone for any genetic testing needs.

The Plan requires you to be responsible for the copayment when you receive services for the treatment of ASD. These services include:

- Habilitative or Rehabilitative care: 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 (Prior Approval required)
- Psychiatric care: direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices
- Psychological care: direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices
- Therapeutic care: Services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers

There is no annual or lifetime dollar or unit of service limit on the coverage for services to diagnose and treat ASD.

What is Not Covered:
Services related to ASD provided by school personnel under an individualized education program

Blood Services — You Pay.....$0

Medicare Blood Deductibles

The Medicare blood "deductible" is the cost of the first three pints of blood you use in a Calendar Year. There are separate blood deductibles for Medicare Part A and Part B. The Part A blood deducible applies when you are an inpatient in a Hospital or Skilled Nursing Facility. The Part B blood deductible applies if you receive blood when you are an outpatient at a Hospital. You have to meet only one Part A **or** Part B blood deductible each Calendar Year. This plan covers your Medicare blood Deductibles.

The blood deductible will be waived if you replace the blood yourself or have it donated by someone else. In most cases the Hospital gets blood from a blood bank at no charge. If the blood was obtained at no charge, you will not have to pay for it or replace it.

Inpatient in a Hospital or Skilled Nursing Facility

The Plan covers the Medicare Part A inpatient blood deductible.

Outpatient

The Plan provides coverage for the Medicare Part B outpatient blood deductible. However, even if the Hospital received the blood from a blood bank at no charge, there will be a charge for blood processing and handling. The Medicare Part B Deductible applies to this charge.

Cardiac Rehabilitation — You Pay……$15/per visit

After Medicare provides coverage, the Plan will cover Medicare approved services and you pay $15 per visit Plan coverage is based on the Allowed Charge.

Diabetic Supplies — You Pay.....$0
Diabetic Services (screenings & diabetic management training) — You Pay...$15/visit

When Covered by Medicare

For supplies and services covered by Medicare, after Medicare provides coverage, the Plan will provide coverage based on the Allowed Charge. Diabetic services such as screenings and diabetic management training, you pay $15 per visit. Part B diabetic supplies are covered under the Durable Medical Equipment benefit. Covered supplies include:

- Blood sugar (glucose) test strips
- Blood sugar monitor (glucometers)
- Lancet devices and lancets
- Insulin for use with a Medically Necessary external insulin pump
- Blood sugar control solutions used to check the accuracy of monitor and test strips
- Therapeutic shoes or inserts (only for members with severe diabetic foot disease)

When Not Covered by Medicare

The Plan also provides coverage for the diabetic-related items listed below. These items are **not** covered by Medicare. These items are covered under the Plan prescription drug benefit which is not administered by HNE. See your "Prescription Drug Coverage" booklet for more information.

- Insulin
- Insulin pens
- Syringes
- Needles
- Prescribed oral diabetes drugs that influence blood sugar levels

Diagnostic Tests — You Pay.....$0

Medicare approved lab tests, x-rays and other diagnostic tests are included in this benefit. After Medicare provides coverage, the Plan will cover Medicare approved services, Plan coverage is based on the Allowed Charge.

Dialysis Services — You Pay.....$0

After Medicare provides coverage, the Plan will cover Medicare approved services. Plan coverage is based on the Allowed Charge. Medicare and the Plan cover:

- Outpatient dialysis treatment
- Self-dialysis training services by a Medicare covered Provider
- Home dialysis

The dialysis facility is responsible for coordinating your dialysis services in a facility or at home.

Durable Medical Equipment and Prosthetic Devices — You Pay.....$0

After Medicare provides coverage, the Plan will cover Medicare approved services based on the Allowed Charge. Only Medicare approved Durable Medical Equipment and prosthetic devices are covered. For Medicare to pay, you must get your covered equipment or supplies and replacement or repair services from a Medicare approved supplier.

Not Covered:

- Durable Medical Equipment that is not covered by Medicare
- Arch supports, orthotic devices, corrective shoes, and inserts (except those for diabetic foot care)

Emergency Room Care — You Pay.....$50/per visit (waived if admitted)

After Medicare provides coverage, the Plan will cover Medicare approved services. Plan coverage is based on the Allowed Charge. This benefit includes services at a Hospital emergency room or other emergency facility. Services for emergency medical care and Accident treatment are covered. As a member, you are responsible to pay a $50 copay per visit, but charge will be waived if admitted.

Enteral Formulas, Low Protein Food Products — You Pay……$0

Enteral Formulas

This benefit covers enteral formulas for home use for treatment of malabsorption caused by:

- Crohn's disease
- Ulcerative colitis
- Gastroesophageal reflux
- Gastrointestinal motility
- Chronic intestinal pseudo-obstruction
- Inherited diseases of amino acids and organic acids

Formulas for the above conditions must be ordered by a physician. After Medicare provides coverage, the Plan will provide coverage. Plan coverage is based on the Allowed Charge. Sometimes an enteral formula is Medically Necessary but is not covered by Medicare. In that case the Plan will provide benefits up the full Allowed Charge.

Foreign Travel — You Pay……$50/per visit (waived if admitted)

(Services you receive outside of the United States – Emergency Services Only)

The Plan covers services you receive outside of the United States and its territories to treat an unexpected Emergency Medical Condition. Emergency Medical Condition is defined on page 56 of this Handbook.

The Plan's coverage is meant for persons who live in the United States and travel to other countries. It is not meant for persons who live outside the United States. These services are **not** covered:

- Routine or preventive services
- Services that could have been received before leaving the United States (even if receiving those services would have delayed travel plans)
- Transportation other than ambulance transport to the nearest hospital
- Transportation back to the United States
- Services that would not have been covered by Medicare or the Plan in the United States

You are responsible for a $50 copay per visit, but if you are admitted, the charge is waived.

Gender Affirmation Operations and Treatment (Requires Prior Approval)

Gender Affirmation Surgery requires Prior Approval. You may access and view the clinical review criteria used by HNE for benefit decisions related to Gender Affirmation Surgery on www.healthnewengland.org. Click on Member, then click on Medical Information, and then click on Medical Policies. To get a paper copy of the criteria, you can call Member Services at (800) 310-2835. There is no charge to you for a paper copy.

WHAT IS COVERED:

- Surgical repair and fertility preservation coverage with a consistent storage limit of **90 days maximum** (inclusive of all diagnoses), and removal of infertility treatment pre-requisites
- Coverage of facial reconstruction, including tracheal shave
- Coverage of mammoplasty and basic breast/chest augmentation
- Coverage of electrolysis/hair removal when part of surgical preparation

WHAT IS NOT COVERED:

- Treatment of authorization requirements for surgical reversal as equivalent to original procedure

Hearing Aids age 21 and under **You Pay……The difference in cost above the $2000 limit**

The Plan covers the cost of one hearing aid per hearing impaired ear, every 24 months, up to a maximum of $2,000 for each hearing aid.

You may choose a higher priced hearing aid and pay the difference in cost above the $2,000 limit. If you choose to pay the difference in cost, the amount you pay will not apply to your Out-of-Pocket Maximum or Deductible.

Coverage for related services prescribed by a licensed audiologist or hearing instrument specialist includes:

- Initial hearing aid evaluation
- Fitting and adjustments
- Supplies, including ear molds

The payment responsibilities and other requirements that are a part of this plan apply to this coverage.

The Plan requires a written statement from the Member's treating physician that the hearing aid is Medically Necessary.

Hearing Aids over age 21 **You Pay……20% Coinsurance after first $500 and all charges in excess of benefit limits**

The plan provides coverage for the first $500 in full, then remaining $1,500 covered at 80% (for both ears combined). You are responsible for 20% coinsurance after the first $500 and all charges in excess of benefit limits.

Low Protein Food Products **You Pay……any costs over $5000 per Policy Year**

This benefit covers food products modified to be low protein to treat inherited disease of amino acids and organic acids. Use of these products must be Medically Necessary. Medicare does not cover these food products. The Plan covers up to a maximum of $5,000 per Calendar Year for these food products. You are responsible for paying any charges over $5,000 in a Calendar Year.

Home Health Care **You Pay……$0**

If you use a Medicare covered home health care Provider, Medicare provides full benefits for home health care. These benefits are based on the Allowed Charge. For full benefits from Medicare, you must get these services from a Medicare covered home health care Provider. Your Medicare handbook has information about home health care services covered by Medicare.

The Plan also covers Durable Medical Equipment required as a part of Medicare approved home health care services. Coverage is based on the Allowed Charge.

Not Covered:

- Special duty or private duty nursing and attendant services

Hospice Services — You Pay…..... $0

This benefit covers these services required for a terminally-ill person (a person with a life expectancy of six month or less):

- These services when provided or arranged for by a hospice care Provider: physician, nursing, social, volunteer and counseling services; inpatient care, home health aide visits; and Durable Medical Equipment.
- Respite care. This is care given to the hospice patient so that the primary care giver can rest.
- Bereavement Services. These are counseling services provided to the family or primary care giver after the death of the hospice patient.

If Medicare does not provide full coverage for hospice services, the Plan will provide coverage for the difference between the amount that Medicare pays and the Allowed Charge for the services. If Medicare does not provide any benefits for hospice services, the Plan provides full coverage as required by state law. Plan coverage is based on the Allowed Charge for hospice services.

Organ and Bone Marrow Transplants

After Medicare provides coverage, the Plan will provide coverage. With one exception, the Plan covers human organ or bone marrow transplants only when they are covered by Medicare. The exception is for bone marrow transplants for a Member who has breast cancer that has spread. These transplants will be covered only when they meet the criteria set by the Massachusetts Department of Public Health. Medicare does not cover these bone marrow transplants. Plan coverage is based on the Allowed Charge. Medicare covers only specific transplants. See your Medicare handbook for more information on Medicare covered transplants.

Inpatient Hospital Admissions in a General Hospital – Medical and Surgical Care

Inpatient Hospital Services

Medicare bases its coverage for Hospital care on Benefit Periods. A Benefit Period begins with your first day of a Hospital stay covered by Medicare. It ends when you have not received any inpatient Hospital care (or skilled care in a SNF) for 60 days in a row. Medicare does not limit the number of Benefit Periods it will cover in a lifetime.

After Medicare provides coverage, the Plan will provide coverage based on the Allowed Charge for all Medicare approved inpatient days in a Benefit Period. This coverage is provided for:

- Days 1 through 60 of a Benefit Period
- Days 61 through 90 of a Benefit Period
- The 60 Medicare Lifetime Reserve Days used.

Inpatient Physician and Professional Services You Pay……$0

After Medicare provides coverage, the Plan will provide coverage based on the Allowed Charge for all inpatient services that Medicare covers. This coverage is for services by a physician or other Medicare covered professional Provider.

The Plan may also provide full benefit for coverage for some services that Medicare does not cover. Plan coverage is based on the Allowed Charge. An example is coverage for inpatient physician services for bone marrow transplants for breast cancer.

Not Covered:

- Custodial care or long term care
- Personal or comfort items, including telephone and television charges
- Private room charges, unless Medicare (or the Plan for services covered only by the Plan) determines that a private room is Medically Necessary.

Medical Care – Specialist, Clinic, Office and Home Visits You Pay……$15/per visit

This benefit is for Medicare approved services to diagnose or treat an illness or injury. Covered Services include:

- Office, clinic and home visits
- Follow up medical related to an Accident or Emergency Medical Condition
- Medical nutrition therapy services
- Hormone replacement therapy for peri- and post-menopausal women
- Medical exams to fit prosthetic lenses when the lenses are covered by Medicare
- Monitoring and medical management for Member who are taking psychiatric drugs
- Neurological assessment services

After Medicare provides coverage, the Plan will cover Medicare approved services. Plan coverage is based on the Allowed Charge. You are responsible for copayment per visit.

Behavioral Health and Substance Use Disorder Services

Please Note: Psychopharmacological services and neuropsychological assessment services are covered as medical benefits. For more information on this coverage, see "Medical Care – Clinic, Office and Home Visits" above.

Treatment for Biologically-Based Disorders (Includes substance use disorder and rape-related behavioral health or emotional disorders)

The Plan provides coverage for biologically based behavioral health disorders and rape-related behavioral health or emotional disorders. Plan coverage is based on the Allowed Charge.

Coverage for biologically based behavioral health disorders is for the disorders listed below. These disorders are described in the most recent edition of the diagnostic and statistical manual of the American Psychiatric Association (DSM):

- Schizophrenia
- Schizoaffective disorder

- Major depressive disorder
- Bipolar disorder
- Paranoia and other psychotic disorders
- Obsessive-compulsive disorder
- Panic disorder
- Delirium and dementia
- Affective disorders
- Eating disorders
- Post-traumatic stress disorder
- Substance use disorders
- Autism
- Any biologically based behavioral health disorders appearing in the DSM that are scientifically recognized and approved by the Commissioner of Mental Health in consultation with the Commissioner of the Division of Insurance

The Plan covers the diagnosis and treatment of rape-related behavioral health or emotional disorders for victims of a rape or victims of an assault with the intent to commit rape.

Inpatient Behavioral Hospital Services You pay……All Charges after Medicare Benefit Period and Reserve Days

After Medicare provides coverage, the Plan will provide coverage. Plan coverage is based on the Allowed Charge for all Medicare approved inpatient days in a Benefit Period. This coverage is provided for your stay in a general or behavioral health Hospital for:

- Days 1 through 60 of a Benefit Period
- Days 61 through 90 of a Benefit Period
- The 60 Medicare Lifetime Reserve Days used

The limits of Plan coverage for biologically based behavioral health disorders are the same limits that apply to all other inpatient stays.

Please note: The lifetime days you use for the treatment of any behavioral health or nervous condition in a general or behavioral health Hospital will reduce the number of lifetime days that are available in a general, chronic disease or rehabilitation Hospital for medical and/or surgical care.

Services covered only by the Plan can be provided in these settings:

- A general hospital licensed to provide such services
- A facility under the direction and supervision of the department of mental health
- A private behavioral health hospital licensed by the department of mental health
- A substance abuse facility licensed by the department of public health

After Medicare provides coverage, the Plan will provide coverage for services by a physician (who is a specialist in psychiatry) or a psychologist. Plan coverage is based on the Allowed Charge. Medicare does not cover benefits for services by a clinical specialist in psychiatric and behavioral health nursing.

When the services are not covered by Medicare, the Plan will provide full benefits for services by a physician (who is a specialist in psychiatry), a psychologist, or a clinical specialist in psychiatric and behavioral health nursing. Plan coverage is based on the Allowed Charge. The Plan covers these services for as many days as are Medically Necessary to treat your condition.

Outpatient Services — You Pay……$0

After Medicare provides coverage, the Plan will provide coverage for services by a Medicare covered behavioral health Provider. Plan coverage is based on the Allowed Charge. Medicare does not cover services by a clinical specialist in psychiatric and behavioral health nursing or a licensed mental health counselor.

When the services are not covered by Medicare, the Plan will provide benefits for services by the Providers listed below.

- Physicians (who are specialists in psychiatry)
- Psychologists
- Clinical specialists in psychiatric and behavioral health nursing
- Licensed independent clinical social workers
- Licensed mental health counselors
- Licensed marriage and family therapist providing services within the scope of practice allowed by law for these therapists

Services covered only by the Plan can be provided in these settings:

- A licensed hospital
- A behavioral health or substance use disorder clinic licensed by the department of public health
- A public community behavioral health center
- A professional office
- The home

Plan coverage is based on the Allowed Charge. The Plan will cover as many visits as are Medically Necessary to treat your condition.

Treatment for Non-Biologically-Based Behavioral Health Disorders Not Included in the Previous Section

The Plan covers treatment for behavioral health disorders not listed in the previous section as shown below.

Inpatient Hospital Benefits — You pay……All Charges after Medicare Benefit Period and Reserve Days

After Medicare provides coverage, the Plan will provide coverage for all Medicare approved inpatient days in a Benefit Period. Plan coverage is based on the Allowed Charge. This coverage is provided for your stay in a general or behavioral health Hospital for:

- Days 1 through 60 of a Benefit Period
- Days 61 through 90 of a Benefit Period
- The 60 Medicare Lifetime Reserve Days used

The Plan provides additional coverage for semi-private room and board charges when:

- You have used up all of your Medicare Lifetime Reserve Days, or
- You have reached Medicare's total lifetime limit of 190 days in a behavioral health Hospital

Under this benefit the Plan provides coverage based on the Allowed Charge for:

- A maximum of 120 days in each Benefit Period (but up to at least 60 days each Calendar Year) in a behavioral health Hospital. This coverage is reduced by any days in a behavioral health Hospital that were already covered by Medicare or the Plan in the same Benefit Period or the same Calendar Year.
- Up to an additional 365 days during your lifetime. This applies to inpatient stays in a general Hospital or behavioral health Hospital.

Please note: The lifetime days you use for the treatment of any behavioral health or nervous condition in a general or behavioral health Hospital will reduce the number of lifetime days that are available in a general, chronic disease or rehabilitation Hospital for medical and/or surgical care.

Services covered only by the Plan can be provided in these settings:

- A general hospital licensed to provide such services
- A facility under the direction and supervision of the department of mental health
- A private behavioral health hospital licensed by the department of mental health
- A substance abuse facility licensed by the department of public health

Inpatient Professional Services — You Pay……Nothing for as Many Days as Medically Necessary

After Medicare provides coverage, the Plan will provide coverage for services by a physician (who is a specialist in psychiatry) or a psychologist. Plan coverage is based on the Allowed Charge. Medicare does not provide benefits for services by a clinical specialist in psychiatric and behavioral health nursing.

When the services are not covered by Medicare, the Plan will provide full benefits for services by the Providers listed below.

- Physicians (who are specialists in psychiatry),
- Psychologists
- Clinical specialists in psychiatric and behavioral health nursing.

Plan coverage is based on the Allowed Charge. The Plan will cover these services for as many days as are Medically Necessary to treat your condition. This applies when you are an inpatient in a general Hospital. When you are an inpatient in a behavioral health Hospital, the Plan will cover these services for up to 120 days in each benefit period (but up to at least 60 days in each Calendar Year).

Outpatient Services You Pay……$15 Per Visit/All Charges after 24 visits

After Medicare provides coverage, the Plan will provide coverage for services by a Medicare covered behavioral health Provider. Plan coverage is based on the Allowed Charge. Medicare does not cover services by a clinical specialist in psychiatric and behavioral health nursing or a licensed mental health counselor.

When the services are not covered by Medicare, the Plan will provide benefits for services by the Providers list below.

- Physicians (who are specialists in psychiatry)
- Psychologists
- Clinical specialists in psychiatric and behavioral health nursing
- Licensed independent clinical social workers
- Licensed mental health counselors
- Licensed marriage and family therapist providing services within the scope of practice allowed by law for these therapists

Services covered only by the Plan can be provided in these settings:

- A licensed hospital
- A behavioral health or substance use disorder clinic licensed by the department of public health
- A public community behavioral health center
- A professional office
- The home

Plan coverage is based on the Allowed Charge. The Plan covers up to 24 visits each Plan Year.

Intermediate Behavioral Health Care Services

Below are some examples of intermediate services. These services are more intensive than outpatient services but do not require an inpatient Hospital admission.

- Intensive outpatient programs (IOP)
- Acute Residential Treatment (ART)
- Partial hospitalization programs (PHP)

Both Medicare and the Plan cover these services. Medicare will decide if intermediate services are Medically Necessary.

When the services are not covered by Medicare, the Plan will provide benefits for treatment in the facilities listed below.

- Day treatment
- In-home therapy services
- Clinically managed detoxification services
- Crisis Stabilization Unit (CSU)

Outpatient Hospital Care – Medical and Surgical — You Pay……$0

After Medicare provides coverage, the Plan will cover Medicare approved services for outpatient care in a Medicare approved facility. Plan coverage is based on the Allowed Charge. This can be a general Hospital or an ambulatory surgical center. The Hospital and medical care covered includes the services listed below.

- Physician services
- Supplies
- Diagnostic tests
- Durable Medical Equipment

Oxygen and Equipment — You Pay……$0

This benefit covers the items listed below:

- Rental of oxygen equipment
- Oxygen and supplies for the delivery of oxygen

After Medicare provides coverage, the Plan will cover Medicare approved services. Plan coverage is based on the Allowed Charge. Medicare classifies oxygen and oxygen equipment in the same category as Durable Medical Equipment.

Podiatry Services — You Pay……$15/ per visit

This benefit covers:

- Treatment for injuries and disease of the foot. For example: hammer toe, bunion deformities and heel spurs.
- Routine foot care for Members being treated for a medical condition affecting circulation of the legs or feet.

After Medicare provides coverage, the Plan will cover Medicare approved services. Plan coverage is based on the Allowed Charge. You are responsible for copayment per visit.

Prescription Drugs

Outpatient Drug Coverage under Medicare Part B

Medicare covers only a limited number of outpatient prescription drugs under Medicare Part B. For example, certain drugs in the categories listed below are covered.

- Injectable drugs given to you by a licensed medical practitioner
- Immunosuppressive drugs
- Oral cancer drugs
- Osteoporosis drugs

The drug categories listed above are only examples. For specific information about the drugs covered by Medicare Part B you must contact Medicare.

After Medicare provides coverage, the Plan will cover Medicare approved services. Plan coverage is based on the Allowed Charge.

Outpatient Prescription Drugs Not Covered by Medicare Part B

The Plan has a benefit for prescription drugs that are not covered under Medicare Part B. See your "Prescription Drug Coverage" booklet for more information on covered drugs and your costs.

Preventive Care

"Welcome to Medicare" preventive visit — You Pay……$0

During the first 12 months that you have Medicare Part B, you can get a "Welcome to Medicare" preventive visit. When you make your appointment, let your doctor's office know that you would like to schedule your "Welcome to Medicare" preventive visit. If the Provider accepts Medicare assignment, Medicare provides full benefits for this visit. However, if your Provider orders services not covered under this preventive benefit, the charges may go towards the Part B Deductible. This Plan pays your Part B Deductible.

Yearly "Wellness" visit — You Pay……$0

If you have had Part B for longer than 12 months, you can get a yearly "Wellness" visit. If the Provider accepts Medicare assignment, Medicare provides full benefits for this visit. However, if your Provider orders services not covered under this preventive benefit, the charges may go towards the Part B Deductible. This plan pays your Medicare Part B Deductible. See your Medicare handbook for more information.

Bone mass density testing — You Pay……$0

This benefit is for bone mass density testing. This testing is to identify bone mass, determine bone quality and detect bone loss. For services from a Medicare Provider, Medicare provides full coverage for Medicare approved services except for the Part B Deductible. This Plan pays your Medicare Part B Deductible.

Cardiovascular screening — You Pay……$0

These screenings include blood tests that help detect conditions that may lead to a heart attack or stroke. After Medicare provides coverage, the Plan will cover screening tests every five years. Plan coverage is based on the Allowed Charge. These tests are for cholesterol, lipid, and triglyceride levels.

Colorectal Screening — You Pay……$0

After Medicare provides coverage, the Plan will cover Medicare approved colorectal cancer screening. Plan coverage is based on the Allowed Charge. Covered Services are listed below.

- Fecal-occult blood test – once every 12 months for Members age 50 or older
- Flexible Sigmoidoscopy – once every 48 months for Members age 50 or older, or 120 months after a previous screen colonoscopy for those not at high risk
- Colonoscopy – once every 120 months (high risk every 48 months) or 48 months after a previous flexible sigmoidoscopy (no minimum age)
- Barium Enema – once every 48 months for Members age 50 or older (high risk every 24 months) when used instead of a sigmoidoscopy or colonoscopy

Diabetes self-management training — You Pay……$0

This benefit is for a program to help people cope with and manage diabetes. You must have diabetes and have a written order from your doctor or other health care Provider. The program may include tips for eating healthy, being active, monitoring blood sugar, taking medication, and reducing risks. After Medicare provides coverage, the Plan will cover Medicare approved services. Plan coverage is based on the Allowed Charge.

Family planning — You Pay……$0

This benefit is not covered by Medicare. The Plan will provide coverage based on the Allowed Charge. You are responsible for copayment per visit. Coverage is for the family planning services listed below.

- Outpatient contraceptive services. This includes consultations, exams, and medical services that are provided on an outpatient basis. The Plan covers services related to the use of all contraceptive methods approved by the United States Food and Drug Administration (FDA) to prevent pregnancy.
- Levonorgestrel implant systems, including insertion and the system itself
- Injection of birth control drug, including a prescription drug the Provider gives to the Member during an office visit
- Intrauterine devices (IUDs), diaphragms and any other contraceptive methods approved by the FDA, as long as the Provider gives these items to the Member during an office visit
- Counseling and diagnostic services for genetic problems and birth defects
- Pregnancy testing

Glaucoma testing — You Pay……$0

These tests are covered once every 12 months for people at high risk for developing glaucoma. Examples of high risk are: having diabetes or a family history of glaucoma. The

test must be provided by an ophthalmologist or an optometrist. After Medicare provides coverage, the Plan will cover Medicare approved services. Plan coverage is based on the Allowed Charge.

GYN exams and Pap smear tests — You Pay……$0

Medicare provides coverage for one gynecological exam and one Pap smear test every two years. If Medicare determines that a Member is at high risk for developing cervical or vaginal cancer, Medicare may cover these services once each year. After Medicare provides coverage, the Plan will cover Medicare approved services. Plan coverage is based on the Allowed Charge.

If Medicare does not provide coverage for a routine Pap smear test each Calendar Year, the Plan will provide full coverage up to the Allowed Charge.

Mammograms — You Pay……$0

For services from a Medicare Provider, Medicare provides full coverage for the tests listed below.

- One baseline mammogram during the five-year period a Member is age 35 through 39
- One routine mammogram every year for a Member who is age 40 or older

Prostate cancer screening — You Pay……$0

Medicare covers the services listed below one time each year for men age 50 and older.

- One digital rectal exam
- One prostate specific antigen (PDSA) blood test each year for Members age 50 or older

After Medicare provides coverage, the Plan will cover Medicare approved services. Plan coverage is based on the Allowed Charge.

Medicare approved smoking cessation program — You Pay……$0

This benefit is for a smoking cessation program covered by Medicare. Medicare will cover up to eight visits during a 12-month period. These visits must be provided by a qualified doctor or other Medicare recognized Provider. After Medicare provides coverage, the Plan will cover Medicare approved services. Plan coverage is based on the Allowed Charge. For more information about coverage for prescription drugs, please contact SilverScript at (877) 876-7214 TTY users should call 711.

Radiation and X-ray Therapy — You Pay……$0

After Medicare provides coverage, the Plan will cover Medicare approved services for radiation and x-ray therapy. Plan coverage is based on the Allowed Charge.

Second Opinions — You Pay……$15/per visit

This benefit is for a physician visit to obtain a second opinion regarding your medical treatment or the need for surgery. A third opinion is covered if the first and second opinions differ. After

Medicare provides coverage, the Plan will cover Medicare approved services. Plan coverage is based on the Allowed Charge. You are responsible for copayment per visit.

Short-Term Rehabilitation Therapy — You Pay……$15/per visit

After Medicare provides coverage, the Plan will cover Medicare approved services for outpatient short term rehabilitation therapy. Plan coverage is based on the Allowed Charge. This includes: physical therapy, occupational therapy, and speech therapy. You are responsible for a copayment for each visit.

The Plan also covers Medically Necessary services needed to diagnose and treat speech, hearing, and language disorders. A licensed speech-language pathologist or audiologist must provide these services. These services are not covered when available in a school based setting.

Not Covered:

- Educational or vocational services or testing

Skilled Nursing Facility Services — You Pay……All Charges After 365 Days

After Medicare provides coverage, the Plan will cover Medicare approved services. Plan coverage is based on the Allowed Charge.

To be covered, a stay at a Skilled Nursing Facility must meet Medicare's rules. For instance, Medicare requires a Member to have been an inpatient in a Hospital for at least 3 days and then transferred to the Skilled Nursing Facility within 30 days of leaving that Hospital. Your doctor must certify that you need daily skilled care like intravenous injections or physical therapy. Coverage is provided only through the 100th day of a Benefit Period. Long term care and custodial care are not covered.

Your benefits for Skilled Nursing Facilities not participating with Medicare will be different. See the Chart of Benefits in Appendix A. To receive benefits, your stay must meet Medicare's rules. This applies even if the facility is not participating with Medicare.

Surgery as an Outpatient — You Pay……$0

After Medicare provides coverage, the Plan will cover outpatient surgery approved by Medicare. Plan coverage is based on the Allowed Charge.

Women's Health and Cancer Rights

After Medicare provides coverage, the Plan will provide coverage based on the Allowed charge for breast reconstruction after a mastectomy. Covered services are listed below.

- Reconstruction of the breast on which the mastectomy was performed
- Reconstruction of the other breast to produce a symmetrical appearance
- Prosthesis
- Treatment for any physical complications resulting from the mastectomy, including lymphedemas

Additional Services Covered by the Plan
(For benefits not covered by Medicare Parts A and B)

Annual Physical Exam — You Pay...$0

The plan covers a comprehensive physical, hands-on exam annually as an additional benefit. This includes: Medical History, Vital Signs (blood pressure, heart rate, respiration, and temperature), General Appearance, Heart Exam, Lung Exam, Head and Neck Exam, Abdominal Exam, Neurological Exam, Dermatological Exam, and Extremities Exam

Eye Exams (Routine Care) — You Pay……$15 Per Visit

The Plan will cover routine eye exams (Medicare covers a yearly eye exam for diabetic retinopathy for Members with diabetes. Medicare also covers a glaucoma test once each 12 months for Members at high risk for glaucoma. (Refractions are only covered as part of an annual eye exam.) You are responsible for a copayment per visit.

Urgent Care — You Pay……$15 Per Visit

Urgent Care Centers are independent, stand-alone locations that treat conditions that should be handled quickly but that are not life-threatening. They often do X-rays, lab tests and stitches. Using an independent urgent care center instead of a hospital emergency room saves you money. Be aware, however, that facilities owned and operated by hospitals are hospital sites, not Urgent Care Centers, and often bill your visit as an emergency room visit. With each visit, you are responsible for a copayment.

Wigs (Scalp Hair Prostheses) — You Pay……after $350

The Plan covers wigs (scalp hair prostheses) worn for hair loss due to the treatment of any form of cancer or leukemia. The Plan will reimburse the Member up to $350 toward the cost of the wig. This benefit is limited to $350 per Calendar Year. You must send your request for reimbursement to:

Health New England
Member Services
One Monarch Place – Suite 1500
Springfield, MA 01144-1500

The request must include:

- Proof of payment
- A written statement from your doctor that the wig is Medically Necessary.

WHAT'S IN THIS SECTION?

In this section we describe services that are not covered. We call these "exclusions."

We also describe services for which the Plan provides only limited coverage.

Exclusions listed in this section are general exclusions. That means they may apply to more than one type of service, or to services that are not described elsewhere in this Handbook. Other specific exclusions are listed in the benefit descriptions in Section 3.

The Plan does not limit or exclude coverage on the basis of any pre-existing condition you may have.

Exclusions

The Plan does not cover services and items listed below. The Plan also does not cover services or items that are listed as "not covered" in this Handbook.

1. Alternative Medicine. This includes types of health care that are generally not accepted by the medical community. Alternative Medicine is defined in Section 12.
2. Any services that Workers' Compensation or other third party insurer is legally responsible to pay.
3. Any services provided by the Veterans Administration for disabilities connected to military service. There also must be facilities which are reasonably available for these Members.
4. Any medical expenses in any government hospital or facility. Services of a government doctor or other government health professional.
5. Any service or supply that is not described as a Covered Service in this Handbook.
6. Care or treatments by family members (by blood or marriage). This applies even if the family member is a Medicare Provider.
7. Charges for failing to keep an appointment.
8. Charges to ship or copy Member medical records.
9. Cosmetic procedures, supplies or medications. Cosmetic surgery is covered if it is needed because of an accidental injury. It is also covered if it is needed to improve the function of a malformed part of the body. Breast reconstruction after a mastectomy is covered.
10. Custodial care. Custodial Care is defined in Section 12.
11. Dental Care. See "Dental Care and Oral Surgery" in Section 3 for some exceptions.
12. Durable Medical Equipment (DME) that is not covered by Medicare.

13. Educational or vocational services or testing.
14. Exams or treatment required by a third party. Some examples are: exams for a job or potential job, and premarital exams.
15. Experimental or investigational medical treatment, devices or drugs. Experimental is defined in Section 12.
16. Eyeglasses, contact lenses, laser vision correction surgery and orthoptics. Medicare and the Plan do cover eyeglasses or contact lenses after each cataract surgery with an intraocular lens.
17. Routine foot care for Members who do not have diabetes. This includes but is not limited to:

    - Cutting or removal of corns and calluses, plantar keratosis
    - Trimming, cutting and clipping of nails
    - Treatment of weak, strained, flat, unstable or unbalanced feet
    - Other hygienic and preventive maintenance care considered self-care (i.e. cleaning and soaking the feet, and the use of skin creams to maintain skin tone)
    - Any service performed in the absence of localized illness, injury or symptoms involving the foot

    The Plan covers routine foot care if you are a diabetic.
18. Arch supports, orthotic devices, corrective shoes, and inserts. These are covered for diabetic foot care.
19. Routine hearing exams
20. Hearing aids or exams to prescribe, fit, or change them (except for Members over age 21 see page 3-5).
21. Marijuana for medical use
22. Private room charges. These charges are covered when Medicare finds that a private room is Medically Necessary. If the services are covered only by the Plan, the Plan may decide if a private room is Medically Necessary.
23. Sales tax on Health Care Services, DME or other items.
24. Services and supplies not covered by Medicare, except if shown as covered elsewhere in this Handbook.
25. Services and supplies that are not Medically Necessary. An exception to this is the preventive services described in Section 3. Medically Necessary is defined in Section 12.
26. Services by non-covered Providers. The Plan only covers services by Providers who are eligible to provide services that are covered by Medicare. Exceptions to this rule are shown in this Handbook.
27. Services for which you are not legally obligated to pay. This includes services for which no charge would be made if you did not have health insurance.
28. Services related to non-covered services.

29. Services, supplies, or medications mainly for your comfort or convenience. Some examples are: telephone and television changes when you are in a Hospital.
30. Services you receive before your Effective Date.
31. Services you receive after the date your coverage ends.
32. Special duty or private duty nursing and attendant services.
33. Travel, transportation, and lodging costs related to your treatment or medical consultation.
34. Weight control programs.

Limitations

Human organ and bone marrow transplants

Human organ and bone marrow transplants are only covered by the Plan if they are covered by Medicare. There is one exception to this. The Plan covers bone marrow transplants for a Member who has breast cancer that has spread. These bone marrow transplants will be covered only when they meet the criteria set by the Massachusetts Department of Public Health. Medicare does not cover these bone marrow transplants.

Immunizations

Medicare and the Plan cover only the vaccines listed below and their administration. No other vaccines are covered.

- Influenza vaccine
- Pneumococcal vaccine
- Hepatitis B vaccine (only if you are at medium or high risk for contracting Hepatitis B.

Chiropractic Services

The only benefit covered is manual manipulation of the spine to correct subluxation. Medicare and the Plan do not cover x-rays and other services by a chiropractor.

Dental Services

The Plan does not cover dental care except when covered by Medicare. Medicare does not cover routine dental care. Medicare does not cover other procedures like cleanings, filings, tooth extractions, dentures, dental plates or other dental devices. Medicare Part A pays for certain dental services you get when you are in a hospital. Medicare may pay for inpatient hospital care if you need to have emergency or complicated dental procedures, even when the dental care is not covered.

WHAT'S IN THIS SECTION?

For services that Medicare covers, Medicare decides what services are Medically Necessary.

For services covered only by the Plan, the Plan decides what services are Medically Necessary. In this section we describe how the Plan makes that decision.

For services that are eligible for benefits under Part A or Part B of Medicare, Medicare decides if the services are Medically Necessary. For those services, the Plan will rely on the decisions that Medicare makes.

For Covered Services covered by the Plan only, the Plan will decide if the services are Medically Necessary. This includes a product or service for which Medicare coverage has ended but the Plan is still covering. This section describes the Plan's review processes.

Please Note: You can call Member Services at (877) 443-3314 to find out the status or outcome of these decisions.

Prior Approval Process

To get Prior Approval, your treating doctor must contact HNE. The doctor can either send HNE a Prior Approval Request Form or contact HNE by phone.

HNE's Health Services Department sends Prior Approval Request Forms to your doctor. HNE will decide whether the service is:

- A Covered Service
- Medically Necessary
- To be provided in the appropriate setting
- In keeping with generally accepted medical practice
- Available within our network
- Consistent with our clinical criteria

Your doctor may also contact HNE by phone. The doctor should call at least seven days before your procedure. HNE will make a decision within two working days after HNE gets all needed information. This information includes the results of any face to face clinical evaluation or second opinion required. If HNE approves coverage, HNE will inform the doctor who will treat you by phone within 24 hours. HNE will send Prior Approval to you and your doctor within two working days thereafter.

If HNE denies coverage for the services HNE will:

- Tell your doctor by phone within 24 hours of the decision
- Send a written denial of coverage to you and your provider within one working day thereafter

For urgent requests, HNE will notify you and your provider in writing within two business days of receiving all information, or within 72 hours of receipt of your request, whichever is earlier.

If your doctor has asked for Prior Approval, you may call (877) 443-3314 (TTY: 711) to know its status or outcome. You may call HNE's Health Services Department if you want a copy of the clinical criteria we use to make its decision.

If HNE reviews a procedure or hospital stay, it does not mean that the Plan will cover all charges. We make decisions about benefits according to all the terms of this Handbook. Whether or not you obtain Prior Approval, items that are not covered under this Handbook may be denied.

Even when we do not require Prior Approval for coverage of a particular benefit, you or your provider may ask HNE to determine whether a proposed admission, procedure or service is Medically Necessary. HNE may choose not to perform such a review if HNE decides that the admission, procedure or service will be covered. If HNE agrees to perform the review, HNE will do so within seven working days of obtaining all necessary information.

Utilization Management Program

The Plan may review some claims to be sure that they are Covered Services and that they are Medically Necessary and appropriate. This review is called "Utilization Management," or "UM."

There may be times when a service is reviewed and not approved. When this happens, payment for the service may be denied. UM denials are made only based on whether the treatment or service is covered under your benefit plan, Medically Necessary, and appropriate.

We know that some treatments may be over-used, but also, that some may be under-used. Our UM program therefore includes these principles:

- Medical decision making is based on whether the care and services are appropriate, and on whether it is covered.
- Clinicians and staff involved in UM work together to help Members get proper health care.
- Providers and staff who review coverage decisions are not rewarded based on the number or type of coverage denials they make.

Concurrent Review Procedures

HNE may pre-approve certain procedures and services. This includes things like some inpatient Hospital stays and ongoing courses of treatment. Once your stay or ongoing treatment

begins, HNE may continue to review whether your care is Medically Necessary and appropriate. This is called "concurrent review." In these cases, if HNE decides to end or reduce coverage, you will be notified. HNE will give this written notice before the coverage ends or is reduced.

If HNE decides to approve an extended stay or additional services, HNE will notify your Provider within one working day. HNE will send written or electronic confirmation within one working day thereafter. This notice will include:

- The number of extended days approved.
- The next review date.
- The new total number of days or services which are approved.
- The date you were admitted or when services began.

If the review leads to an Adverse Determination, HNE will tell your Provider by telephone. This will take place within 24 hours. HNE will send written or electronic confirmation to you and your Provider within one working day thereafter. You will continue to receive services without liability until you have been notified of HNE's decision.

You can appeal HNE's decision. If you decide to appeal, the Plan will continue to cover these services until the appeal is done. Requests to extend care must be made at least 24 hours before the end of treatment. These urgent requests will be decided and communicated within 24 hours after the Plan gets them.

Retrospective Review Procedures

Retrospective review is a review of a service that was already received. If HNE concludes that the service was not Medically Necessary or appropriate, the Plan may deny your claim for benefits. If a claim is denied on this basis, HNE will notify you within 30 days after HNE receives the claim.

Written Notification of an Adverse Determination

If HNE concludes that a service is not Medically Necessary, or appropriate, Plan coverage may not be approved. HNE will send you and your Provider written notice of any such Adverse Determination. The written notice will tell you the clinical reason for the decision. The clinical reason will be consistent with generally accepted principles of professional medical practice.

HNE will:

- Identify the specific information on which the Adverse Determination was based
- Discuss your 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 the Plan, if any
- Reference and include applicable clinical practice guidelines and review criteria
- Offer your doctor or treating practitioner a case discussion or reconsideration (see below)

- Provide you with clear, concise information about the Plan's grievance process.

Case Discussion and Reconsideration

If your doctor or treating practitioner disagrees with an Adverse Determination, he or she may request a case discussion with an HNE physician reviewer. Sometimes this discussion may result in reversal of HNE's decision. Your doctor or treating practitioner may also ask a clinical peer reviewer to reconsider HNE's decision. This will take place between your doctor (or treating practitioner) and the clinical peer reviewer within one working day of the request.

If you are still dissatisfied, you may request a clinical appeal or an expedited appeal. Your doctor or treating practitioner may also request a clinical appeal or an expedited appeal for you. The case discussion and reconsideration process do not need to take place before you begin the Plan's grievance process or an expedited appeal. More information is available in Section 7 of this Handbook.

WHAT'S IN THIS SECTION?

This section explains how the Plan pays for Covered Services.

Your healthcare Provider is usually responsible for filing claims for Covered Services with Medicare and the Plan.

There are some instances when you will need to file claims. There is a time limit for filing a claim.

When a Healthcare Provider Files a Claim

Medicare Part A Services

Providers of Medicare Part A Covered Services must file Medicare claims for you. These Providers include Hospitals, skilled nursing facilities and other covered Providers. You do not have to file claims with Medicare for these services.

Medicare Part B Services

Physicians and other covered Providers must file Medicare claims for you. They must file claims even if they do not accept assignment. We explain claims assignment later is this section. Your Medicare handbook also explains the assignment method and the non-assignment method of paying Medicare Part B claims.

Medicare Part A and Part B Services

The Plan will accept a notice from a Medicare carrier and make a payment decision based on the information included in the Medicare notice. The Plan will advise you and the Provider of its claim decision. The Plan will make payments directly to the Provider.

Services Covered Only by this Plan

Some Covered Services under this Plan are covered by the Plan only and not by Medicare. Certain Providers have an agreement with the Plan and will file claims with the Plan for you. You need to show Providers your Plan ID card at the time you receive services. You must give the Provider any other information needed to file a claim with the Plan.

Processing of Claims from Providers

When HNE receives a claim from a Provider, within 45 days of when HNE gets the claim, HNE will:

- Pay the claim and advise you of payment, or
- If HNE does not pay the claim, tell you and the Provider the reason for non-payment, or
- Ask in writing for any additional information HNE needs to pay the claim.

If HNE does not do one of these within 45 days, HNE will pay interest to the Provider. This interest is in addition to any payment for Health Care Services provided. Interest will accrue beginning 45 days after HNE received the request for payment. Interest applied will be at the rate of 1.5% per month, not to exceed 18% per year. Interest payments will not apply to a claim that HNE is investigating because of suspected fraud.

When a Member Files a Claim

Most of the time Providers will file claims for you with Medicare and the Plan. However, there may be times when you will need to file claims.

Medicare Part A Services

Generally, you will need to file a claim for Part A services only in these instances:

- You receive Medicare Covered Services and HNE does not receive the claim from Medicare. Your Provider may also file the claim for you.
- When you receive Hospital services outside of the United States that are covered by Medicare.

Medicare Part B Services

You will need to file a claim for Medicare Part B services only in these instances:

- You receive Medicare Covered Services and HNE does not receive the claim from Medicare. Your Provider may also file the claim for you.
- You need a formal Part B coverage determination. This is for services or supplies that Medicare does not cover.
- The physician or other Provider will not file a claim for you for Covered Services (even though the law requires it).
- You receive Medicare Covered Services outside of the United States.

For services in the United States, you must send the claim to the Medicare carrier for the state where you received the services. Your Medicare handbook tells you how to file Medicare claims.

Services Covered Only by this Plan

Some Covered Services under this Plan are covered only by the Plan only and not by Medicare. Claims for services covered only by the Plan must be sent to HNE. The Provider may agree to file claims for these services for you. If the Provider will not do this, you must file a claim.

Filing a Claim with HNE

These are the steps to follow when you have to file a claim with HNE:

- Fill out an HNE claim form, and attach itemized bills that show the date on which you received the services. You can get a claim form by calling Member Services at (877) 443-3314.
- Attach the notice you received from Medicare to the claim form. This applies if the Covered Services are also eligible for benefits under Medicare.

- Mail the claim to Member Services at this address:

  Health New England, Inc.
  Claims Department
  One Monarch Place, Suite 1500
  Springfield, MA 01144-1500

Within 45 days of when we get the claim, HNE will:

- Pay the claim, or
- If HNE does not pay the claim, tell you the reason for non-payment, or
- Ask in writing for any additional information HNE needs to pay the claim.

If HNE does not do one of these within 45 days, HNE will pay interest to you. This interest is in addition to any reimbursement for Health Care Services provided. Interest will accrue beginning 45 days after we received the request for reimbursement. Interest applied will be at the rate of 1.5% per month, not to exceed 18% per year. Interest payments will not apply to a claim that the Plan is investigating because of suspected fraud.

Time Limit for Filing a Claim

HNE must receive any claim for services within one year from the date you received the services.

Assignment of Benefits under Medicare Part B

The Assignment Method

Some Medicare Providers have agreed (or are required by law) to accept the Medicare approved amount as full payment for Covered Services. These Providers have accepted assignment. They will charge you only for the Medicare Deductible and Coinsurance, which are covered by this Plan. Providers who have accepted assignment will bill Medicare for you. Medicare will make payment directly to Providers who have accepted assignment.

The Non-Assignment Method

If the Provider does not accept assignment they can charge you more than the Medicare approved amount. You will be responsible for the difference between the Medicare approved amount and the Provider's charge, which is sometimes called the remaining balance. The Plan does **not** cover this remaining balance.

If the Provider does not accept assignment you may have to pay the entire charge at the time you receive services. The Provider is supposed to submit a claim for you, even if the Provider does not accept assignment. Your Medicare handbook explains what to do if the Provider will not file a claim for you with Medicare.

WHAT'S IN THIS SECTION?

Please Note: The grievances and appeals processes outlined below apply only to benefits covered by this Plan. If you do not agree with a decision or claim denial made by Medicare, you must appeal to Medicare. Your Medicare handbook explains how to appeal a decision or claim denial made by Medicare. Procedures to file an appeal are also explained on the Medicare Summary Notice. The Medicare Summary Notice is the document sent to you by Medicare every three months. You can also visit www.medicare.gov for detailed information about the Medicare Appeals Process.

In this section we describe what to do if you are unhappy with the Plan or any of the care you receive. We define the different types of inquiries and grievances. These include: complaints, benefit appeals, clinical appeals, and expedited appeals. We also outline the time frames for resolving each type.

This section lists your rights to file grievances. The Plan is required to describe these rights as they are below. If you do not know what a term or a section means, call Member Services.

The Plan is responsible for reviewing benefit claims for services covered by the Plan.

Appealing Denied Claims

If your claim is denied, you may appeal to the Plan for a review of the denied claim. The Plan will decide your appeal according to the Inquiries and Grievances procedures described below.

Important Appeal Deadlines

If you do not appeal on time, you will lose your right to file suit in a state or federal court. You will not have exhausted your internal administrative appeal rights (which generally is a condition for bringing suit in court).

Inquiry Process

You can ask the Plan to reconsider:

- An action we have taken or not taken
- A Plan policy
- The absence of a policy you think we should have

These requests are also called "inquiries." If you have an inquiry:

- Please call Member Services. We will review your inquiry and respond by phone or letter within three business days.

- Sometimes there are concerns about a Provider, or a Provider's office. If that is the case the Plan may share the details of your concern with that Provider or office.
- After the Plan responds to your inquiry, we will ask if you are *satisfied* with our response.
- If you are not satisfied, the Plan will offer to start a review of your complaint through the internal grievance process. If you wish, you can begin the grievance right on the phone.
- If you choose not to start a grievance during the call, the Plan will send a letter to you to explain your right to have your inquiry processed as an internal grievance.
- Some Plan decisions are called "Adverse Determinations." Adverse Determinations are reviewed through the Plan's internal grievance process, which is described below.

Internal Grievance Process

A "grievance" can be any of the following:

- A complaint about any aspect or action of the Plan that affects you
- An issue about quality of care
- A complaint about how the Plan is run
- A benefit appeal
- An appeal of an Adverse Determination
- Clinical appeals

A grievance can be oral or written.

The chart below these paragraphs describes different types of grievances and shows how soon the Plan must respond to each type. Response times begin on the earliest of:

- The day that we receive your grievance
- The day you tell us that you are not satisfied with our response to an inquiry
- The day after the three business days we have to process an inquiry, if we do not respond within the three-day period.

If the Plan does not act on a grievance within the time shown in the chart (including any agreed-extensions) the grievance will be decided in your favor. Time limits in the chart can be waived or extended if both the Plan and the Member agree. Any agreement to waive or extend time limits will state the new time limit agreed on; the new time limit will not be longer than 30 business days from the date the agreement is signed.

Overview: Grievances and Decision Time Frames This chart is for quick reference only. See the rest of this section for more detail.			
Type of Grievance	**Example**	**HNE will acknowledge within:**	**The Plan will respond within:**
Complaint (Oral)	An inquiry that is not resolved to a Member's satisfaction, or a complaint about a Provider or a plan policy or procedure that causes concern to a Member.	48 hours	30 calendar days
Compliant (Written)	An inquiry that is not resolved to a Member's satisfaction, or a complaint about a Provider or a plan policy or procedure that causes concern to a Member.	5 business days	30 calendar days
Benefit Appeal	Appeal of a service or request that is denied as "not a covered benefit" because it is excluded from coverage by your plan.		
Clinical Appeal	Appeal of a decision to deny, reduce, change or end coverage of a health service for failure to meet the requirements for coverage, if the decision was based upon a review of information provided and based on: • Medical necessity • Appropriateness of health care setting and level of care, or Effectiveness.		
Pre-Service (Oral)	Appeal of a benefit or clinical denial for a service you have not received yet.	48 hours	30 calendar days
Post-Service (Oral)	Appeal of a benefit or clinical denial for a service you have already received.	48 hours	60 calendar days
Pre-Service (Written)	Appeal of a benefit or clinical denial for a service you have not received yet.	5 business days	30 calendar days

Overview: Grievances and Decision Time Frames This chart is for quick reference only. See the rest of this section for more detail.			
Type of Grievance	**Example**	**HNE will acknowledge within:**	**The Plan will respond within**
Post-Service (Written)	Appeal of a benefit or clinical denial for a service you have already received.	5 business days	60 calendar days
Expedited Appeal	Appeal of a clinical denial for a service that your doctor feels is urgent, or for continued coverage while you are still in the Hospital.	48 hours	72 hours

Submitting Your Grievance

After you receive notice that the Plan has denied your claim for service you have 180 calendar days to file a grievance. You must submit your grievance within this 180-day calendar period.

Grievances may be submitted:

- By telephone
- In person
- By mail
- By electronic means (such as email)

Please include the following information:

- ✓ Member ID number.
- ✓ Daytime telephone number.
- ✓ Detailed explanations of your grievance and any applicable documents related to your grievance, such as copies of medical records or billing statements.
- ✓ Specific resolution you are requesting.
- ✓ Any other documents that you feel are relevant to the review.

You may contact HNE by:

Mail: Health New England, Inc.
Complaints and Appeals Department
One Monarch Place
Springfield, MA 01144-1500

Fax: (413) 233-2685
(For complaints and appeals only)

Telephone: **(**877) 443-3314

Electronically: To find out how, please call HNE Member Services at the number at the bottom of this page.

You or your authorized representative may submit the grievance. If you submit a grievance by mail, HNE will send a written receipt to you within five business days. If you submit your grievance orally, for example, on the telephone, HNE will put your grievance in writing. HNE will then send a written copy of your oral grievance to you within 48 hours. If your grievance is about a clinical denial, HNE may ask you to sign a form releasing your medical or treatment information to the Plan.

Review Process

The Plan will fully investigate the substance of all complaints and appeals. All appeals will be reviewed by a person or persons who were not involved in the initial decision nor subordinate to anyone who was involved.

Requests for Medical Records

In most cases, HNE either already has the medical records relevant to your grievance or HNE can obtain the records without obtaining a signed medical record release from you. In some cases, however, such as when HNE needs records from Out-of-Plan Providers, HNE may ask you to send a medical record release in order to obtain the records.

If HNE has asked you to agree in writing to the release of your medical records, HNE will also ask you to agree, in writing, to an extension of up to 30 calendar days after you return the release to issue a decision. You may choose not to sign the release, or HNE may not receive a signed release within the required time limit (refer to the Overview chart above). If so, HNE may, at its discretion, issue a decision without review of some or all of your medical records.

If HNE does issue a decision without review of all your medical records, the Plan may offer you reconsideration. The Plan will only offer this if, through no fault of your own, relevant medical information was received too late to review within the required time limit (refer to the Overview chart above) or was not received but is expected to become available within a reasonable time period following the written resolution. If the Plan offers you a reconsideration based on these facts, the Plan will agree in writing on a new time period for review. In no event will this time period be greater than 30 calendar days from the agreement to reconsider. The time period for requesting external review will begin to run on the date of the resolution of the reconsidered grievance.

Complaints and Benefit Appeals

A person knowledgeable about the subject matter of your complaint or benefit appeal will review it and will issue a decision based on all available information.

Appeals of Clinical Denials

A practitioner who is actively practicing and who was not involved in the initial decision will review your appeal. This practitioner will have clinical expertise in those medical issues that are the subject of the appeal.

If you do not agree with HNE's decision, in many cases, you have a right to an external review.

See “External Appeals Process” later in this section.

A Member may file a grievance concerning the termination (end) of ongoing coverage or treatment that the Plan previously approved. In these cases, the Plan will continue to cover the disputed service or treatment:

- Through the completion of the internal grievance process regardless of the final decision,
- Provided that the grievance is filed in a timely basis, and
- Based on the course of treatment.

The Plan will not continue to cover medical care that was terminated because the coverage benefit is limited to a specific amount of time or limited per episode.

Expedited Review Process: For Urgent, Inpatient, or Immediately Needed Services

The Plan will “expedite” the review of an appeal for coverage of services that are immediate or urgently needed. A practitioner who is actively practicing and who was not involved in the initial decision will review your appeal. This practitioner will have clinical expertise in those medical issues that are the subject of the appeal.

If you are an inpatient in a Hospital, HNE will make a decision on your grievance before you are discharged from the Hospital. In all other cases, HNE will make a decision on your grievance and notify you and your Provider within 72 hours of receipt of your request.

For services or durable medical equipment (DME) that, if not immediately provided, could result in serious harm to you, the Plan will reverse its decision to deny coverage within 48 hours (or sooner in some cases) pending the outcome of the grievance process. For a reversal to occur within 48 hours, your doctor must certify that:

1. The service or DME at issue in your appeal is Medically Necessary.
2. The denial of coverage would create a substantial risk of harm to you.
3. Such risk of serious harm is so immediate that the provision of such services or DME should not await the outcome of the normal grievance process. The reversal will last until the appeal is decided.

If the physician requests automatic reversal earlier than 48 hours for DME, the physician must further certify as to the specific, immediate, and severe harm that will result to you absent action within the 48-hour time period.

Expedited Review Process: For Members with a Terminal Illness

A person knowledgeable about the subject matter will review a complaint or benefit appeal. A practitioner who is actively practicing and who was not involved in the initial decision will review clinical appeals. This practitioner will have clinical expertise in those medical issues that are the subject of the appeal. HNE will make a decision on your grievance within five business days of receipt. If you are a Member with a terminal illness and you appeal a decision of an immediate or urgently needed service, HNE will make a decision on your grievance and

notify you and your Provider within the time frames listed above for expedited appeals.

If HNE continues to deny coverage or treatment, you have the right to request a conference. HNE will schedule a conference within 10 days of receipt of your request. If your doctor, after consulting with an HNE Medical Director, decides that the effectiveness of the proposed service or treatment would be materially reduced if it is not provided at the earliest possible date, HNE will schedule the conference within five business days. You and/or your authorized representative may attend the conference. The Plan will authorize its representative at the conference to decide your grievance.

Health New England's Written Response

HNE's written response to your grievance will:

- Include the specific reason for the decision.
- Identify the specific information on which the decision was based.
- Refer to and include the specific plan provisions on which the decision was based.
- Specify alternative treatment options covered by the Plan, if any.
- Notify you of the process for requesting an external review or, where applicable, an expedited external review.

In addition, for clinical appeals, the written response will also:

- Include a substantive clinical reason that is consistent with generally accepted principles of professional medical practice.
- Discuss your presenting symptoms or condition, diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet the Plan's medical review criteria.
- Reference and include applicable clinical practice guidelines and review criteria.

You also have the right to request copies, free of charge, of all documents, records or other information relevant to your appeal.

External Appeal Process

If your clinical appeal has been denied, you can ask for an external review. To do so, you must file a written request with HNE. HNE will provide you with the filing forms you'll need when you are notified of the Plan's final decision. You must submit the request within 120 days after you receive the final decision. You may appoint someone to submit your external review for you. This person is called your authorized representative. A request is eligible for external review if:

- The denial was made because the requested service is:
    - Not Medically Necessary
    - Experimental or investigational
- The request for external review was submitted within 120 days after you receive HNE's final decision HNE will send requests to an independent review organization (IRO). The IRO will review the request to determine if it meets the external review criteria. If the service or treatment you are requesting is a covered benefit, the IRO will decide if it is Medically Necessary. They will notify you and HNE of their decision within 45 days

of receipt of the request for review. The Plan will abide by the decision of the IRO.

Expedited External Review Process

You, or your authorized representative, can ask for a quicker decision by requesting an expedited review. There is a specific form to use for requesting an expedited external review. This form contains a written certification that your physician must complete. Your physician must agree that a delay in providing the health care services would pose a serious and immediate threat to your health. HNE will immediately forward your request to the IRO. The IRO will screen the request within 48 hours of receipt, and will determine whether the request meets the requirements for expedited external review. If the request meets the requirements, the IRO will decide the request within 72 hours. The Plan will abide by the decision of the IRO.

WHAT'S IN THIS SECTION?

In this section we describe:

Eligibility – The requirements you must meet to be enrolled with the Plan.

Enrollment – The steps you must take to become a Member.

Effective Date of Coverage – When you can begin to receive benefits under the Plan.

Eligibility

Subscribers

- You must meet all of the requirements below to be eligible to enroll in the Plan.
- You must be enrolled in free Medicare Part A and Medicare Part B
- You must be eligible for GIC health coverage as a state or municipal retiree, spouse or dependent, and you must meet the GIC's and the Plan's eligibility rules.
- Age 65 or older, or
- Under age 65 and enrolled in Medicare A and B due to disability. If the disability is due to End State Renal Disease (ESRD), you must satisfy the Medicare COB period to be eligible for the plan.

We may ask you for proof of eligibility. We may also ask you for proof of your continuing eligibility. For instance, we may ask for proof of your continued enrollment in Medicare Part B.

Spouses and Dependents

Enrollees in the Plan must have Medicare Parts A and B. For a spouse or eligible dependent who is not covered by Medicare, the GIC may offer coverage on another plan. Contact the GIC for information on possible coverage for spouses and eligible dependents.

Enrollment

You must apply to the GIC to enroll in this plan. The GIC may ask for more information about your eligibility before enrolling you in the Plan. The GIC will not enroll you in the Plan until we have received the information requested.

Effective Date of Coverage

Upon receipt of your application and required Medicare documentation, the GIC will determine the effective date of enrollment in the Plan. There are no waiting periods or pre-existing condition limitations.

SECTION 9 – TERMINATION OF COVERAGE

WHAT'S IN THIS SECTION?

In this section we explain how and when your coverage under the Plan may end.

You May Cancel Your Coverage

You may cancel your coverage within 60 days of a qualifying event or during the GIC's Annual Enrollment period. Contact the Group Insurance Commission at 617-727-2310 or visit www.mass.gov/gic for more information.

The Plan May Cancel Your Coverage for Specific Reasons

You do not have to worry that the Plan will cancel your policy or refuse to renew your coverage because you are using your benefits or because you will need more Covered Services in the future. The Plan will only cancel your coverage for the reasons below.

Loss of Eligibility

Your coverage with this plan will end if:

- You no longer meet the GIC's eligibility rules
- You are no longer enrolled or eligible for Medicare Parts A and Part B and enrolled in Medicare Part B

Your termination date will be determined by the GIC and may be retroactive the date you are no longer eligible for coverage.

The Group Insurance Commission's Contract Ends

Your coverage with the Plan will end if the contract between HNE and the Group Insurance Commission ends.

Material Misrepresentation or Fraud

Your coverage with this Plan will end if you make some material misrepresentation to us or commit fraud. These are some examples:

- Giving false information on your enrollment form
- Allowing someone else to use your ID card to receive services
- Receiving benefits for which you are not eligible.

Your coverage will end as of your effective date or a later date that we choose.

Physical or Verbal Abuse

If you commit an act of physical or verbal abuse that poses a threat to Providers, other Plan Members, or our employees or agents. This rule does not apply to acts related to your physical or mental condition. The effective date of termination may, at our option, be any day after the date of the abuse.

WHAT'S IN THIS SECTION?

In this section, we describe what the Plan does when another insurer or someone else should be paying for Covered Services. HNE will work with the other insurer to decide who should pay for the claim. This is called "coordination of benefits."

We also describe what happens if you are injured or ill and someone else should be paying for your treatment. For example, this applies to automobile accidents. The Plan may pay for your care and then seek reimbursement from the other party who is responsible. This is called "subrogation."

You must cooperate with us and give us the information that we need to coordinate benefits or subrogate a claim.

At times, the Plan provides coverage for benefits and services under this Plan when it is the duty of another plan to pay. If this happens, we have the right to recover from a Member's other insurance the value of the services that were paid by the Plan. Also, whenever payments which should have been made by us in accordance with this section have been made by any other plan, we will have the right, at our discretion, to pay that plan any amount we determine to be warranted. The amounts paid will be considered as benefits that the Plan paid. The Plan will be fully released from liability to the extent of such payments.

For the purposes of this section, the Plan may give or obtain any information on a Member that it deems necessary. Any Member claiming benefits under this Plan must provide the Plan with the information that it needs to carry out this section.

Benefits under this Plan will be coordinated to the extent permitted by law with other plans that cover health benefits. This includes all health benefit plans, government benefits, motor vehicle insurance, medical payment policies, and homeowner insurance.

The Plan's rights under this section will remain even after the Member's ends, but only as to services provided while the Member's coverage was in effect.

Coordination of Benefits

Which Insurance Pays First

Coordination of benefits (COB) takes place when one or more health plans covers a service. Under COB one plan pays full benefits according to its plan as the primary payer. The other (the secondary payer) then pays any remaining benefits according to its plan. The Plan decides which insurance is primary based on rules used throughout the insurance industry, or as required by law. A copy of these rules in available upon request.

This Plan provides coverage secondary to Medicare Part A and Part B. For any service covered by Medicare, Medicare is the primary payer and the Plan is the secondary payer. We will not duplicate payment for any services paid by Medicare. We will not pay more than the full benefit provided by this Plan.

If You Have Benefits Under a "Medical Payment" Benefit

In some cases, Members who are injured have benefits under the "medical payment" clause of an insurance policy. Examples of these are homeowner's or auto insurance policies. In the case of a homeowner's policy, "med pay" coverage will be primary for coverage under this Handbook. HNE will work with the other carriers. If you are in a motor vehicle accident, you must use $2,000 of your auto insurance carrier's Personal Injury Protection (PIP) coverage before we will pay for any of your expenses. You must send to us any explanation of payment or denial letters from an auto insurance carrier in order for us to pay a claim that is related to a motor vehicle accident. Claims paid by HNE will be subject to any copay, deductible or coinsurance required by your plan.

If You Are Injured at Work

In some cases, we have information showing that that a Member's care is covered under Workers' Compensation, or similar programs, or by a government agency. If so, the Plan may suspend payment for such services until we find if payment will be made by such program or agency. If the Plan provides or pays for services covered under such programs or agencies, we will be entitled to recover its expenses from the Provider or the party obligated to pay.

Subrogation

When you are enrolled in this Plan, you agree to give us a right of subrogation and a right of reimbursement. These terms are explained in this section.

If Another Party Is Responsible for Your Injuries or Illness

Sometimes, the Plan may pay medical bills for which another person (or his or her insurer) is legally responsible. We then have the right to make a claim against the liable person to recover the benefits the Plan provided. This is known as "subrogation." For example, if you are in an accident and another party is liable for your injuries, we will file a lien to recover the amount paid or owed to the Provider by the Plan (which may differ from the Provider's fee-for-service charges) for any benefits provided to you under this Plan. We have a right to recover even if you do not receive full settlement. Our recovery is limited to the amount you received by suit or settlement.

We also have the right to sue in your name at our expense. If a suit brought by us results in an award greater than the Provider's charges, we then have the right to recover costs of the suit and attorney's fees out of the excess.

If You Have Already Received Payment for Your Injuries

If you receive payment from another party for injuries caused by the acts or omissions of a third party, we have a right of reimbursement. The right of reimbursement arises only after you

receive payment. We then have the right to ask that you pay us for the benefits and services you received.

If you are paid by a third party, we will ask you to pay for the Provider's charges for the benefits and services you received. Our right to reimbursement will apply even if you did not receive full settlement for your injuries. We will not ask for more than you received by suit or settlement.

Your Responsibilities as a Member If the Plan Decides to Subrogate

As a Member, it is your duty to cooperate with us and provide us with any documents and information needed to help us receive repayment. You must not do anything to hinder or prevent us from seeking this recovery. If you have a lawyer, you must ask him or her to cooperate as well. If you fail to cooperate or provide requested assistance, you may be liable for any expenses incurred by us, including reasonable attorney fees, in enforcing our rights under this Plan.

SECTION 11 – OTHER PLAN ADMINSTRATIVE PROVISIONS

WHAT'S IN THIS SECTION?

This section describes some other contractual provisions of the Plan that we have not explained already in this Handbook. We describe how we will tell you of any changes to your coverage. We explain the relationship between HNE Insurance Company and you. We tell you how to contact us. We outline certain situations when the Plan may cease to operate.

Handbook

This Handbook is issued by the Group Insurance Commission.

Type of Plan

The Plan is a Group Medicare Supplement plan.

Changes to the Plan

HNE will work with the Group Insurance Commission if the Group Insurance Commission makes a change.

If Massachusetts law changes mandated benefits, HNE will work with the Group Insurance Commission to address those changes to your Plan.

If Medicare changes your Medicare deductible amount or coinsurance percentage, HNE will work with the Group Insurance Commission to make those changes to your Plan.

If we make a change, we will send you a notice that describes the change. The notice will give you the effective date of the change.

Contracting Parties

Nothing in this Handbook will create or is meant to create any relationship between the parties other than that of independent contracting parties. The Group Insurance Commission and HNE are independent entities, and neither party is the partner, agent, employee, or servant of the other.

Members and Other Third Parties

This Handbook will not create any rights in a Member or any other person as a third party beneficiary, except as specifically provided in this Handbook.

Agreement Binding on Members

When you enroll, or receive benefits or coverage under the Plan, you agree to all terms and conditions of this Handbook.

Members and Providers

The relationship of a Member to a Provider is based solely on the relationship between the Provider and the Member. Each Provider is solely responsible for all Health Care Services furnished to a Member. We are not liable for any acts or omissions by Providers.

Waiver

No waiver occurs if we fail to enforce any provision of this Handbook. We may enforce the provision at a future date. Similarly, no waiver occurs if we fail to enforce any remedy that arises from a default under the terms of this Handbook.

Severability

If any part of this Handbook is declared not enforceable or not valid, the remaining sections of this Handbook will remain in full force and effect.

Amendment, Termination of the Plan Amendment or Termination

The Group Insurance Commission has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument signed by the authorized representative of the Group Insurance Commission. The Group Insurance Commission is authorized to amend or terminate the Plan and to sign contracts, including amendments to those contracts.

Power and Authority of HNE

Benefits are provided under a plan document or documents created by the Group Insurance Commission. Claims for benefits are sent to HNE. The Group Insurance Commission is responsible for paying claims. HNE will help administer the claims.

Claims for benefits are sent to us as at this address:

Health New England, Inc.
One Monarch Place Suite 1500
Springfield, MA 01144-1500
Telephone: (877) 443-3314

We also have the authority to require eligible individuals to furnish it with such information as it determines is necessary for the proper administration of the Plan.

Circumstances Beyond Our Control

The Plan will try to arrange for services in the case of major disasters. However, we will not be liable for any failure to arrange, or for delay on arranging, services or supplies in the event of any of the following:

- Natural disaster
- Acts of Terrorism
- Civil insurrection
- Epidemic
- War
- Riot
- Strikes
- Any other emergency or event caused by an act of God or person which is beyond our control

Accident

An injury for which benefits are provided is a bodily injury you sustain as the direct result of an accident. This does not include injuries you sustain from disease, bodily infirmity or any other cause while coverage is in force under this plan.

Injuries do not include injuries for which benefits are provided or available under the following (unless prohibited by law):

- Workers' compensation, employer's liability or similar law
- Motor vehicle no-fault plan
- Or motor vehicle insurance-related plans.

Adverse Determination

- A rescission is a retroactive cancellation of coverage. The Plan will not rescind coverage unless there is fraud or an intentional misrepresentation of material fact. Rescission does not include termination for non-payment of premiums.
- A decision, based upon a review of information provided, to deny, reduce, change, or end coverage of a health service for failure to meet the requirements for coverage based on:
    - Medical necessity
    - Appropriateness of health care setting and level of care, or
    - Effectiveness.

Allowed Charge

The charge that is used to determine payment of benefits under this Plan. The Allowed Charge depends on whether a service is eligible for benefits under Medicare, or eligible for benefits under the Plan only.

- For a service eligible for benefits under Medicare: This is the payment amount Medicare has established for a service.
- For a service eligible for coverage and a Covered Service under this Plan only: This is the maximum amount on which payment is based for Covered Services.

Alternative Medicine

Types of health care that are generally not accepted by the medical community. Alternative Medicine is practiced outside of and/or in place of conventional medicine. Examples include, but are not limited to, treatment systems such as:

- Special diets
- Homeopathic remedies
- Electromagnetic fields
- Therapeutic touch

- Chiropractic services (except certain specific Covered Services, if any, listed elsewhere in this Handbook)
- Herbal medicine
- Acupuncture
- Homeopathy
- Naturopathy
- Hypnosis
- Spiritual devotions or culturally based healing traditions such as Chinese, Ayurvedic, and Christian Science
- Holistic medicine

Alternative Medicine is also called complementary medicine.

Autism Definitions

Applied Behavior Analysis: the design, implementation and evaluation of environmental 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.

Autism Services Provider: a person, entity or group that provides treatment of autism spectrum disorders.

Autism Spectrum Disorders: any of the pervasive developmental disorders as defined by 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.

Board Certified Behavior Analyst: a behavior analyst credentialed by the behavior analyst certification board as a board certified behavior analyst.

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.

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; psychological care; and therapeutic care.

Benefit Period

The way that Medicare measures your use of Hospital and skilled nursing facility (SNF) services under Medicare Part A. A Benefit Period begins with your first day of a Hospital stay covered by Medicare. It ends when you have not received any inpatient Hospital care (or skilled care in a SNF) for 60 days in a row.

Calendar Year
The 12-month period beginning January 1 and ending December 31.

Centers for Medicare and Medicaid Services (CMS)
The agency that manages Medicare and the Medicaid programs.

Coinsurance
An amount you must pay as your share of the cost of Medicare Covered Services after you pay any Medicare Deductibles. Coinsurance is usually a percentage (for example, 20%). This plan provides benefits for Medicare Coinsurance.

Copay
The amount you must pay when receiving certain Covered Services.

Covered Services
The services and supplies for which the Plan provides benefits as described in this Handbook. This includes any riders or amendments to this Handbook. These services and supplies must be:

- As described in Section 3
- For Medicare approved services, obtained from a healthcare Provider who accepts assignment from Medicare
- Medically Necessary (except for preventive care)

Custodial Care
Services to assist in the activities of daily living, such as:

- Assistance in walking
- Getting in and out of bed
- Bathing
- Dressing
- Feeding
- Using the toilet
- Preparation of special diets
- Supervision of medication that usually can be self-administered

This includes personal care that does not require the continuing attention of trained medical or paramedical personnel. For Covered Services that are eligible for benefits under Medicare, the Plan uses Medicare's guidelines to determine if care is considered to be custodial care.

Durable Medical Equipment (DME)
Medicare approved equipment that:

- Is made primarily to serve a medical purpose
- Is not useful if you are not ill or injured
- Can withstand repeated use
- Is primarily intended for activities of daily living
- Is appropriate for home use

Examples are: oxygen equipment, wheelchairs, hospital beds, canes, nebulizers and other items that are Medically Necessary.

Effective Date

The date when you become a Member and are first eligible for benefits for Covered Services under this Plan.

Emergency Medical Condition

A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in:

- Placing the health of a person (including an unborn child) in serious jeopardy
- Serious impairment to body function, or
- Serious dysfunction of any body organ or part

Some examples of Emergency Medical Conditions are:

- Suspected heart attacks
- Severe pain
- Strokes
- Loss of consciousness
- Convulsions
- Suicide attempts

Experimental

Services considered to be unsafe, experimental, or investigational. This applies to any:

- medical procedure
- equipment
- treatment or course of treatment
- implant
- drugs or medicines

This is determined by sources including:

- Formal or informal studies
- Opinions and references to or by:
    - American Medical Association
    - Food and Drug Administration
    - Department of Health and Human Services
    - National Institutes of Health
    - Council of Medical Specialty Societies
    - Experts in the field
    - Any other association or federal program or agency that has the authority to approve medical testing or treatment

Group Insurance Commission

The state agency responsible for the design and payment of all benefits for state, participating municipalities and other governmental entities' employees and retirees.

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.

Hospital

A hospital as defined by Medicare and authorized for payment by Medicare. When used in connection with Massachusetts mandated benefits a hospital is an accredited or licensed hospital. The Plan provides benefits as described in this Handbook for some services for which Medicare does not pay. The term "hospital" does not include:

- Convalescent nursing homes
- Rest facilities
- Facilities for the aged that primarily furnish custodial care

Lifetime Reserve Days

These are additional days that Medicare will cover when a Member is in a Hospital for more than 90 days in a benefit period. A Member has a total of 60 reserve days that can be used during his or her lifetime.

Medically Necessary

For services eligible for coverage under Medicare, Medically Necessary is as determined by Medicare.

For services that are Covered Services under this Plan only, Medically Necessary has the following meaning:

Those Covered Services and supplies that are consistent with generally accepted principles of professional medical practice as determined by whether the service is:

- The most appropriate available supply or level of service for the Member in question considering potential benefits and risks to the individual.
- Known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes.
- Based on scientific evidence if the services and interventions are not in widespread use.

Medicare

The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted and later amended. Medicare is a federal health insurance program administered by the Centers for Medicare and Medicaid Services (CMS).

Medicare Deductible

The dollar amount of the Medicare allowed charge that you must pay before Medicare begins to pay. There are two types of Deductible, Part A and Part B. The Part A Deductible is paid once each Benefit Period. The Part B Deductible is paid once each Calendar Year. Medicare may change the amounts of these Deductibles. For the Deductible amounts, see the most current Medicare handbook. This Plan provides benefits for the Medicare Deductibles.

Medicare Eligible Expenses

Expenses covered by Medicare Part A and Part B that are recognized as reasonable and Medically Necessary by Medicare.

Member

Any person enrolled in the Plan who has a right to services described in this Handbook.

Open Enrollment Period

The period each year when eligible persons may enroll in the Plan or change options.

Physician

A physician as defined by Medicare. Or a person who is licensed as a physician in the state where he or she practices. The Plan provides the benefits described in this Handbook for covered physician services when Medicare does not make any payment for the services.

Plan

The Health New England Medicare Supplement Plus benefit plan offered by the Group Insurance Commission and described in this Handbook.

Plan Year (or Policy Year)

The 12-month period from July 1 through June 30 of the following year.

Provider

A health care professional or facility licensed in accordance with applicable law. Providers do not have to contract with the Plan in order to offer services for the benefits listed in this Handbook.

The types of Providers covered under the Plan include, but are not limited to:

- Ambulatory surgical centers
- Hospitals
- Physicians
- Certified registered nurse anesthetists
- Certified nurse midwives
- Chiropractors
- Nurse practitioners
- Optometrists
- Physician Assistants
- Podiatrists
- Psychologists
- Licensed mental health counselors
- Licensed independent clinical social workers
- Skilled Nursing Facilities

Rider

An amendment that changes the terms described in this Handbook. A Rider describes the material change made to the Plan described in this Handbook. We will send you a copy of any Riders that apply to this Plan. You should keep any riders with your Handbook.

Routine

Health care for the prevention of or screening for health problems.

Sickness

An illness or disease for which you receive services while covered under this Plan.

Sickness does not include sicknesses for which benefits are provided or available under the following (unless prohibited by law):

- Workers' compensation
- Occupational diseases
- Employer's liability or similar law

Skilled Nursing Facility (SNF)

A skilled nursing facility as defined by Medicare. This does not include:

- Convalescent nursing homes
- Rest facilities
- Facilities for the aged that primarily furnish custodial care

The Plan pays certain benefits for covered services in SNFs that are not participating with Medicare. Medicare does not cover services in those facilities.

Subscriber

An enrolled person who meets the eligibility requirements for enrollment in the Plan, and for whom HNE has received the administrative fee specified by the Plan.

Medicare Pays	Plan Pays	You Pay *
Ambulance Services		
Full benefits, except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Autism Spectrum Disorder		
• Not covered by Medicare	• All costs less any applicable Copay per visit	• $15 per visit (Neuropsychological evaluation, psychological care, therapeutic care when services provided by licensed or certified speech therapist, occupational therapist or physical therapist)
Blood Services – Inpatient		
First 3 pints of blood per Calendar Year – Medicare pays nothing	• All costs	• Nothing
Beyond 3 pints per Calendar Year – Medicare pays all costs	• Nothing	• Nothing
Blood Services – Outpatient		
First 3 pints per Calendar Year – Medicare pays nothing	• All costs	• Nothing
After the first 3 pints, charges up to the Part B deductible – Medicare pays nothing	• Part B Deductible	• Nothing
Remainder of Medicare approved amounts – Medicare pays 80%	• Part B Coinsurance	• Nothing
Cardiac Rehabilitation		
Full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• $15 per visit

* Benefits for Covered Services are provided based on the Allowed Charges. You may have to pay any amount over the Allowed Charge.

Medicare Pays	Plan Pays	You Pay *
Diabetic Supplies		
When covered by Medicare: Full benefits except: • Part B Deductible • Part B Coinsurance	**When covered by Medicare:** • Part B Deductible • Part B Coinsurance	**When covered by Medicare:** • Nothing
Diabetic Services		
Full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• $15 per visit (screenings and diabetic management training)
Diagnostic Tests: Lab tests, X-Rays and Other Tests		
Full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing (other settings)
Dialysis Services		
Full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Durable Medical Equipment and Prosthetic Devices		
Full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Emergency Room Care		
Full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• $50 per visit (waived if admitted)
Eye Care (Routine)		
When not covered by Medicare: • Nothing (Refractions are only covered as part of an annual eye exam)	**When not covered by Medicare:** Allowed amount charged less member copayment. Covered for 1 routine eye exam every 24 months.	• $15 Copay per visit

* Benefits for Covered Services are provided based on the Allowed Charges. You may have to pay any amount over the Allowed Charge.

Medicare Pays	Plan Pays	You Pay *
Enteral Formulas, Low Protein Food Products		
When covered by Medicare: Full benefits except: • Part B Deductible • Part B Coinsurance	**When covered by Medicare:** • Part B Deductible • Part B Coinsurance	**When covered by Medicare:** • Nothing
When not covered by Medicare: • Nothing	**When not covered by Medicare:** Benefits in full for: • Certain enteral formulas • Low protein food products up to $5,000 per Calendar Year.	**When not covered by Medicare:** • Nothing for certain enteral formulas • All charges for low protein food products after the Plan pays $5,000 in a Calendar Year.
Foreign Travel – Services received outside of the United States – Emergency Services Only		
Nothing for emergency services. Medicare does not cover because services were received outside of the United States.	All expenses for emergency services that Medicare would have paid for if you received the services in the United States, plus the remainder of the emergency charges	$50 copay per visit (waived if admitted)
Hearing Aids over age 21		
• Nothing	First $500 covered in full, then remaining $1500 covered at 80% (for both ears combined)	20% Coinsurance after the first $500 and all charges in excess of the benefit limit (for both ears combined)
Hearing Aids under age 21		
• Nothing	The cost of one hearing aid per hearing impaired ear, every 24 months, up to a maximum of $2,000 for each hearing aid.	The difference in cost above the $2,000 limit.
Home Health Care		
When covered by Medicare: Medicare covered home health care visits – covered in full	• Nothing	• Nothing
When covered by Medicare: Durable medical equipment covered by Medicare – full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing

* Benefits for Covered Services are provided based on the Allowed Charges. You may have to pay any amount over the Allowed Charge.

Medicare Pays	Plan Pays	You Pay *
When not covered by Medicare: Nothing	**When not covered by Medicare:** • Services paid in full	• Nothing
Hospice Services		
When covered by Medicare: Full benefits for most services	**When Medicare does not provide full benefits:** • The difference between the amount Medicare pays and the Allowed Charge.	**When covered by Medicare:** • Nothing
When not covered by Medicare: • Nothing	**When not covered by Medicare:** • Services paid in full	**When not covered by Medicare:** • Nothing
Inpatient Hospital Admissions in a General Hospital – Medical and Surgical Care		
Hospital charges per Benefit Period – full semi- private benefits except: • Day 1–60: Part A Deductible • Day 61-90: Part A Coinsurance • 60 Lifetime Reserve Days: Part A Coinsurance	Per Benefit Period: • Day 1-60: Part A Deductible • Day 61-90: Part A Coinsurance • 60 Lifetime Reserve Days: Part A Coinsurance	Per Benefit Period • Day 1-60: Nothing • Day 61-90: Nothing • 60 Lifetime Reserve Days: Nothing • After the above, you pay all charges
Inpatient Hospital Admissions in a General Hospital – Physician and Professional Provider Services		
Physician and other professional Provider services – full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Inpatient Behavioral Health Services		
Inpatient stay in a general or behavioral health Hospital, per Benefit Period – full benefits except: • Day 1–60: Part A Deductible • Day 61-90: Part A Coinsurance • 60 Lifetime Reserve Days: Part A Coinsurance **Note:** Medicare benefits in a mental behavioral health Hospital are limited to 190 days per lifetime.	**Inpatient stay** in a general or behavioral health Hospital Per Benefit Period: • Day 1-60: Part A Deductible • Day 61-90: Part A Coinsurance • 60 Lifetime Reserve Days: Part A Coinsurance	**Inpatient stay** in a general or mental behavioral health Hospital Per Benefit Period: • Day 1-60: Nothing • Day 61-90: Nothing • 60 Lifetime Reserve Days: Nothing • After the above, you pay all charges

* Benefits for Covered Services are provided based on the Allowed Charges. You may have to pay any amount over the Allowed Charge.

Medicare Pays	Plan Pays	You Pay *
Inpatient Behavioral Health Admission in a Behavioral Health Hospital – Physician and Professional Provider Services		
Inpatient physician and other covered professional behavioral health Provider services for as many days as Medically Necessary – full benefits except: • Part B Deductible • Part B Coinsurance	**Inpatient physician and other covered professional behavioral health Provider services** covered by Medicare and the Plan for as many days as Medically Necessary in a general Hospital: • Part B Deductible • Part B Coinsurance Covered Services for as many days as Medically Necessary in a general Hospital, and up to 120 additional days per benefit period (at least 60 days per Calendar Year) in a behavioral health Hospital when covered only by the Plan.	**Inpatient physician and other covered professional behavioral health Provider services**: Nothing for as many days as Medically Necessary
Medical Care – Specialists, Clinic, Office and Home Visits		
Full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• $15 per visit
Medical Care – Specialists, Clinic, Office and Home Visits Outpatient Hospital Care – Medical or Surgical		
Charges in a general Hospital facility – full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing

* Benefits for Covered Services are provided based on the Allowed Charges. You may have to pay any amount over the Allowed Charge.

Medicare Pays	Plan Pays	You Pay *
Medical Care – Specialists, Clinic, Office and Home Visits Outpatient Hospital Care – Medical or Surgical		
Charges in a general Hospital facility or Ambulatory Surgical Center – full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Oxygen and Equipment		
Full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Podiatry Services		
Full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• $15 per visit
Prescription Drugs		
Outpatient Drug Coverage under Medicare Part B **When covered by Medicare**, full benefits except: • Part B Deductible • Part B Coinsurance	**When covered by Medicare**: • Part B Deductible • Part B Coinsurance	**When covered by Medicare**: • Nothing
Outpatient Drug Coverage for drugs not covered under Medicare Part B • Nothing	Benefits are administered through SilverScript® For questions about your prescription drug coverage, please contact SilverScript® at (877) 876-7214. TTY user should call 711.	

* Benefits for Covered Services are provided based on the Allowed Charges. You may have to pay any amount over the Allowed Charge.

Medicare Pays	Plan Pays	You Pay *
Preventive Care		
"Welcome to Medicare" preventive visit within 12 months after Part B coverage begins, full benefits	• Nothing †	• Nothing †
Yearly "Wellness" visit, full benefits	• Nothing †	• Nothing†
Annual physical exam: • Nothing †	Covered for one exam per calendar year	• Nothing
Bone mass density testing, full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Cardiovascular screening (routine), full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Colorectal Screening (routine), full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Diabetes self-management training, full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing

† If your provider orders services not covered under this preventive benefit, Part B Deductible and Part B Coinsurance may apply. The Plan will cover the Part B Coinsurance and the Part B Deductible.

* Benefits for Covered Services are provided based on the Allowed Charges. You may have to pay any amount over the Allowed Charge.

Medicare Pays	Plan Pays	You Pay *
Family planning, counseling & treatment • Nothing	• Benefits as required by Massachusetts state mandate	• Nothing
Glaucoma testing, full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
GYN exams (routine) and Pap smear tests (routine) covered by Medicare, full benefits	• Nothing	• Nothing
Pap smear tests (routine) not covered by Medicare: • Nothing	• Full coverage for one routine PAP smear test each Calendar Year	• Nothing
Mammograms (routine), full benefits	• Nothing	• Nothing
Prostate cancer screening (routine), full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Medicare approved smoking cessation program, full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing For information about coverage for prescription drugs, please contact SilverScript® at (877) 876-7214 (TTY user should call 711)
Radiation and X-Ray Therapy		
Full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing

* Benefits for Covered Services are provided based on the Allowed Charges. You may have to pay any amount over the Allowed Charge.

Medicare Pays	Plan Pays	You Pay *
Scalp Hair Prosthesis (Wigs) for hair loss due to treatment of any form of cancer or leukemia		
• Nothing	• Up to $350 per benefit year	• All charges after $350 per benefit year
Second Opinions		
Full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• $15 per visit
Short-Term Rehabilitation Therapy Physical, Occupational and Speech/Language Therapy		
For services covered by Medicare, full benefits except: • Part B Deductible • Part B Coinsurance	For services covered by Medicare: • Part B Deductible • Part B Coinsurance	• $15 per visit
Skilled Nursing Facility Services		
In a **Skilled Nursing Facility that participates with Medicare**, per Benefit Period: • Day 1-20: full benefits • Day 21-100: full benefits except the Part A Coinsurance • Day 101-365: Nothing • Beyond day 365: Nothing	In a **Skilled Nursing Facility that participates with Medicare**, per Benefit Period: • Day 1-20: Nothing • Day 21-100: Part A Coinsurance • Day 101-365: $10 a day • Beyond day 365: Nothing	In a **Skilled Nursing Facility that participates with Medicare**, per Benefit Period: • Day 1-20: Nothing • Day 21-100: Nothing • Day 101-365: All charges after $10 a day • Beyond day 365: All charges

* Benefits for Covered Services are provided based on the Allowed Charges. You may have to pay any amount over the Allowed Charge.

Medicare Pays	Plan Pays	You Pay *
In a Skilled Nursing Facility that does not participate with Medicare, per Benefit Period: • Day 1-365: Nothing • Beyond the day 365: Nothing	**In a Skilled Nursing Facility that does not participate with Medicare**, per Benefit Period: • Day 1-365: Nothing • Beyond the day 365: Nothing	**In a Skilled Nursing Facility that does not participate with Medicare**, per Benefit Period: • Day 1-365: All charges • Beyond the day 365: All charges
Surgery as an Outpatient		
Full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Urgent care		
Full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• $15 Copay per visit

* Benefits for Covered Services are provided based on the Allowed Charges. You may have to pay any amount over the Allowed Charge.

YOUR PRESCRIPTION DRUG PLAN

Description of Benefits

SilverScript Employer PDP sponsored by the Group Insurance Commission

A Medicare Prescription Drug Plan (PDP) offered by SilverScript®
Insurance Company with a Medicare contract

For questions about any of the information in Part 2 of this handbook, please contact SilverScript at 877-876-7214. TTY users should call 711.

Administered by

SilverScript®

Part 2: Prescription Drug Plan

Section I – Introduction

SilverScript Employer PDP sponsored by the Group Insurance Commission (SilverScript) is a Medicare-approved Part D prescription drug plan with additional coverage provided by the GIC to expand the Part D benefits. "Employer PDP" means that the plan is an employer-provided Prescription Drug Plan. The Plan is offered by SilverScript® Insurance Company which is affiliated with CVS Caremark®, the GIC's pharmacy benefit manager for GIC Medicare approved Part D Prescription drug plan.

This handbook gives you a summary of what SilverScript covers and what you pay. It does not list every service that SilverScript covers or list every limitation or exclusion. To get a complete list of services, call SilverScript and ask for the *Evidence of Coverage*.

You have choices about how to get your GIC Medicare prescription drug benefits

You make the choice. However, **if you decide to enroll in one of the GIC's Medicare products but choose <u>not</u> to be enrolled in or are disenrolled from SilverScript Employer PDP sponsored by the GIC, you will lose your GIC medical, prescription drug and behavioral health coverage.**

As a Medicare beneficiary, the GIC Medicare prescription drug coverage option offered is:

- **SilverScript Employer PDP sponsored by the Group Insurance Commission** as the prescription drug coverage for members enrolled in one of the GIC's Medicare products.

Information in this handbook

- Things to Know About SilverScript
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Prescription Drug Benefits

Things to Know About SilverScript

SilverScript Phone Numbers and Website

- Call toll free 877-876-7214. TTY users should call 711.
- Website: gic.silverscript.com

Hours of Operation

You can call SilverScript 24 hours a day, 7 days a week.

Who can join?

To join SilverScript, you must

- Be eligible for Medicare Part A for free, and enrolled in Medicare Part B, and
- Be a United States citizen or are lawfully present in the United States, and
- Live in our service area which is the United States and its territories, and
- Meet any additional requirements established by the GIC.

Which drugs are covered?

The plan will send you a list of commonly used prescription drugs selected by SilverScript and **covered under the Medicare Part D portion of the plan**. This list of drugs is called a *Formulary*.

You may review the complete plan formulary and any restrictions on the website at gic.silverscript.com. Or call SilverScript and you will be sent a copy of the formulary. This formulary does not include drugs covered through the additional coverage provided by the GIC.

The formulary may change throughout the year. Drugs may be added, removed or restrictions may be added or changed. These restrictions include:

- **Quantity Limits (QL)** – For certain drugs, SilverScript limits the amount of the drug that it will cover.
- **Prior Authorization (PA)** – SilverScript requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from SilverScript before they fill your prescription. If you don't get approval, SilverScript will not cover the drug.
- **Step Therapy (ST)** – In some cases, SilverScript requires you to first try a certain drug to treat your medical condition before SilverScript will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, SilverScript will not cover Drug B unless you try Drug A first. If Drug A does not work for you, SilverScript will then cover Drug B.

How will I determine my drug costs?

SilverScript groups each medication into one of three tiers:

- **Generic drugs (Tier 1)** – most cost-effective drugs to buy. The active ingredients in generic drugs are exactly the same as the active ingredients in brand drugs whose patents have expired. They are required by the Food and Drug Administration (FDA) to be as safe and effective as the brand drug.
- **Preferred Brand drugs (Tier 2)** – brand drugs that do not have a generic equivalent and are included on a preferred drug list. They are usually available at a lower cost than Non-Preferred Brand drugs.
- **Non-Preferred Brand drugs (Tier 3)** – brand drugs that are not on a preferred drug list and usually are a high cost. Certain drugs are limited to a 30-day supply. These

drugs have "NDS" (for "Non-Extended Day Supply") next to the drug name in the formulary.

You will need to use your formulary to find out the tier for your drug or if there are any restrictions on your drug, as well as to determine your cost. The amount you pay depends on the drug's tier and whether you are in the Initial Coverage, Coverage Gap or Catastrophic Coverage stage. If the actual cost of a drug is less than your normal copay for that drug, you will pay the actual cost, not the higher copay amount.

Additional drugs covered by the GIC

The GIC provides additional coverage to cover drugs that are not included on the SilverScript formulary, as well as certain drugs not covered under Medicare Part D, such as:

- Prescription drugs when used for anorexia, weight loss or weight gain
- Prescription drugs when used for the symptomatic relief of cough or cold
- Prescription vitamins and mineral products not covered by Part D
- Prescription drugs when used for treatment of sexual or erectile dysfunction
- Certain diabetic drugs and supplies not covered by Part D
- Prescription drugs for tobacco cessation
- Part B products, such as oral chemotherapy agents

These drugs are not subject to SilverScript appeals and exceptions process and the cost of these drugs will not count towards your Medicare out-of-pocket costs or Medicare total drug costs. There may be other drugs covered by the additional coverage from the GIC. Contact SilverScript for details.

Drugs used to treat opioid use disorder

Generic drugs used to treat opioid use disorder (generic buprenorphine-naloxone, naloxone, and naltrexone products) are covered with no copayment or prior authorization.

Which pharmacies can I use?

The plan has a network of pharmacies, including retail, mail-order, long-term care and home infusion pharmacies. You must use a SilverScript network pharmacy, unless it is an emergency or non-routine circumstance.

SilverScript has **preferred** network retail pharmacies where you can get up to a 90-day supply of your maintenance medications for the same copay as mail order. You will also be able to get up to a 90-day supply of your maintenance medication at **non-preferred** network retail pharmacies, but the copay will be three times the retail 30-day supply copay.

The pharmacies in SilverScript's network can change at any time. To find a preferred or non-preferred network pharmacy near your home or where you are traveling in the United States or its territories, use the pharmacy locator tool on the website at gic.silverscript.com or call SilverScript at 877-876-7214, 24 hours a day, 7 days a week. TTY users should call 711.

You may use an out-of-network pharmacy only in an emergency or non-routine circumstance. If you use an out-of-network pharmacy, you may be required to pay the full cost of the drug at the pharmacy. In this case, you must complete a paper claim and send it to SilverScript to request reimbursement. You are responsible for your copay and will be reimbursed the plan's share of the cost.

If you may need to get your prescription filled while you are traveling outside the country, contact SilverScript Customer Care **before** you leave the U.S. You can request a vacation override for up to a 90-day supply of your medication. If you are traveling outside of the country and have an emergency drug expense, submit your itemized receipt with the completed SilverScript claim form to the GIC at P.O. Box 556, Randolph, MA 02368.

Claim forms are available at gic.silverscript.com or by calling 877-876-7214. TTY users should call 711.

Please note: Veterans Affairs (VA) pharmacies are not permitted to be included in Medicare Part D pharmacy networks. The federal government does not allow you to receive benefits from more than one government program at the same time.

If you are eligible for VA benefits, you may still use VA pharmacies under your VA benefits. However, the cost of those medications and what you pay out-of-pocket will not count toward your Medicare out-of-pocket costs or Medicare total drug costs. Each time you get a prescription filled, you can compare your GIC benefit through SilverScript to your VA benefit to determine the best option for you.

Section II – Summary of Benefits

How Medicare Part D Stages Work

The **standard Medicare Part D plan** has four stages or benefit levels. This is how these stages work in 2021

Table 1. How Medicare Part D Stages Work

Stage	Standard Medicare Part D Plan without your additional coverage provided by the GIC	SilverScript with your additional coverage provided by the GIC This is what you pay
Deductible	$ 435	$ 0
Initial Coverage	After meeting the deductible, a person pays 25% of the drug cost until he reaches $4,020 in total drug costs	Since you have no deductible, you start in this stage and pay your GIC copay.
Coverage Gap	Also called the "donut hole," this is when a person pays a large portion of the cost, either ▪ 25% brand-name drug cost ▪ 25% generic drug cost	You continue to pay only your GIC copay.

Catastrophic Coverage	After you reach $6,350 in Medicare Part D out-of-pocket costs, a person pays the **greater of**:
	• 5% of the drug cost, or
	• $3.60 for generic drugs
	• $8.95 for brand-name drugs
		After you reach $6,350 in Medicare Part D out-of-pocket costs, you pay the **lower of**:
		• Your GIC copay,
		or
		• The Medicare Catastrophic Coverage cost-share, the greater of
		  • 5% of the drug cost, or
		  • $3.60 for generic drugs
		  • $8.95 for brand-name drugs

In calendar year 2021 the standard Medicare Part D plan maximum out-of-pocket expense of $6,350 includes the deductible, any amount you have paid for your copay, any amount you have paid during the coverage gap, any manufacturer discounts on your brand-name drugs in the coverage gap, and any amount paid by Extra Help or other governmental or assistance organizations on your behalf.

Medicare's maximum out-of-pocket cost does not include the monthly premium, if any, the cost of any prescription drugs not covered by Medicare, any amount paid by SilverScript, or any amount paid through the additional coverage provided by the GIC.

Please note: Standard Medicare Part D stages and plan changes can occur every year. For further information, please visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. For plan changes, please call SilverScript Customer Care at 1-877-876-7214, 24 hours a day, 7 days a week or visit gic.silverscript.com. TTY users should call 711.

Your Prescription Drug Benefits – Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

	SilverScript
How much is the monthly premium?	There is no separate prescription drug premium. This benefit is provided as part of your medical coverage. If you have any questions about your premium, contact the GIC's Public Information Unit at 617-727-2310, ext. 1 (TTY users: Relay Service 711); available 8:45 a.m. to 5:00 p.m., Monday through Friday.

If your individual income is over $87,000, or if your income is over $174,000 and you are married filing your taxes jointly, you will be required to pay an income-related additional monthly premium to the federal government in order to maintain your Medicare prescription drug coverage. This premium is adjusted based on your income.

You will receive a letter from Social Security letting you know if you have to pay this extra amount. This letter will explain how they determined the amount you must pay and the actual Income Related Monthly Adjustment Amount (IRMAA).

If you are responsible for an additional premium, the extra amount will be deducted automatically from your Social Security check. If your Social Security check is not enough to cover the additional premium, Medicare will send you a bill. You do not pay this amount to the GIC or SilverScript. You send your payment to Medicare.

For more information about the withholdings from your check, visit ssa.gov/medicare/mediinfo.html, call 800-772-1213, 7 a.m. to 7 p.m., Monday through Friday, or visit your local Social Security office. TTY users should call 800-325-0778.

For more information about Part D premiums based on income, call Medicare at 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

	SilverScript
How much is the deductible?	This plan does not have a deductible.

	SilverScript
Initial Coverage	You pay the amounts below until your total yearly drug costs reach $4,020. Total yearly drug costs are the total drug costs for Part D drugs paid by both you and the plan. You may get your drugs at network retail pharmacies and mail order pharmacies. Some of our network pharmacies are preferred network retail pharmacies. You pay the same as mail order for a 90-day supply of a maintenance medication at **preferred** network retail pharmacies.

	SilverScript		
	Up to a 30-day supply at a retail network pharmacy	**Up to a 90-day supply at a preferred retail network pharmacy**	**Up to a 90-day supply at a non-preferred retail network pharmacy**
Tier 1 Generic	$10	$25	$30
Tier 2 Preferred Brand	$30	$75	$90
Tier 3 Non-Preferred Brand	$65	$165*	$195*

	SilverScript
	Up to a 90-day supply through the mail order pharmacy
Tier 1 Generic	$25
Tier 2 Preferred Brand	$75
Tier 3 Non-Preferred Brand	$165*

	SilverScript
	Up to a 31-day supply at a long-term care (LTC) facility
Tier 1 Generic	$10
Tier 2 Preferred Brand	$30
Tier 3 Non-Preferred Brand	$65*

* Certain drugs are limited to a 30-day supply. These drugs have "**NDS"** next to them in the formulary.

Coverage Gap	Due to the additional coverage provided by the GIC, you pay the same copay that you paid during the Initial Coverage stage. You will see no change in your copay until you qualify for Catastrophic Coverage.

	SilverScript

Catastrophic Coverage	After you reach $6,350 in Medicare out-of-pocket drug costs for the year, you pay the **lower** of:
	• Your GIC copay, or
	• Medicare's Catastrophic Coverage, which is the **greater** of
	  ○ 5% of the cost, or
	  ○ $3.60 copay for generic, including brand drugs treated as generic, or
	  ○ $8.95 copay for all other drugs

Quality Management Program

A Quality Management Program is developed yearly by HNE. It addresses the quality and safety of clinical care provided to the Plan's Members. It also addresses the quality of services provided to the Plan's Members. The written program description defines HNE's quality management program structure, objectives, and processes. It also describes the resources HNE uses to identify, review, measure, monitor, and evaluate the activities implemented to meet the goals of the program.

A Quality Management Work Plan is also developed yearly by HNE. This is the listing of activities that HNE does to meet its program goals. Projects focusing on the areas below have been implemented.

- Patient safety
- Behavioral health issues
- Use of services
- Member and Provider communications
- Confidentiality
- Disease management
- Prevention
- Continuity of care for Members

The time frame for completion of each project is very different. Some are very simple and can be completed in a matter of months. Others are ongoing, and will be followed by HNE throughout the year.

HNE's Quality Management Committee is responsible for the performance of the Plan. The Quality Management Committee meets about three times a year to review and monitor the progress of the activities listed in the Work Plan. Participation by individual network Providers is also essential to the functioning of the Quality Management Program.

If you would like any information regarding HNE's Quality Management Program Description or Work Plan, please contact HNE Member Services at the number listed below. HNE will provide this information on request.

Summary Description of HNE's Process for Developing Clinical Guidelines and Utilization Review Criteria for Services Not Covered by Medicare but Covered by the Plan

HNE has a written program for how Health Care Services and delivery are reviewed. The program is made up of activities in the areas of utilization, case, and disease management. Its purpose is to help Members to receive the appropriate care. HNE may conduct reviews before or during the delivery of services. HNE uses nationally recognized guidelines and resources for these reviews. HNE also uses criteria developed with the input of local practicing physicians. Physicians outside HNE's staff may be consulted to help make a decision of medical

appropriateness. Only HNE's Medical Directors can make a decision to deny coverage for reasons of medical necessity. At times, HNE may delegate certain utilization management functions to other entities. When this occurs, HNE requires the entity to use program procedures and criteria approved by HNE. HNE reviews its utilization review program yearly.

Summary Description of HNE's Procedures in Making Decision about the Experimental or Investigational Nature of Individual Drugs, Medical Devices or Treatments in Clinical Trials for Services Not Covered by Medicare but Covered by the Plan

HNE has several programs to address this area. In general, the decision process is as follows:

- HNE uses Hayes, Inc. to research new and emerging medical technologies. Hayes also researches new uses of existing technologies. The research is structured and evidence-based. Analyses of market, regulatory, legal, ethical, and actuarial issues are part of the study. Hayes then makes coverage recommendations to us.
- The recommendations by Hayes are then screened by HNE's internal committee. If more medical input is needed, an In-Plan physician will be consulted. He or she will provide a written opinion to HNE.
- The findings are then reported to another committee for discussion at its next meeting. The committee includes In-Plan physicians. This allows for local practicing physician input.
- Recommendations will then go to HNE's Medical Policy Committee for final decision. The committee makes a decision based on its review of the recommendations and other specific data, such as:
    - Prevalence of disease(s) associated with proposed technologies.
    - Benefits to Members.
    - Cost.
    - Use of current technologies and projected use of new technology.

The Plan does not cover any Experimental or investigational device or treatment unless it has been reviewed and approved by our Medical Technology Assessment Committee.

Physician Profiling Information

You can get this information from the Massachusetts Board of Registration in Medicine. Information is available for physicians who are licensed to practice in Massachusetts. You can request a printout on a doctor by calling (781) 876-8230. Or, in Massachusetts only you can call (800) 377-0550. You can also find information by visiting massmedboard.org.

APPENDIX C. NOTICE OF PRIVACY PRACTICES

This section lists your rights to Privacy. Health New England is required to describe these rights as they are below. If you do not know what a term or a section means, call Member Services.

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.

We know how important it is to protect your privacy at all times and in all settings. We are required by law to maintain the privacy of your protected health information (PHI), to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information.

"Protected health information" or "PHI" is information about you, including demographic information, that:

- Can reasonably be used to identify you; and
- That relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

Protected health information excludes individually identifiable health information regarding a person who has been deceased for more than 50 years.

How does Health New England collect protected health information?

We get PHI from:

- Information we receive directly or indirectly from you, your employer or benefits plan sponsor through applications, surveys, or other forms. For example: name, address, social security number, date of birth, marital status, dependent information and, employment information.
- Providers (such as doctors and hospitals) who are treating you or who are involved in your treatment and/or their staff when they submit claims or request authorization on your behalf for certain services or procedures.
- Attorneys who are representing our Members in automobile accidents or other cases.
- Insurers and other health plans.

How does Health New England protect my personal health information? We have many physical, electronic, and procedural safeguards in place to protect your information. Information is protected whether it is in oral, written or electronic form. Our policies and procedures require all of our employees to protect the confidentiality of your PHI.

An employee may only access your PHI when they have an appropriate reason to do so. Each employee must sign a statement that he or she has read and understands Health New England's privacy policy. On an annual basis, we will send a notice to employees to remind them of this policy. Any employee who violates Health New England's privacy policies is subject to discipline, up to and including dismissal.

How does Health New England use and disclose my protected health information?

We use and discloses your PHI for many different reasons. We can use or disclose your PHI for some reasons without your written agreement. For other reasons, we need you to agree in writing that we can use or disclose your PHI.

Uses and Disclosures for Treatment, Payment and Health Care Operations

Health New England uses and discloses your PHI in a number of different ways in connection with your treatment, the payment for your health care, and our health care operations. We can also disclose your information to Providers and other health plans that have a relationship with you, for *their* treatment, payment and some limited health care operations. The following are only a few examples of the types of uses and disclosures of your protected health information that we are permitted to make *without* your authorization:

Treatment: We may disclose your protected health information to health care Providers (doctors, dentists, pharmacies, hospitals and other caregivers) who request it in connection with your treatment. We may also disclose your protected health information to health care Providers (including their employees or business associates) in connection with preventive health, early detection and disease and case management programs.

Payment: We will use and disclose your protected health information to administer your health benefits policy or contract. For example, we may use your PHI to pay claims for medical services you have received, to determine your eligibility for benefits, or to coordinate your Health New England coverage with that of other plans (if you have more than one plan).

Health Care Operations: We will use and disclose your protected health information to support our general health care operations. For example, we may use your PHI to conduct quality assessment activities, develop clinical guidelines, operate preventive health, early detection and disease and case management programs, including contacting you or your doctors to provide appointment reminders or information about treatment alternatives, therapies, health care Providers, settings of care or other health-related benefits and services. In addition, we may use your information to send fundraising communications to you. If we do, we will provide you with an opportunity to elect not to receive any further fundraising communications from us.

We do not and will not use PHI that is genetic information about you for underwriting purposes.

Other Permitted or Required Uses and Disclosures of Protected Health Information

In addition to treatment, payment and health care operations, federal law allows or requires us to use or disclose your protected health information in the following additional situations without your authorization:

Required by Law: We may use or disclose your protected health information to the extent we are required by law to do so. For example, the law compels us to disclose PHI when required by the Secretary of the Department of Health and Human Services to investigate our compliance efforts.

Public Health Activities: We may disclose your protected health information to an authorized public health authority for purposes of public health activities. The information may be disclosed

for such reasons as controlling disease, injury or disability, or to report child abuse or neglect. We also may have to disclose your PHI to a person who may have been exposed to a communicable disease or who may otherwise be at risk of contracting or spreading the disease. In addition, we may make disclosures to a person subject to the jurisdiction of the Food and Drug Administration, for the purpose of activities related to the quality, safety or effectiveness of an FDA-regulated product or activity.

Abuse or Neglect: We may make disclosures to government authorities if we believe you have been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when we are required or authorized by law to do so.

Health Oversight: We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs, or its contractors (e.g., state insurance department, U.S. Department of Labor) for activities authorized by law, such as audits, examinations, investigations, inspections and licensure activity.

Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal and, in certain cases, in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may disclose your protected health information under limited circumstances to law enforcement officials. For example, disclosures may be made in response to a warrant or subpoena or for the purpose of identifying or locating a suspect, witness or missing persons or to provide information concerning victims of crimes.

Coroners, Funeral Directors and Organ Donation: We may disclose your protected health information in certain instances to coroners, funeral directors and organizations that help find organs, eyes, and tissue to be donated or transplanted.

Threat to Health or Safety: If we believe that a serious threat exists to your health or safety, or to the health and safety of any other person or the public, we will notify those persons we believe would be able to help prevent or reduce the threat.

Military Activity and National Security: We may disclose your protected health information to Armed Forces personnel under certain circumstances and to authorized federal officials for the conduct of national security and intelligence activities.

Correctional Institutions: If you are an inmate in a correctional facility, we may disclose your protected health information to the correctional facility for certain purposes, including the provision of health care to you or the health and safety of you or others.

Workers' Compensation: We may disclose your protected health information to the extent required by workers' compensation laws.

Research: We may use or disclose PHI for research provided certain requirements are met.

Will Health New England give my PHI to my family or friends?

We will only disclose your PHI to a family member or a close friend in the following circumstances:

- You have authorized us to do so.
- That person has submitted proof of legal authority to act on your behalf.
- That person is involved in your health care or payment for your health care and needs your PHI for these purposes. If you are present or otherwise available prior to such a disclosure (whether in person or on a telephone call), we will either seek your verbal agreement to the disclosure, provide you an opportunity to object to it, or reasonably infer from the circumstances, based on our exercise of professional judgment, that you would not object to the disclosure. We will only release the PHI that is directly relevant to their involvement.
- We may share your PHI with your friends or family members if professional judgment says that doing so is in your best interest. We will only do this if you are not present or you are unable to make health care decisions for yourself. For example, if you are unconscious and a friend is with you, we may share your PHI with your friend so you can receive care.
- We may disclose a minor child's PHI to their parent or guardian. However, we may be required to deny a parent's access to a minor's PHI, for example, if the minor is an emancipated minor or can, under law, consent to their own health care treatment.
- If an individual is deceased, we may disclose to a family member or friend who was involved in the individual's care or payment for care prior to the individual's death, PHI of the individual that is relevant to such person's involvement, unless doing so is inconsistent with any prior expressed preference of the individual that is known to us.

Will Health New England disclose my personal health information to anyone outside of Health New England?

We may share your protected health information with affiliates and third party "business associates" that perform various activities for us or on our behalf. For example, we may delegate certain functions, such as medical management or claims repricing, to a third party that is not affiliated with Health New England. We may also share your personal health information with an individual or company that is working as a contractor or consultant for Health New England. Our financial auditors may review claims or other confidential data in connection with their services. A contractor or consultant may have access to such data when they repair or maintain our computer systems. Whenever such an arrangement involves the use or disclosure of your protected health information, we will have a written contract that contains terms designed to protect the privacy of your protected health information.

We may also disclose information about you to your Primary Care Provider, other Providers that treat you and other health plans that have a relationship with you, and their business associates, for their treatment, payment and some of their health care operations.

Will Health New England disclose my personal health information to my employer?

In general, we will only release to your employer enrollment and disenrollment information, information that has been de-identified so that your employer can not identify you, or

summary health information. If your employer would like more specific PHI about you to perform plan administration functions, we will either get your written permission or we will ask your
employer to certify that they have established procedures in their group health plan for protecting your PHI, and they agree that they will not use or disclose the information for employment- related actions and decisions. Talk to your employer to get more details.

When does Health New England need my written authorization to use or disclose my personal health information?

We have described in the preceding paragraphs those uses and disclosures of your information that we may make either as permitted or required by law or otherwise without your written authorization. For other uses and disclosures of your PHI, we must obtain your written authorization. Among other things, a written authorization request will specify the purpose of the requested disclosure, the persons or class of persons to whom the information may be given, and an expiration date for the authorization. If you do provide a written authorization, you generally have the right to revoke it.

Your prior written authorization is required and will be obtained for: (i) uses and disclosures of psychotherapy notes; (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

Many Members ask us to disclose their protected health information to third parties for reasons not described in this notice. For example, elderly Members often ask us to make their records available to caregivers. To authorize us to disclose any of your protected health information to a person or organization for reasons other than those described in this notice, please call our Member Services Department and ask for an Authorization and Designation of Personal Representative Form. You should return the completed form to Health New England's Enrollment Department at One Monarch Place, Springfield, MA 01144-1500. You may revoke the authorization at any time by sending us a letter to the same address. Please include your name, address, Member identification number and a telephone number where we can reach you.

What are my rights with respect to my PHI?

The following is a brief statement of your rights with respect to your protected health information:

Right to Request Restrictions: You have the right to ask us to place restrictions on the way we use or disclose your protected health information for treatment, payment or health care operations or to others involved in your health care. **However, we are not required to agree to these restrictions.** If we do agree to a restriction, we may not use or disclose your protected health information in violation of that restriction, unless it is needed for an emergency.

Right to Request Confidential Communications: You have the right to request to receive communications of protected health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you. We will accommodate reasonable requests. Your request must be in writing.

Right to Access Your Protected Health Information: You have the right to see and get a copy

of the protected health information about you that is contained in a "designated record set," with some specified exceptions. You also have the right to request an electronic copy of PHI that we maintain electronically (ePHI) in one or more designated records sets. Your "designated record set" includes enrollment, payment, claims adjudication, case or medical management records and any other records that we use to make decisions about you. Requests for access to copies of your records must be in writing and sent to the attention of the Health New England Legal Department. Please provide us with the specific information we need to fulfill your request. We will provide ePHI in the electronic form and format requested by you, if it is readily producible in that format. We reserve the right to charge a reasonable fee for the cost of producing and mailing the copies.

Right to Amend Your Protected Health Information: You have the right to ask us to amend any protected health information about you that is contained in a "designated record set" (see above). All requests for amendment must be in writing and on a Health New England Request for Amendment form. Please contact our Legal Department to obtain a copy of the form. You also must provide a reason to support the requested amendment. In certain cases, we may deny your request. For example, we may deny a request if we did not create the information, as is often the case for medical information in our records. All denials will be made in writing. You may respond by filing a written statement of disagreement with us, and we would have the right to rebut that statement. If you believe someone has received the unamended protected health information from us, you should inform us at the time of the request if you want them to be informed of the amendment.

Right to Request an Accounting of Certain Disclosures: You have the right to have us provide you an accounting of times when we have disclosed your protected health information for any purpose other than the following:

i. Treatment, payment or health care operations.
ii. Disclosures to others involved in your health care.
iii. Disclosures to you or that you or your personal representative has authorized.
iv. Certain other disclosures, such as disclosures for national security purposes.

All requests for an accounting must be in writing. We will require you to provide us the specific information we need to fulfill your request. This accounting requirement applies for six years from the date of the disclosure, beginning with disclosures occurring after April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable fee.

Right to Request a Copy of this Notice: If you have received this notice electronically, you have the right to obtain a paper copy of this notice upon request.

Who should I contact if I have a question about this notice or a complaint about how HNE is using my personal health information? Complaints and Communications with Us

If you want to exercise your rights under this Notice, communicate with us about privacy issues, or if you wish to file a complaint with us, you can write to:

Health New England, Inc.
Complaints and Appeals
Department One Monarch Place
Springfield, MA 01144-1500

You can also call us at (413) 787-0010 or (877) 443-3314. You will not be retaliated against for filing a complaint with us.

Complaints to the Federal Government

If you believe your privacy rights have been violated, you also have the right to file a complaint with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint with the federal government.

Effective Date of Notice

This Notice takes effect on July 1, 2013. We must follow the privacy practices described in this Notice while it is in effect. This Notice will remain in effect until we change it. This Notice replaces any other information you have previously received from us with respect to privacy of your medical information.

Changes to this Notice of Privacy Practices

We may change the terms of this Notice at any time in the future and make the new Notice effective for all PHI that we maintain – whether created or received before or after the effective date of the new Notice. Whenever we make an important change, we will post the change or the revised Notice on our website by the effective date of the material change to the Notice, and provide the revised Notice, or information about the material change and how to obtain the revised Notice, in our next annual mailing to individuals then covered by the plan.

The Commonwealth of Massachusetts
Group Insurance Commission

(617)727-2310
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www.mass.gov/gic

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 continuation of health coverage. You will receive a COBRA election 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 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 556, Randolph, MA 02368 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 Qualifying Events:

If you are an employee of the Commonwealth of Massachusetts (the "Commonwealth") 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 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.

Additionally, you or other qualified beneficiaries may qualify for MassHealth (Medicaid), Medicare, or the Children's Health Insurance Program (CHIP) or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

IMPORTANT INFORMATION REGARDING MEDICARE

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

YOUR COBRA COVERAGE RESPONSIBILITIES

- **You must inform the GIC of any address changes to preserve your COBRA rights.**

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

- **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 556, Randolph, MA 02368.***

If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617/727-2310, ext. 1 or write to the Public Information Unit at P.O. Box 556, Randolph, MA 02368. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at **www.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**.

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