HEALTH NEW ENGLAND

MEMBER HANDBOOK FOR THE COMMONWEALTH OF MASSACHUSETTS

GROUP INSURANCE COMMISSION

EFFECTIVE JULY 1, 2019

Commonwealth of Massachusetts
Group Insurance Commission

EMPLOYEES
AND
RETIREES WITHOUT MEDICARE

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 (www.mahealthconnector.org).

This health plan **meets Minimum Creditable Coverage standards** that are in effect January 1, 2019 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, 2019. 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.

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	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើមបីដសនើស ំអ្នកបកប្រប សូមទូរស័ពទដៅដលខឥតដេញថ្លៃសំរាប់សមាជិក ឬ លមានកត់ដៅកនុងប័ណ្ណ ID គំដរាងស 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 क करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 7
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. ເພື່ອຂ ໍ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).

Member Handbook for the Commonwealth of Massachusetts
Group Insurance Commission
Active Employees and Retirees without Medicare – Effective July 1, 2019

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SECTION 1 – INTRODUCTION

HOW TO USE THIS MEMBER HANDBOOK

This Member Handbook describes benefits for you and your dependents covered under Health New England (HNE), 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 Health New England Advisory Services, Inc. (HNE).

Health New England provides administrative services to the GIC including claims processing, customer service, preapproval reviews and case management. HNE. Member Services Department is located at One Monarch Place, Suite 1500, Springfield, MA 01144.For your convenience, HNE's telephone numbers appear at the bottom of each page, along with our website. Our Member Services Representatives are available Monday through Friday, from 8:00 a.m. to 6:00 p.m.

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. This shaded box contains a summary of the most important things to know about that section. Words in this Handbook that begin with a capital letter may have a special meaning that is defined in the Definition section.

If you have any questions, please call us.

ABOUT HEALTH NEW ENGLAND (HNE)

Health New England is a Massachusetts licensed Health Maintenance Organization (HMO) servicing members in Berkshire, Franklin, Hampden and Hampshire Counties in Western Massachusetts. As a HMO this requires you and your dependents to get your care from specific doctors, hospitals, and other health care providers that are contracted with us. We call these providers "In-Plan Providers." HNE In-Plan Providers are independent contractors. HNE does not control the methods of In-Plan Providers use to perform their work or to provide services. To find out what hospitals, doctors, and providers are in our network, please go to Healthnewengland.org/GIC and click on provider search located at the bottom of the page.

We also make available printed provider directories upon request. The information in the provider directories and on our website are updated annually and as needed throughout the year. Please note, providers are free to join and leave our network at any time and HNE cannot guarantee the continued participation of any specific provider or group of providers listed in our directory.

YOUR PAYMENT RESPONSIBILITIES

With HNE, your monthly premium covers a large array of medical services, including preventive care when you are healthy and care when you are injured or sick. When you receive care from In-Plan Providers, you will not have to submit claim forms or pay bills. However, you do have payment responsibilities as explained below.

Health care is covered only when Medically Necessary and appropriate. Your Primary Care Provider must provide or arrange your care, except when otherwise stated in this Member Handbook.

For some services, you are responsible for meeting a Deductible before the Plan pays benefits. If you have individual coverage, you must meet the individual Deductible before the Plan begins paying benefits for those services. If you have family coverage (even just one person other than yourself), your family must satisfy the family Deductible before the Plan begins paying benefits for those services. However, once any member of the family pays

the individual Deductible amount towards the family Deductible, the Plan will begin paying benefits for that family member, even if the family Deductible has not yet been met.

The table below shows member payment responsibility in relation to the Individual and Family Deductible.

	Family Deductible not met	Family Deductible met
Individual Deductible not met	Deductible + Copayment/Coinsurance	Copayment/Coinsurance
Individual Deductible met	Copayment/Coinsurance	Copayment/Coinsurance

You must pay any Copay or Coinsurance for a service. If the Deductible applies to that service, you must pay the difference between your Copay or Coinsurance amount and the amount of Health New England's contracted payment to the provider until the Policy Year Deductible is satisfied. If the Deductible does not apply to a service, you will only be responsible for your Copay or Coinsurance, if any, for that service. Your Plan has two Copay levels (Tiers) for services from certain specialists.

The Plan has an Out-of-Pocket Maximum that includes the Deductible, Coinsurance and Copays for all in-network medical services including behavioral health. Once you have met this Out-of-Pocket Maximum, you will not have to pay Copays or Coinsurance for those services for the rest of the policy year. Other limits on the number of Copays per year you pay for inpatient admissions and outpatient surgery are explained in the "Covered Benefits" section of this Member Handbook.

The Chart of Benefits that starts on page 11 has specific information about your Deductible, Copays, Coinsurance and Out-of-Pocket Maximum.

Cost Estimator for Services & Out-of-Pocket Costs

HNE provides a tool to help you make the most effective choice on health care services. Our Cost of Care Calculator allows you to estimate the costs for medical treatment or services and know your cost. The tool informs you of:

- The estimated or maximum allowed amount or charge for a proposed admission, procedure or service.
- The estimated amount you will be responsible to pay for a proposed admission, procedure, or service. This includes any Deductible, Copay, Coinsurance, facility fee or other amount you pay. This will be based on the information HNE has at the time the request is made. The service must be a Medically Necessary covered benefit.

If you then receive the proposed health care services, your Member responsibility will be no more than the estimated amount. However, if unforeseen services arise out of the proposed admissions, procedure or service, you may have additional Cost Sharing as required by this HNE Plan.

To get cost estimates for health care services you can:

- Register or log on to our member portal at my.healthnewengland.org, from the "coverage" menu, click "Cost of Calculator."
- Call HNE Member Services toll free at (800) 310-2835. TTY users call 711.
- Email us at memberservices@hne.com.

SECTION 2 – HOW TO OBTAIN BENEFITS

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- You must choose a Primary Care Provider (PCP).
- If you need care, call your PCP.
- There are two levels (or Tiers) of Copays for services from certain specialists.
- You do not need a referral for specialty care from In-Plan Providers.
- Always show your HNE ID card when receiving services.
- In an emergency, you may go straight to the emergency room (ER). If there is time, call your PCP first.
- If you do not follow the rules described in this Member Handbook, you may lose all or part of your coverage for that service or supply.

CHOOSING YOUR PRIMARY CARE PROVIDER (PCP)

Why must I choose a PCP?
Choosing a PCP is the first and most important decision you must make when you join HNE. Your PCP is the first person you should call when you need medical care. A PCP may be a doctor, a participating Pediatric, Adult or Family Nurse Practitioner or a participating Physician Assistant (PA). You may choose a different PCP for each member of your family. HNE's Provider Directory lists PCPs, their locations, and phone numbers. You can get a copy of our Provider Directory by calling HNE Member Services, or visit our website.

If you choose a PCP that you have not seen before, we suggest you do the following:

- Call your PCP's office as soon as possible and tell the staff you are a new HNE Member.
- Make an appointment to see your new PCP so he or she can get to know you and begin taking care of any of your medical needs. You do not have to wait until you are sick to make this appointment. You should get to know your doctor as soon as possible.
- Ask your previous doctor(s) to send your medical records to your new PCP.

You must choose a PCP so that HNE can process your claims for benefits correctly. We will notify you in writing if your PCP stops being an In-Plan Provider. You will then need to select a new PCP. Please note that HNE does not cover services that you receive from an In-Plan PCP who is not listed by HNE as your PCP or your PCP's covering doctor.

What can I do if I am not happy with my PCP?
You can change your PCP by calling our Member Services Department. PCP changes will be effective on the next business day after your request. You may change to any PCP, unless the newly chosen doctor has notified HNE that he or she is no longer accepting new patients.

Can my PCP decide to transfer me to someone else?
Yes. Your PCP may request that you transfer to another In-Plan Doctor. HNE does not allow transfers based on the amount of medical services required by a Member or the physical condition of a Member. Your PCP must ask for HNE's approval before requesting a transfer to a new PCP. Your PCP must send you a letter requesting that you choose another PCP.

HOW TO OBTAIN MEDICAL CARE FROM AN IN-PLAN PROVIDER

How do I get medical care?
Call your PCP. It is your PCP's duty to provide or arrange most of your medical care. The services you receive must be Medically Necessary. Care by Out-of-Plan Providers must be approved, in advance, by HNE.

Do I need my Identification Card to receive care?
Yes. You must present your HNE ID Card to receive medical services. Your HNE ID Card provides important information, such as: HNE's mailing address and telephone number; Subscriber name; Group number; benefit plan, including some Copay amounts; identification number; as well as the name, and Member number of each person covered. Having an HNE ID Card does not guarantee you coverage for services. To receive covered services, you must be an HNE member at the time you receive the service. If you permit others to use your HNE ID Card to obtain services to which they are not entitled, your coverage may end. You should report the loss or theft of your HNE ID Card to HNE Member Services as soon as possible. You may only use the most recent card provided to you by HNE.

You will also receive a prescription drug card from Express Scripts. A welcome packet and Express Scripts Prescription Member Identification card will be mailed to you along with cards for your dependents, a drug list and mail order claim form. For more information, please see the "Your Prescription Drug Plan" booklet at the end of this handbook.

What if I need Non-Emergency care after normal business hours?
At HNE, we know that medical problems may occur at any time — day or night. That is why we ask our PCPs to be on call 24 hours a day, seven days a week. You should talk to your PCP to find out about arrangements for care after normal business hours. At times, you may reach your PCP's answering service. You may also reach the doctor who is on call for your PCP. If you reach an answering service, here is what to do:

1. Say that you are an HNE Member
2. Give your name and phone number
3. Describe your symptoms
4. Ask your doctor or the on-call doctor to call you back

How do I get specialty care?
For In-Plan specialty services, you do not need a referral. Just make your appointment, present your HNE ID card, and pay your usual Copay. **See "Important Information about Copay Tiers" on page 5.**

To find out about obtaining behavioral health or substance use disorder services, see *"How to Get Behavioral Health or Substance Use Disorder Services"* later in this section.

It is your responsibility to make sure that any doctor you see on recommendation from your PCP is an HNE In-Plan Doctor. ***If you are not sure, check the Plan Provider Directory, visit the HNE website, or call HNE.***

Can I get podiatry services from a podiatrist?
HNE does not cover routine foot care, such as care of corns, calluses, and trimming of nails, unless you are a diabetic. However, other covered podiatry services, such as the treatment of podiatric diseases and conditions, are available from an In-Plan podiatrist. For additional information, see the *"Exclusions and Limitations"* section of this Member Handbook.

What do I do if I need to go into the hospital?
For non-emergency care, talk to your PCP or treating In-Plan Provider. If you need to be admitted to a hospital, your PCP or treating In-Plan Provider will make the necessary hospital arrangements and supervise your care. Except in Emergencies, your treating In-Plan Provider must get HNE's Prior Approval before admitting you to an Out-of-Plan hospital.

How much do I pay for services?
Some HNE services are free of charge. For most services, however, you pay a set dollar amount. This is called a Copay. For some services you pay a percentage of the total payment to the provider. This is called Coinsurance. Copays and Coinsurance are listed in the "Covered Benefits" section of this Member Handbook. **Also, see "Important Information about Copay Tiers" on page 5.** Please remember that, in general, you must pay any Copays at the time you receive services. Some services are subject to a Deductible. **Other than Copays, Coinsurance and the Deductible, In-Plan Providers cannot bill you for Covered Services. If you do not understand a bill you get from an In-Plan Provider for a Covered Service that you received, please call HNE's Member Services Department.**

Do I have to submit claims?
For In-Plan Providers, you do not have to submit claims to HNE. In-Plan Providers do this for you. If you receive services from an Out-of-Plan Provider, show your HNE ID Card. Most providers will bill HNE directly. If possible, ask the Out-of-Plan Provider to submit a standard medical claim form to HNE.

IMPORTANT INFORMATION ABOUT COPAY TIERS FOR SPECIALISTS

Copays for Specialists

There are different levels (or tiers) of copays for office visits with specialist physicians. You pay a copay amount based on the tier assignment of the doctor you visit. Tier assignments are included in the provider listings in the HNE Provider Directory.

Tier 1: Specialists other than those who are at Academic Medical Centers (AMC) – **$30**

Tier 2: Specialists at Academic Medical Centers (AMC) – **$60**

(An AMC has two components: a teaching or university-based hospital and a medical school)

Copays for Gastro Intestinal and Eye Procedures at Ambulatory Surgical Centers (ASCs)

There are different levels of copays for gastro intestinal and eye procedures (including diagnostic procedures) at an Ambulatory Surgical Center.

- **Freestanding ASCs** listed in the Health New England Provider Directory – **$150**
- **Hospital Outpatient Surgical Facilities** – **$250**

For all other procedures that take a copay at a freestanding ASC or a hospital outpatient surgical facility, the copay is $250.

You can also get information on a specialist's Tier assignment by calling Health New England Member Services at (800) 310-2835 (TTY: 711) or via our website at www.healthnewengland.org.

HOW TO OBTAIN MEDICAL CARE FROM AN OUT-OF-PLAN PROVIDER

What if I need to receive specialty care that is not available from an In-Plan Provider?
HNE contracts with a broad network of providers. Most of the time, the care you need will be available locally. Sometimes, however, you may need care outside of the HNE network. For example, if you need highly specialized care that is not available from In-Plan Providers, your doctor may request to send you to an Out-of-Plan Provider.

Our Member Services Department can get you going in the right direction. Simply contact Member Services at (413) 787-4004 or (800) 310-2835 (TTY: 711). Our staff will tell you if you can get the right care close to home. If not, we will explain what you need to do to get the services you need.

In order to receive specialty care from an Out-of-Plan Provider, you must first have the approval of HNE. In general, most health care services can be provided by HNE In-Plan Providers. Therefore, before HNE will consider a request for you to see an Out-of-Plan Provider, you must first have your PCP refer you to an In-Plan Specialist. If HNE determines that there is no appropriate In-Plan Specialist available to treat you, HNE may authorize treatment from an Out-of-Plan Provider.

To initiate this process, your PCP or treating In-Plan Provider must submit a Prior Approval Request Form to HNE. HNE will notify you and your doctor in writing of its decision to approve or not approve the services from an Out-of-Plan Provider. If you have not received a response from HNE, you should call HNE to determine whether HNE has approved your request. You should not make an appointment with the Out-of-Plan Provider before you receive HNE's response. **Please note:** HNE does not verify the credentials of Out-of-Plan Providers. Only In-Plan Providers go through HNE's credentialing process.

Reimbursement for Covered Services Received from Out-of-Plan Providers
If you have paid for Covered Services from an Out-of-Plan Provider and want to be reimbursed, you must submit a claim to HNE. To submit a claim, you must use a "Member Reimbursement Medical Claim Form." Instructions for submitting a claim are on the Claim Form. To get a Claim Form, visit www.healthnewengland.org or call Member Services.

Claims for member reimbursement for services from Out-of-Plan providers must be received by HNE within one year from the date of the services. Member Cost Sharing will apply to services from Out-of-Plan providers.

HNE may require you to supply documents that show the services you received were Medically Necessary and/or Covered Services under your plan. If HNE determines that the services you received were not Covered Services or were not Medically Necessary, we may deny coverage. If HNE denies coverage, you will be responsible for the cost of the services.

Please note: You are covered for services from Out-of-Plan Providers only in an emergency or when you have Prior Approval from HNE for the services.

HOW TO OBTAIN CARE IN AN EMERGENCY

What is an Emergency?
Massachusetts law defines an "Emergency" as follows:

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

Stated simply, an Emergency is a medical condition that you believe will place your life or health in serious danger if you do not receive immediate medical attention. In an Emergency, go to the nearest emergency facilities, call 911, or call your local emergency number. You are always covered for care in an Emergency. Your Primary Care Provider will arrange for any follow-up care you may need. Some problems are Emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Other problems are Emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisoning, inability to breathe, severe bleeding, loss of consciousness, and severe trauma. What all Emergencies have in common is a serious threat to health and the need for quick action.

Routine care, care that is not required immediately, or care of minor illnesses or injuries are not Emergencies. Examples of routine care or minor illnesses that are *not* Emergencies are: colds, minor sore throats, injuries of more than 24 hours' duration, or persistent or chronic illness treatable by your PCP.

All Members have the opportunity to obtain health care services for an Emergency Medical Condition. This includes the options of going to the nearest emergency facility, calling the local pre-hospital emergency medical service system, or dialing the emergency telephone access number (911), or its local equivalent, whenever you are confronted with an Emergency Medical Condition which, in the judgment of a prudent layperson, would require pre-hospital Emergency services.

No Member will be discouraged in any way from using emergency facilities, local pre-hospital emergency medical service systems, or the 911 telephone number, or the local equivalent.

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

What should I do in an Emergency?
You always have coverage for care in an Emergency. You do not need a referral from your PCP. However, in all cases, if your situation allows, call your PCP first. Say that you are an HNE Member and clearly state your symptoms. Your PCP may ask you to go to an emergency room or ask you to visit a doctor's office. Your PCP or a covering doctor is on call 24 hours a day, seven days a week.

If you do not have time to call your PCP, follow these rules:

When an Emergency Occurs:

- **Seek medical care at once. Go to the nearest emergency room (ER) or dial "911". (If two hospitals are equally close, use an In-Plan Hospital listed in the Plan Provider Directory.)**
- **Contact your PCP to notify him or her of your visit and to arrange for any follow-up care**

If you are admitted to a hospital on an inpatient basis directly from the emergency room, you will not have to pay the emergency room Copay. However, you will have to pay any applicable hospital admission Copay.

What if I am out of the HNE Service Area when an Emergency occurs?
If you are out of the HNE Service Area when an Emergency occurs, the guidelines listed above still apply. Call HNE Member Services to notify us of any Emergency services *not* received in a hospital emergency room (for example, at a walk-in clinic or physician's office). You should also be aware that HNE does not cover routine care, elective surgery, or care that you could have foreseen before leaving the HNE Service Area. In addition, your PCP must coordinate your follow-up care. HNE does not cover care (including follow-up care) you receive outside the Service Area once you are medically able to return to the HNE Service Area.

What if I am admitted to an Out-of-Plan hospital directly from the Emergency Room?
If you are admitted to an Out-of-Plan hospital directly from the Emergency Room, you must contact HNE to report the admission or someone must do this for you. Services from an Out-of-Plan hospital will be covered only until you are medically able to return to the HNE Service Area or be transferred to an In-Plan Hospital. Any admission to an Out-of-Plan hospital will be subject to concurrent and retrospective review procedures (see page 66). Your payment responsibility for an approved emergency admission to an Out-of-Plan hospital will be the same as for an admission to an In-Plan Hospital.

What should I do if I am in an auto accident?
If you are in an auto accident, you should follow the rules in this Member Handbook, including the rules for obtaining care in an Emergency. Remember that your PCP should coordinate all follow-up care. You must receive follow-up care from an In-Plan Provider. For more information, please see the *"Coordination of Benefits and Subrogation"* section of this Member Handbook. If you are not sure if the Provider that you are being referred to is an In-Plan Provider, please check your Provider Directory, visit our website, or call our Member Services Department.

HOW TO GET BEHAVIORAL HEALTH OR SUBSTANCE USE DISORDER SERVICES

Outpatient Services
To get outpatient treatment for behavioral health or substance use disorder services:

- Call the In-Plan Provider of your choice directly. Your doctor, a family member, or your In-Plan Provider may also call for you.
- You do not have to contact HNE before receiving services.

- You do not need Prior Approval for medication management services with an In-Plan psychiatrist or clinical nurse specialist.

To look up In-Plan behavioral health providers, please check your Provider Directory, visit www.healthnewengland.org or call HNE Member Services at (413) 787-4004 or (800) 310-2835 (TTY: 711). If you need help choosing a provider, you may call HNE's Health Services department at (413) 787-4000 ext. 5028, or (800) 842-4464 ext. 5028. Our staff can help you choose a provider based on the nature of your concerns, your location, and appointment availability.

Inpatient Services

Inpatient admissions do not require Prior Approval from HNE. The admitting facility must contact HNE's Health Services department within one business day to obtain authorization for continued stay. For information please call HNE's Health Services department at (413) 787-4000 ext. 5028, or (800) 842-4464 ext. 5028.

Emergency care

If you need behavioral health or substance use disorder emergency care, follow the steps listed under the heading *"How to Obtain Care in an Emergency"* in the "How to Obtain Benefits" section of this Member Handbook.

For detailed information on benefits for behavioral health and substance use disorder services, please see the *"Covered Benefits"* section of this Member Handbook.

Employee Assistance Program (EAP) Benefits

If you have a question about Employee Assistance Program (EAP) benefits	
Optum (844) 263-1982 www.liveandworkwell.com (*Website Access Code: Mass4You*)	▪ What your Employee Assistance Program (EAP) benefits are ▪ The status of (or a question about) an EAP claim

SECTION 3 – COVERED BENEFITS

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- To be covered, care must be Medically Necessary and appropriate and, unless approved in advance by your PCP and HNE, provided by an In-Plan Provider.
- Some services are *not* covered.
- For some services, you are responsible for meeting a Deductible before the Plan pays benefits. Copays and Coinsurance do not count toward the Deductible.
- Many services require you to pay a Copay at the time of service.
- There are two levels (or Tiers) of Copays for specialists and ambulatory surgery copays.
- Some services require you to pay Coinsurance.

HNE covers the services and supplies described in this section only if they are Medically Necessary and appropriate. Your PCP must provide or arrange most of your health care following HNE policies and rules. Treatment by an Out-of-Plan Provider requires the advance written approval of both your PCP (or treating In-Plan Provider) *and* HNE. The only exceptions are the Emergency situations described in this Member Handbook.

All covered care is subject to the conditions in this Member Handbook. You should read the *"Exclusions and Limitations"* section of this Member Handbook to learn more about care that is limited or excluded. HNE does not pay for medical care unless it is a Covered Benefit as described in this Member Handbook. HNE also does not cover medical care that is not provided and obtained as required by this Member Handbook.

CHART OF BENEFITS

The chart on the following pages is only a summary guide that we have included to assist you in locating certain benefits. The detail for each of these benefits, including any limitations or exclusions associated with the benefit, can be found on the pages referenced. You are responsible for the Deductible and Copays listed on the Chart of Benefits.

DEDUCTIBLE

For some services, you are responsible for meeting a Deductible before the Plan pays benefits. If you have individual coverage, you must meet the individual Deductible before the Plan begins paying benefits for those services. If you have family coverage (even just one person other than yourself), your family must satisfy the family Deductible before the Plan begins paying benefits for those services. However, once any member of the family pays the individual Deductible amount towards the family Deductible, the Plan will begin paying benefits for that family member, even if the family Deductible has not yet been met.

You must pay any Copay or Coinsurance for a service. If the Deductible applies to that service, you must pay the difference between your Copay or Coinsurance amount and the amount of Health New England's contracted payment to the provider until the Policy Year Deductible is satisfied.

COPAYS

The Chart of Benefits lists the Copay, if any, for each service. The Copay is the amount that you must pay when receiving Covered Services.

Your Copay for the specialists depends on the specialist's Tier assignment. Your plan has the following two levels (or Tiers) of Copay for services:

Tier 1 – Copay will be $30
Tier 2 – Copay will be $60

For more information please see “Important Information about Copay Tiers for Specialists” on page 5.

IN-NETWORK OUT-OF-POCKET MAXIMUM

The Plan has an Out-of-Pocket Maximum that includes Copays, Coinsurance and the Deductible for all in-network medical services including pharmacy and behavioral health. Once you have met this Out-of-Pocket Maximum, you will not have to pay Copays or Coinsurance for in-network medical services for the rest of the Policy Year. Other limits on the number of Copays per you pay for inpatient admissions and outpatient surgery are shown in the Chart of Benefits on the following pages.

INPATIENT COPAY WAIVER

There is a maximum of four inpatient admission Copays per year (one Copay per quarter). If you have paid an inpatient Copay for an admission and are then readmitted to a hospital within 30 days of discharge from the previous admission, the Copay for the readmission may be waived. Both admissions must take place during the same Policy Year. For example, if you are admitted to a hospital in June and then again in July that same year, the Copay for the July admission cannot be waived. The readmission does not have to be to the same hospital as the first admission. The inpatient Copay waiver applies only to acute hospital care and does not apply to inpatient rehabilitation care.

Important Note: This inpatient Copay waiver is not automatic. You must call HNE Member Services to request a waiver of the inpatient Copay.

Medical Deductible

- For some services, members are responsible for meeting a Policy Year Deductible before the plan pays benefits. This deductible is: **$400 per individual Member / $800 per family**.
- **You must pay any Copay or Coinsurance for a service**. If the deductible applies to that service, you must pay the difference between your Copay or Coinsurance amount and the amount of Health New England's contracted payment to the provider until the Policy Year Deductible is satisfied.
- The chart below shows whether or not this deductible applies. **Important Note:** Ancillary services such as tests and procedures performed during an office visit may be subject to the deductible, even if the visit itself is not subject to the deductible.
- The deductible does not apply to prescription drugs.

Prescription Drug Deductible

- You pay all costs for prescription drugs from an In-Plan pharmacy until you reach a deductible of $100 per individual member or $200 per family.
- After you reach your prescription drug deductible, for the rest of the year you will only have to pay the Copays shown below. Each copay is for up to a 30-day supply of prescription drugs from an In-Plan pharmacy.
- The Deductible for prescription drugs is separate from the deductible your plan has for medical services.
- Prescription Drug Benefits are administered by Express Scripts Inc.

In-Network Medical Out-of-Pocket Maximum

- The out-of-pocket maximum includes copays, coinsurance and deductible for all in-network medical services including pharmacy and behavioral health. Once you have met the out-of-pocket maximum, you will not have to pay copays or coinsurance for these services for the rest of the policy year.
- The out-of-pocket maximum is **$5,000 per individual member / $10,000 per family.**

BENEFIT	Deductible Applies	Copay
Inpatient Care		
Acute Hospital Care	Yes	$275/admission † ‡
Inpatient Rehabilitation	Yes	$275/admission †

† Maximum of one inpatient admission Copay per quarter.

‡ If you have paid an inpatient Copay for an admission and are then readmitted to a hospital within 30 calendar days of discharge from the previous admission, the Copay for the readmission is waived if both admissions occur during the same Policy Year. See page 11 for details.

BENEFIT	Deductible Applies	Copay
Skilled Care Facility *(maximum of 100 days per Policy Year)*	Yes	$0
Outpatient Preventive Care		
Adult Routine Physical Exams by your PCP	No	$0
Pediatric Preventive Care	No	$0
Annual Gynecological Exam	No	$0
Screening Mammographic Exam	No	$0
Medically Necessary Adult and Child Immunizations by your PCP	No	$0
Screening colonoscopy	No	$0
Nutritional Counseling *(maximum of four visits per Policy Year)*	No	$0
Other Outpatient Care		
PCP Office Visits	No	$20/visit
Specialist Office Visits	No	Tier 1: $30/visit Tier 2: $60/visit
Second Opinions	No	Tier 1: $30/visit Tier 2: $60/visit
Telephone and video consultations with internists, family practitioners, pediatricians, behavioral health and urgent care services for non-emergency medical conditions through Teladoc™	No	$15/consultation
Routine Eye Exams *(one each 24 months)*	No	$20/visit

BENEFIT	Deductible Applies	Copay
Hearing Tests in your PCP's office	No	$20/visit
Diabetic-Related Items		
Endocrinology Specialist Office Visits	No	Tier 1: $30/visit Tier 2: $60/visit
Laboratory/Radiological Services	Yes	$0
Durable Medical Equipment *(diabetic-related; require Prior Approval)*	No	$0
Individual Diabetic Education	No	$20/visit
Group Diabetic Education	No	$20/session
Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder	No	$0
Urgent Care Center or retail clinic visits	No	$20/visit
Emergency Room Care *(Copay waived if admitted directly from ER)*	Yes	$100/visit
Diagnostic Testing *(some services may be subject to the Outpatient Surgical Services and Procedures copay. Not all services are subject to a copay.)*		
In a PCP's Office	Yes	$20/visit
In a Specialist's Office	Yes	Tier 1: $30/visit Tier 2: $60/visit
In All Other Settings	Yes	$150/visit for freestanding Ambulatory Surgical Center (ASC) facilities (GI/Eye Procedures Only) $250/visit for hospital outpatient facilities§
Laboratory Services	Yes	$0

BENEFIT	Deductible Applies	Copay
Radiological Services: Ultrasound, X-rays, Nuclear Cardiology (*Nuclear Cardiac Imaging requires Prior Approval*)	Yes	$0
Advanced Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans *(requires Prior Approval)*	Yes	$100/scan (maximum one copay per day)
Outpatient Short-Term Rehabilitation Services *(Physical and occupational therapy; covered for 90 days per acute episode, per Policy Year. The limit does not apply when services are provided to treat Autism Spectrum Disorder.*)	No	$25/visit/treatment type
Day Rehabilitation Program *(limited to 15 full day or half day sessions per condition per lifetime)*	No	$25/day or half day
Early Intervention Services *(covered for children from birth to age 3)*	No	$0
Outpatient Surgical Services and Procedures *(some services require Prior Approval)*		
In a PCP's Office	Yes	$20/visit
In a Specialist's Office	Yes	Tier 1: $30/visit Tier 2: $60/visit
All Other Settings	Yes	$150/visit for freestanding Ambulatory Surgical Center (ASC) facilities (GI/Eye Procedures Only) $250/visit for hospital outpatient facilities[§]
Allergy Testing and Treatment in an Allergist's Office	No	Tier 1 $30/visit Tier 2 $60/visit; $0 for injection

[‡] If you have paid an inpatient Copay for an admission and are then readmitted to a hospital within 30 calendar days of discharge from the previous admission, the Copay for the readmission is waived if both admissions occur during the same Policy Year. See page 11 for details.

BENEFIT	Deductible Applies	Copay
Infertility Services *(Some infertility treatments require Prior Approval. Some Assisted Reproductive services consist of outpatient surgical procedures. If members receive these services applicable outpatient surgical services and procedures Copays will apply.)*		
Office Visits *(Deductible may apply to some office services)*	No	Tier 1 $30/visit Tier 2 $60/visit
Outpatient Care	Yes	Tier 1 $30/visit Tier 2 $60/visit
Laboratory Tests	Yes	$0
Inpatient Care	Yes	$275/admission † ‡
Maternity Care		
Routine Prenatal and Postpartum Care	No	$0
Delivery/Hospital Care for Mother and Child *(Coverage for child limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 30 days of date of birth.)*	Yes	$275/admission † ‡
Dental Care		
Surgical Treatment of Non-Dental Oral Conditions and Emergency Dental Care		
In a Specialist's Office	Yes	Tier 1 $30/visit Tier 2 $60/visit
At an Emergency Room	Yes	$100/visit

§ Maximum of four outpatient surgery Copays per Policy Year.

† Maximum of one inpatient admission Copay per quarter.

‡ If you have paid an inpatient Copay for an admission and are then readmitted to a hospital within 30 calendar days of discharge from the previous admission, the Copay for the readmission is waived if both admissions occur during the same Policy Year. See page 11 for details.

BENEFIT	Deductible Applies	Copay
Hospital Inpatient	Yes	$275/admission † ‡
Outpatient Surgical Facility	Yes	$250/visit §
Other Services		
Home Health Care *(requires Prior Approval)*	Yes	$0
Hospice Services	Yes	$0
Durable Medical Equipment and Prosthetic Equipment *(some items require Prior Approval)*	Yes	20% Coinsurance
Scalp Hair Prostheses (Wigs) for hair loss due to treatment of any form of cancer or leukemia (*Health New England covers one prosthesis per Policy Year)*	No	$0
Emergency Ambulance and Chair Van Services	Yes	$0 after deductible
Non-Emergency Ambulance and Chair Van Services *(requires Prior Approval)*	Yes	$25/member/day
Reconstructive or Restorative Surgery	Yes	$275/admission † ‡
Kidney Dialysis	No	$0
Human Organ Transplants and Bone Marrow Transplants *(requires Prior Approval)*	Yes	$275/admission † ‡

§ Maximum of four outpatient surgery Copays per Policy Year.

† Maximum of one inpatient admission Copay per quarter.

‡ If you have paid an inpatient Copay for an admission and are then readmitted to a hospital within 30 calendar days of discharge from the previous admission, the Copay for the readmission is waived if both admissions occur during the same Policy Year. See page 11 for details.

BENEFIT	Deductible Applies	Copay
Nutritional Support *(requires Prior Approval)*	Yes	$0
Cardiac Rehabilitation	No	$20/visit
Speech, Hearing, and Language Disorders *(requires Prior Approval after the initial evaluation)*	No	$20/visit
Coronary Artery Disease Program *(Provided for members with documented coronary artery disease, this program helps participants reduce coronary artery disease risk factors through lifestyle changes. The program must be authorized by your PCP.)*	Yes	10% Coinsurance
Hearing aids		
Members 21 and under *(Health New England 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. Prior Approval is required.)*	No	100% coverage up to $2,000 per device per ear (you are responsible for all costs beyond maximum)
Members over 21 years' old *(Health New England reimburses for hearing aids at 100% for the first $500 and 80% for the next $1,500 per person, up to a maximum of $1,700,* ***every two Policy Years.)***	No	100% coverage for the first $500 and 80% for the next $1,500 per person, every two Policy Years
Behavioral Health Services (Behavioral Health and Substance Abuse) *(Some services may require Prior Approval)*		
Inpatient Services	Yes	$0
Intermediate Services *(such as Partial Hospitalization)*	Yes	$0
Outpatient Services	No	$20/visit
Chiropractic Care		
Chiropractic Care (limited to 20 visits per plan year) *(children under age 13 require Prior Approval)*	No	$20/visit

BENEFIT	Deductible Applies	Copay
This benefit is administered by OptumHealth Care Solutions, Health New England's chiropractic services manager.		
What your plan covers	• We cover up to 20 visits per plan year for medically necessary chiropractic services. • When you receive services, your In-Plan chiropractor must notify OptumHealth Care Solutions. OptumHealth Care Solutions will work with your In-Plan chiropractor to determine the appropriate level of covered services to treat your condition. If your chiropractor does not notify OptumHealth Care Solutions, the service will not be covered. • We will cover your visits with an In-Plan chiropractor. A $20 Copay applies for each visit.	
For more information or to find a provider	*On the web:* You can find information about OptumHealth participating chiropractors through our web site. • Go to healthnewengland.org/provider-search • Go down to "Find a Chiropractic Provider" and click Search *On the phone:* • Call Health New England Member Services at (413) 787-4004 or (800) 310-2835 • Call OptumHealth Care Solutions at (888) 676-7768	

INPATIENT CARE

If you need to be admitted to a hospital, your PCP or treating In-Plan Provider will make the arrangements for your care. He or she will coordinate any diagnostic or pre-admission work-ups. There is a maximum of one inpatient admission Copay per quarter.

A. Acute Hospital Care: **You Pay… $275 †**

HNE covers acute hospital care to the extent Medically Necessary. There is no limit on the number of days covered per Policy Year. If you have paid an inpatient Copay for an admission and are then readmitted to a hospital within 30 days of discharge from the previous admission, the Copay for the readmission can be waived if both admissions occur during the same Policy Year. See page 10 for details.

B. Skilled Nursing Care Facility: **You Pay… $0**

HNE covers non-Custodial Care in a facility licensed to provide skilled nursing care on an inpatient basis. (For a definition of Custodial Care, see the "*Definitions"* section of this Member Handbook.) HNE covers up to a maximum of 100 days per Policy Year for care you receive in a skilled nursing care facility. Services will only be covered when you need daily skilled care that must be provided in an inpatient setting. All skilled care is subject to HNE's ongoing medical review for medical necessity.

C. Rehabilitation Care Facility: **You Pay… $275 †**

HNE covers non-Custodial Care in a facility, or part of one, licensed to provide rehabilitative care on an inpatient basis. There is no limit on the number of days covered per Policy Year. Services will only be covered when you need daily rehabilitative services that must be provided in an inpatient setting. All rehabilitative care is subject to HNE's ongoing medical review for medical necessity.

WHAT IS COVERED *(for inpatient care):*

Admission into any inpatient facility includes, but is not limited to, the following services:

- Semi-private room and board
- Private room (when Medically Necessary and ordered by a doctor)
- Physician and surgeon services
- General nursing services
- Laboratory and pathology services
- Intensive care
- Coronary care
- Dialysis services
- Short-term rehabilitation services

WHAT IS NOT COVERED:

Items or services that are not covered under the inpatient care benefit include, but are not limited to, the following:

- Personal or comfort items, including telephone and television charges, during hospitalization or as an outpatient
- Rest or Custodial Care or long-term care
- Blood or blood products, this includes the cost of donating blood for use during surgery or medical procedures. Blood products do not include Antihemophilic Factor (Recombinant), e.g. factors VII and VIII.
- Charges after the date on which your membership ends
- Unskilled nursing home care
- Any additional charges incurred for a patient who remains in the hospital for his/her convenience beyond the discharge hour.

† Maximum of one inpatient admission Copay per quarter.

OUTPATIENT PREVENTIVE CARE

HNE covers outpatient care that you receive from your PCP or an In-Plan Specialist at a doctor's office or in a hospital.

A. Preventive Care: **You Pay…$0 per visit**

HNE covers preventive care according to your individual medical needs. Your PCP generally provides these services.

1. **Routine Exams**
   HNE covers Routine health exams for adults and children over age 6.

2. **Well Child (Pediatric) Care**
   From birth to age 6, HNE covers "well child care." HNE covers exams including:
   - Physical exams
   - History
   - Measurements
   - Sensory screening
   - Neuropsychiatric evaluation
   - Developmental screening and assessment

   HNE covers exams:
   - Six times during the child's first year of life
   - Three times during the next year
   - Once per year until age 6

   For newborns, HNE covers:
   - Screening for inherited diseases
   - Metabolic screening
   - Newborn hearing tests

   HNE also covers these tests recommended by your doctor:
   - TB
   - Hematocrit
   - Hemoglobin
   - Lead screening under state law
   - Other appropriate blood tests and urine tests

3. **Routine Prenatal & Postpartum Care**
   HNE covers routine prenatal and postpartum care. For more information, see "Maternity Care" later in this section.

4. **Routine Child and Adult Immunizations**
   HNE covers immunizations based on guidelines published by the Massachusetts Health Quality Partners (MHQP) or other state of federal guidelines. Information about MHQP's guidelines is at mhqp.org, under the tab for guidelines. HNE provides Subscribers with the updated guidelines we use on an annual basis.

WHAT IS COVERED:

- MHQP immunizations
- Some Non-Routine immunizations, such as for:
- Exposure to rabies
- Exposure to hepatitis
- Many travel immunizations
- Zostavax® vaccine for the prevention of shingles (herpes zoster)
    - Covered for members 60 years of age and older.

5. **Annual GYN Exams**
   HNE covers one Routine GYN exam per Policy Year. We cover a Pap smear (cytology) and pelvic exam. In addition, HNE covers any subsequent obstetric or GYN services determined by that provider to be Medically Necessary because of such exam. (You may schedule your exam by calling an In-Plan OB/GYN.)

6. **Breast Cancer Screening**
   HNE covers mammographic exams, or mammograms, as follows:
   - One baseline mammogram for women 35 – 40
   - Once per year for women 40 and older
   - At other times when Medically Necessary

   (NOTE: HNE will waive the Deductible for mammograms by an In-Plan Provider one time each Policy Year.)

7. **Cervical Cancer Screening**
   HNE covers one Routine GYN exam per Policy Year. Coverage includes a Pap smear (cytological screening) and pelvic exam.

8. **Colorectal Cancer Screening**
   HNE covers fecal occult blood tests for colorectal cancer screening.

9. **Screening Colonoscopy or Sigmoidoscopy**
   HNE covers one screening colonoscopy or sigmoidoscopy every five Policy Years.

10. **Prostate Cancer Screening**
    HNE covers PSA tests for prostate cancer screening.

11. **Heart and Vascular Diseases Screening**
    HNE covers heart and vascular diseases screenings for lipid disorders.

12. **Infectious Diseases Screening**

    HNE covers infectious diseases screening for chlamydial infection and Human Immunodeficiency Virus (HIV) infection.

13. **Musculoskeletal Disorders Screening**

    HNE covers screening for osteoporosis.

14. **Low-dose Computed Tomography Screening for Lung Cancer**
    HNE covers screening for lung cancer with low-dose computed tomography. The screening is covered only for adults ages 55 to 80. Members must be in a high risk category for developing lung cancer. The screening must be approved by the vendor HNE uses to review high cost imaging services.

    These services can be best provided at a facility with a lung cancer program. HNE has determined which facilities have such a program. When the screening is done at one of these facilities, the Member will not be responsible for a Deductible or Copay. If the screening is done at any other facility, the services will be covered subject to Deductible and Copay. You can contact Member Services to find out what facilities HNE has specified for these services.

15. **Obstetric and Gynecological Conditions Screening**
    HNE covers screening for obstetric and gynecological conditions. This includes:
    - Screening for neural tube defects
    - RH incompatibility
    - Rubella
    - Ultrasonography during pregnancy

16. **Women's Preventive Health Services**
    HNE covers the preventive health services listed below. For services provided by an In-Plan Provider, the services are covered in full. There is no Copay, Coinsurance, or Deductible for these services when provided In-Plan.
    - Well-women visits
    - Screening for gestational diabetes
    - Human papillomavirus (HPV) testing
    - Counseling for sexually transmitted infections
    - Counseling and screening for human immunodeficiency virus (HIV)
    - Contraceptive methods and counseling (Full coverage is limited to certain contraceptive methods, certain generic prescription drugs, and certain devices.)
    - Breastfeeding support, supplies, and counseling
    - Screening and counseling for interpersonal and domestic violence.

17. **Nutritional Counseling**

    HNE covers up to a maximum of four outpatient visits per Policy Year for nutritional counseling.

    NOTE: Treatment of medical complications that are the result of preventive services or procedures are covered – however, you may have a Copay or Coinsurance and/or be responsible for a Deductible. This is the case even if the preventive service or procedure did not have a Copay. All services must be Medically Necessary.

OTHER OUTPATIENT CARE

A. PCP Office Visits: **You Pay… $20 per visit**

B. Specialist Office Visits:

You Pay: **Tier 1: $30 per visit**
Tier 2: $60 per visit

HNE covers care you receive from In-Plan Specialists. See the *"Claims and Utilization Management Procedures"* section of this Member Handbook for a list of services that require Prior Approval.

Obstetrics/Gynecology services – All female Members may receive the services listed below from an obstetrician, gynecologist, certified nurse midwife, or family practitioner:

- Annual preventive GYN health exams, including any subsequent obstetric or GYN services determined by that provider to be Medically Necessary because of such exam.
- Maternity care
- Medically Necessary evaluations and health care services for GYN conditions

You may schedule these visits yourself. Normal Copay rules apply to these visits. (See also Preventive Care, Maternity Care)

C. Telehealth Services through Teladoc®: **You Pay… $15 per consultation**

Members have access to phone or online video consultations through Teladoc. This benefit allows Members to speak with a Teladoc physician about non-emergency medical issues. Examples are cold and flu, urinary tract infections, or ear infections. Teladoc physicians are U.S. board-certified in internal medicine, family practice, emergency medicine or pediatrics.

This service is available 24 hours a day, 7 days a week. Member cost is the same as you would pay for a visit to your PCP. Teladoc is not intended to replace your PCP. Teladoc may follow up with your PCP after your consultation. To request a Teladoc consultation, call (800) 835-2362 or visit Teladoc.com.

Please note: Telehealth services are only available through Teladoc.

D. Eye Examinations: **You Pay… $20 per visit**

HNE covers one routine eye examination each 24 months. You may schedule your exam by calling an In-Plan optometrist or ophthalmologist.

E. Hearing Tests by your PCP: **You Pay… $20 per visit**

HNE covers hearing tests when Medically Necessary.

F. Diabetic-Related Items:

HNE covers the following items and services when they are prescribed by an In-Plan Provider and are Medically Necessary for the diagnosis or treatment of insulin-dependent, insulin-using, gestational, and non-insulin-dependent diabetes:

1. **Endocrinology** **You Pay… Tier 1: $30 per visit**
Tier 2: $60 per visit

HNE covers the services of specialists in endocrinology.

2. **Individual Diabetic Education** **You Pay… $20 per visit**
HNE covers outpatient diabetes self-management training and education, including medical nutrition therapy and nutritional counseling.

3. **Laboratory/Radiological services** **You Pay… $0**
HNE covers laboratory tests including glycosylated hemoglobin, HbAlc tests, urinary protein/microalbumin, and lipid profiles.

4. **Durable medical equipment (DME)** **You Pay… $0**
HNE covers the following DME for diabetics:
    - Blood glucose monitors
    - Continuous glucose monitoring devices (Prior Approval is required)
    - Voice synthesizers for blood glucose monitors for use by the legally blind. (You must receive Prior Approval. If approved, these items are not subject to the DME Copay amounts.)
    - Visual magnifying aids for use by the legally blind
    - Insulin pumps and insulin pump supplies (You must receive Prior Approval for insulin pumps. If approved, insulin pumps and insulin pump supplies are not subject to the DME Copay amounts.)
    - Therapeutic/molded shoes and shoe inserts. Coverage for footwear and inserts is limited to one of the following per Policy Year:
        - One pair of custom-molded shoes (including inserts provided with those shoes) and two additional pairs of inserts
        - One pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with those shoes)

      To be covered:
        - The treating doctor must certify the need for these shoes and inserts
        - They must be prescribed by a podiatrist or other qualified doctor
        - You must get them from a podiatrist, orthotist, prosthetist, or pedorthist

5. **Group Diabetic Education Series** **You Pay… $20/session**
HNE covers Group Diabetic Education services. This is a specific education program targeted at individuals with either newly diagnosed diabetes or uncontrolled diabetes. A Registered Nurse certified in diabetes education and a Registered Dietitian teach these services. Participants learn self-management techniques, as well as information about medical testing, prescription medication and insulin.

G. Autism Spectrum Disorder:

HNE covers Medically Necessary services for the diagnosis and treatment of Autism Spectrum Disorder (ASD) as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Health Disorders. This includes autistic disorder, Asperger's disorder, and pervasive developmental disorders not otherwise specified.

HNE covers Medically Necessary services to diagnose ASD. This includes:

- Neuropsychological evaluations (Prior Approval required)
- Genetic testing (Prior Approval required)
- Other tests to diagnose ASD (some services may require Prior Approval)

HNE covers Medically Necessary services for the treatment of ASD. This includes:

- Habilitative or Rehabilitative care: professional, counseling and guidance services and treatment programs, including, but not limited to, Applied Behavior Analysis is 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)

- Pharmacy care: Please see the *"Prescription Drugs"* in Section 3 of this Handbook for details about your prescription coverage.
- 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. All services are subject to applicable Copays, Coinsurance, and Deductibles.

WHAT IS NOT COVERED:

- Services related to ASD provided by school personnel under an individualized education program

H. Emergency Room Care: **You Pay…$100 per visit (waived if admitted directly from ER)**

See the *"How to Obtain Benefits"* section of this Member Handbook for information about how to obtain care in an Emergency. If you need follow-up care after you are treated in an emergency room, you should call your PCP. He or she will provide or arrange for the care you need.

WHAT IS NOT COVERED:

Services that are not covered under the emergency room care benefit include, but are not limited to, the following:

- Non-Emergency care provided in an emergency room
- Care that you could have foreseen before leaving the HNE Service Area
- Care from an Out-of-Plan Provider once you are medically able to return to the HNE Service Area

I. Urgent Care Center / Retail Medical Clinic: **You Pay… $20 per visit**

Urgent Care Centers are groups of providers who treat conditions that should be checked right away, but aren't as severe as emergencies. They can 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.

Retail Medical Clinics are licensed medical clinics located at certain pharmacies that provide services by nurse practitioners or physician assistants for basic primary medical services. These services are limited to episodic, urgent care such as treatment for an earache or sinus infection.

J. Observation Room: **You Pay…$100 per visit**

If you are in a hospital in observation status:

- Health New England will pay for the observation room charges.
- Services provided while you are in observation are subject to applicable Deductible, Copays and Coinsurance.
- You must pay the ER Copay or Coinsurance, if it applies.

K. Diagnostic Testing:

You Pay… **PCP's Office: $20/visit**
Specialist's Office:
Tier 1: $30 per visit
Tier 2: $60 per visit

Other Surgical Settings: $250 §

HNE covers outpatient diagnostic testing to diagnose illness, injury, or pregnancy. ***Note: Some services, including, but not limited to, sigmoidoscopies, endoscopies, colonoscopies, arthroscopies, needle aspirations, and biopsies are covered under the outpatient surgical services and procedures benefit.***

Sleep Studies

HNE covers sleep studies that do not record EEG (non-polysomnogram or non-PSG), including those that are performed in the Member's home. HNE covers two sleep studies per Policy Year.

You must have Prior Approval for sleep studies. This applies both to home sleep studies and to sleep studies done in a facility. You must also have Prior Approval for Positive Airway Pressure devices and supplies that may be prescribed as a result of a sleep study. These devices include, for example:

- CPAP (Continuous Positive Airway Pressure device)
- BiPAP (Bi-level Positive Airway Pressure device)
- Pressure Support Ventilator

L. Laboratory and Radiological Services: **You Pay… $0**

HNE covers laboratory testing and radiological services when performed in a doctor's office or other lab facility. These services include, but are not limited to: x-rays, ultrasound, and mammography. Nuclear Cardiac Imaging requires Prior Approval in all outpatient settings. This includes outpatient facilities and doctors' offices. You do not need Prior Approval for these services when they are provided in an emergency room or during an inpatient stay.

M. Advanced Diagnostic Imaging (Requires HNE's Prior Approval): **You Pay… $100/scan**

Some services must be approved in advance. These services are:

- Computed Tomography (CT) scans
- Positron Emission Tomography (PET) scans
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiograms (MRA)

You do not need Prior Approval for diagnostic imaging services provided in the Emergency Room or during an inpatient admission. ***Note***: HNE requires providers who provide the technical component of certain high cost imaging services to be accredited by one of three independent organizations. Providers who are not accredited will be considered Out-of-Plan providers. For the most current list of In-Plan Providers, go to healthnewengland.org or contact HNE Member Services.

N. Outpatient Short-term Rehabilitation Services: **You Pay… $25 per visit per treatment type**

Short-term rehabilitation services include physical, occupational, and respiratory therapy. HNE only covers short-term therapy for rehabilitation. This benefit is limited to 90 days per acute episode, per Year for physical, occupational and respiratory therapy; there is no limit for speech therapy. The limit does not apply when services are provided to treat Autism Spectrum Disorder (ASD). *(See page 28 for a description of speech therapy coverage.)* The number of days is unlimited when provided as part of a home health care plan. There must be objective, measurable improvements in your medical or clinical condition during the course of the therapy for coverage to continue.

§ Maximum of four outpatient surgery Copays per Policy Year.

O. Day Rehabilitation Services: **You Pay … $25 for one full day or for one half day**

This includes full or half day programs with more than one treatment type, including physical, occupational, and speech therapy. HNE covers a maximum of 15 days of Day Rehabilitation services per condition per lifetime. Half day sessions count as one day.

Note: "lifetime" refers to the life of the Member who receives the services.

HNE does not cover rehabilitative treatment for non-acute chronic conditions. Chronic conditions are those that exist for an extended time or continue past the expected recovery time for acute or short-term conditions. For example, HNE defines chronic pain as pain continuing more than three months after the injury or illness causing the original pain. HNE covers treatment for acute episodes of an illness related to your chronic condition.

HNE does not cover maintenance treatment. Maintenance treatment is designed to retain health or bodily function, to continue your current state or condition, or to monitor your current state or condition. HNE only covers therapy that will lead to significant measurable improvement in your condition and not just temporary improvement or relief of symptoms.

WHAT IS NOT COVERED:

Services that are not covered under the outpatient short-term rehabilitation benefit include, but are not limited to, the following:

- Rehabilitative treatment for non-acute chronic conditions
- Maintenance treatments designed to retain health or bodily function, or to continue or monitor your current state or condition
- Massage therapy, including myotherapy
- Vocational rehab, or vocational evaluations focused on job adaptability, job placement, or therapy to restore function for a specific occupation
- Educational services or testing, except services covered under the benefit for Early Intervention Services
- Occupational and Physical therapy services for children with developmental delays or disabilities that fall under MGL 71B (referred to as Chapter 766) are not covered. Members must seek benefits available under MA state law and seek a Chapter 766 evaluation. See the Exclusions section of your Member Agreement.

P. Early Intervention Services: **You Pay… $0 per visit**

Covered Services consist of Medically Necessary early intervention services delivered by certified early intervention specialists who are working in early intervention programs certified by the Department of Public Health. Coverage is provided for Members from birth until age 3.

Q. Outpatient Surgical Services and Procedures:

You Pay…

PCP's Office: $20 per visit
Specialist's Office:
Tier 1: $30 per visit
Tier 2: $60 per visit

Other Surgical Settings: $250 §

HNE covers outpatient or ambulatory surgery, including related services. In addition, HNE covers certain procedures, such as sigmoidoscopies, endoscopies, colonoscopies, arthroscopies, needle aspirations, and biopsies under the outpatient surgical services and procedures benefit. *Certain outpatient surgical services and procedures require Prior Approval by HNE.* Examples of services requiring Prior Approval include, but are not limited to, the following: laser-assisted uvulopalatoplasty or uvulopalatopharyngoplasty (corrective surgery of the palate, uvula, or

§ Maximum of four outpatient surgery Copays per Policy Year.

related structures); oral surgery for treatment of non-dental conditions; reduction mammoplasty; and rhinoplasty. HNE will only approve these services if they are Medically Necessary Covered Services and meet HNE's clinical review criteria.

R. ***Second Opinions:***
You Pay… **Tier 1: $30 per visit**
Tier 2: $60 per visit

.Additional information concerning Specialist Copay Tiers is on page 5.

S. ***Allergy Testing and Treatment:*** **You Pay in an Allergist's Office Tier 1: $30/visit**
Tier 2: $60/visit
. **$0 Copay for allergy injection only**

HNE covers testing, antigens, and allergy treatments

T. ***Speech, Hearing and Language Disorders (Requires HNE's Prior Approval):*** **You Pay… $20 per visit**

This plan covers Medically Necessary diagnosis and treatment of speech, hearing and language disorders. HNE does not cover these services when available in a school-based setting. You must have HNE's Prior Approval for visits after the initial evaluation.

You Pay…

- **Office visits Tier 1 $30 Tier 2 $60/visit**
- **Outpatient Care Tier 1 $30 Tier 2 $60/visit**
- **$0 for laboratory tests**
- **$275 for inpatient care † ‡**
- **$250 for outpatient surgery** §

A. Family Planning Services:

HNE covers family planning services when provided by your PCP or an In-Plan OB/GYN Provider. This includes pregnancy testing and genetic counseling.

What is Covered:

HNE covers the following services under the family planning benefit:

- Counseling and diagnostic services for genetic problems and birth defects
- Family planning information and consultation
- Pregnancy testing
- Sterilizations
- Voluntary termination of pregnancy
- Medications approved by the FDA for emergency contraception or to end an early pregnancy
- Physician office visits related to the Member's use of contraceptive drugs or devices
- Services related to fitting a diaphragm or administering Depo-Provera
- Intrauterine Devices (IUDs) and their insertion and removal

What is not Covered:

- Reversal of voluntary sterilization

† Maximum of one inpatient admission Copay per quarter.

‡ If you have paid an inpatient Copay for an admission and are then readmitted to a hospital within 30 Policy days of discharge from the previous admission, the Copay for the readmission can be waived if both admissions occur during the same Policy Year. See page 11 for details.

§ Maximum of four outpatient surgery Copays per Policy Year.

B. Infertility Treatment (some services require HNE's Prior Approval):

For assisted reproductive technologies and intra-uterine insemination procedures, you or your treating In-Plan Provider must obtain HNE's Prior Approval for the services to be covered. See the *"Claims and Utilization Management Procedures"* section of this Member Handbook for information on the Prior Approval process.

Health New England covers all infertility procedures that are not experimental. Covered infertility procedures include but are not limited to the items below:

- Artificial Insemination/Intra-Uterine Insemination (AI/IUI)
- Assisted Hatching
- Cryopreservation of eggs during an active IVF cycle or as Medically Necessary (in the case of impeding or possible loss or damage of reproductive tissue because of medical treatments (chemo or radiation))
- In Vitro Fertilization and Embryo Transfers (IVF-ET)
- Gamete Intrafallopian Transfer (GIFT)
- Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent the donor's insurer does not cover them
- Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor Infertility
- Zygote Intrafallopian Transfer (ZIFT)

There are limits to the benefits and there are some exclusions. Health New England must approve some services in advance. Health New England covers infertility services for Massachusetts and Connecticut residents only. This is defined in the terms of Health New England's Infertility Protocol. You can ask Health New England Member Services to send you a copy of the Protocol.

What is Covered:

- Sperm or egg banking that is not connected with approved infertility treatment and is not Medically Necessary because of impending or possible loss or damage of reproductive tissue related to medical treatments or conditions that may diminish fertility.

MATERNITY CARE

You Pay… $275 per admission † ‡

Prenatal care must be provided by an In-Plan Provider. An In-Plan Provider must make all arrangements for inpatient care.

Important Notice of Rights

Massachusetts law (M.G.L. c.175, §47F) gives you the right to stay in the hospital with your baby for at least 48 hours after giving birth (or 96 hours after birth if you have a cesarean section). If this time period ends between 8:00 p.m. and 8:00 a.m., you have the right to stay in the hospital until after 8:00 a.m., unless you want to leave earlier. If you would like to go home from the hospital early (before 48 hours after giving birth or 96 hours after a cesarean section), you may do so. HNE covers one home visit to check you and your new baby. This home visit must occur within 48 hours after you go home. HNE may cover more than one home visit if it is Medically Necessary. Any decision to go home early is made by the attending provider in consultation with the mother. The term attending provider includes the obstetrician, pediatrician, or certified nurse midwife attending the mother and newly born child.

If you have any questions about your rights under this law, talk to your doctor or nurse, or call the Department of Public Health at (800) 436-7757.

If you feel your rights have been denied under this law, you may file an appeal with the Department of Public Health at (800) 436-7757 (TTY: 711). Filing an appeal will prevent you from being discharged while the appeal is being considered.

What is Covered:

HNE covers the following services under the maternity care benefit:

- Prenatal and postpartum care, including outpatient lactation consultation and parent education
- Diagnostic tests
- Delivery
- Routine nursery charges (This includes common services given to a healthy newborn. For continued coverage of your child, you must enroll your child as a Member within 30 days of the date of birth.)
- Newborn hearing screening
- One home visit within 48 hours after you go home. Other home visits are covered if Medically Necessary, and require Prior Approval.

What is not Covered:

Services that are not covered under the maternity benefit include, but are not limited to, the following:

- Routine maternity (prenatal and postpartum) care when you are traveling outside the HNE Service Area.
- Delivery outside the HNE Service Area after the 37th week of pregnancy, or after you have been told that you are at risk for early delivery
- Home deliveries

† Maximum of one inpatient admission Copay per quarter.

‡ If you have paid an inpatient Copay for an admission and are then readmitted to a hospital within 30 days of discharge from the previous admission, the Copay for the readmission can be waived if both admissions occur during the same Policy Year. See page 11 for details.

BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

How to Get Services:

Outpatient Services
To obtain outpatient treatment for behavioral health and substance use disorder services, you may call the In-Plan Provider of your choice directly. Your doctor, family member, or your In-Plan Provider may also call for you. You do not have to contact HNE before receiving services.

You do not need Prior Approval for medication management services with an In-Plan psychiatrist or clinical nurse specialist. There is no annual limit to the number of medication management visits you may obtain.

To look up In-Plan behavioral health providers, please check your Provider Directory, visit healthnewengland.org or call HNE Member Services at (413) 787-4004 or (800) 310-2835 (TTY: 711). If you need help choosing a provider, you may call HNE's Health Services department at (413) 787-4000 ext. 5028, or (800) 842-4464 ext. 5028. Our staff can help you choose a provider based on the nature of your concerns, your location, and appointment availability.

Inpatient Services
Inpatient admissions do not require Prior Approval from HNE. The admitting facility must contact HNE's Health Services department within one business day to obtain authorization for continued stay. For information please call HNE's Health Services department at (413) 787-4000 ext. 5028, or (800) 842-4464 ext. 5028.

Emergency care
If you need emergency care, follow the steps listed in the *"How to Obtain Benefits"* section under "How to Obtain Care in an Emergency."

Disclosure of Information
As a condition to receiving benefits outlined in this section, HNE will not require consent to the disclosure of information regarding services for behavioral disorders under different terms and conditions than for other medical conditions. Only licensed behavioral health professionals will make decisions about the medical necessity of services described in this section. However, denials of service based on lack of insurance coverage or use of an Out of Plan provider will not be made by a licensed behavioral health professional.

A. Behavioral Health Services:

Psychiatrists, psychologists, psychotherapists, licensed independent clinical social workers, licensed marriage and family therapists*, behavioral health counselors, or clinical specialists in psychiatric and behavioral health nursing may provide behavioral health services. HNE will only cover behavioral health services when they are Medically Necessary.

HNE will provide coverage as follows:

1. **In-hospital care (no limit; please ask your provider to contact HNE for Prior Approval)**
   You Pay… $0
2. **Intermediate care (no limit; please ask your provider to contact HNE for Prior Approval)**
   Intermediate care includes intensive outpatient visits, partial hospitalization programs, crisis stabilization programs, and acute residential treatment for children and adolescents. **You Pay… $0**
3. **Outpatient care (no limit)** **You Pay… $20 per visit**

* Services by licensed marriage and family therapists must be within the scope of practice allowed for these therapists.

Biologically based mental disorders

HNE covers the following biologically based mental disorders, as 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 mental 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.

There are no limits on Medically Necessary outpatient visits or inpatient admissions for these conditions.

Rape-related behavioral health treatment

HNE covers the diagnosis and treatment of rape-related behavioral or emotional disorders for victims of a rape or victims of an assault with the intent to commit rape. There are no limits on Medically Necessary outpatient visits or inpatient admissions for these conditions.

Services for children and adolescents under the age of 19

HNE covers services to treat mental, emotional or behavioral disorders in children and adolescents under the age of 19 as described in this section. These services cover two kinds of disorders: disorders that are biologically based, and those that are not. Disorders that are not biologically based must meet these conditions:

- They must interfere with, or truly limit, the function or social interactions of a person less than 19 years old
- The interference or limit must be important, and must be documented
- The disorders also must be described in the DSM
- The person must be referred by the PCP, the pediatrician, or a licensed behavioral health provider

Here are some examples. Problems or disorders would qualify for coverage if:

- They keep a student from going to school
- They require admission to a hospital
- They cause a pattern of conduct that poses serious danger to self or others

If a person under 19 is being treated, HNE will continue to cover treatment after the person's 19th birthday, until the earlier of:

- The time the course of treatment (in the treatment plan) is over
- The time the person's coverage ends under this Member's Handbook
- The time a person's coverage ends under an HNE plan replacing this Member's Handbook

There are no limits on Medically Necessary outpatient visits or inpatient admissions for these conditions.

* The Autism benefit mandate excludes benefits for educational services, such as special education instruction to improve the school performance of a child, or other services designed to improve a person's developmental functioning including but not limited to services covered under MGL 71B the "Special Education Law".

All other mental disorders

HNE covers all other mental disorders which are described in the most recent edition of DSM. Coverage for services is based on Medical Necessity.

Psychopharmacological services and neuropsychological assessment services

HNE covers these services to the same extent as all other medical services.

B. Substance Use Disorder Services:

HNE covers the diagnosis and treatment of substance use disorders. The treatment can be inpatient or outpatient treatment. Outpatient treatment must be provided by a physician or psychotherapist who spends a large part of their time treating substance use disorders. HNE also covers Medically Necessary inpatient detoxification. All treatment must be Medically Necessary.

1. **Inpatient Drug or Alcohol Rehabilitation Services:**
   (please ask your provider to contact HNE for Prior Approval) **You Pay… $0**
   HNE covers inpatient detoxification as long as it is Medically Necessary.

2. **Intermediate Drug or Alcohol Rehabilitation Care**:
   (please ask your provider to contact HNE for Prior Approval) **You Pay… $0**
   Intermediate care includes crisis outpatient visits, day and evening partial hospitalization programs, and crisis stabilization programs.

3. **Outpatient Drug or Alcohol Rehabilitation Services:** **You Pay… $20 per visit**
   HNE covers outpatient services including services provided by a physician or psychotherapist who devotes a substantial portion of his or her time to treating drug addicted and intoxicated persons or alcoholics.

   What is Covered:

   - Clinical Stabilization Services (CSS) and Acute Treatment Services (ATS) for the treatment of substance use disorders. (Prior Approval is not required when you use an In-Plan facility licensed by the Massachusetts Department of Public Health. Your provider must contact Health New England within 48 hours of the admission. After the first 14 days of your stay, we may review whether your care continues to be Medically Necessary and appropriate. This 14-day period is a combined total for CSS and ATS.)
   - Inpatient services
   - Outpatient services
   - Intermediate services, including, but not limited to:
     - Level III community-based detoxification
     - Community Based Acute Treatment program (CBAT). CBAT is a short term, intensive, structured 24- hour community based program. The typical length of stay is from 1 to 14 days. CBAT is used as a clinically appropriate diversion to inpatient hospitalization. Sometimes it is used as a step down from an inpatient hospitalization. Health New England has clinical review criteria for admissions to CBAT programs. Notification is required.
     - Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP)
     - Day treatment
     - Clinically managed detoxification services
     - Crisis Stabilization Unit (CSU)
     - Family Stabilization Team (FST)
   - Medically Assisted Therapies (MAT) for opioid use disorder
   - Services by licensed alcohol and drug counselors who have a Massachusetts LADC-I level license

What is Not Covered:

- Educational services or testing, except services covered under the benefit for early intervention services
- Services for problems of school performance
- Faith-based counseling
- Social work for non-behavioral health care
- Christian Science practitioner and sanitarium stays
- Residential/custodial services (including residential treatment programs and halfway houses)
- Services required by a third party or court order. For example, HNE excludes exams for:
    - A job or potential job
    - School
    - Sports
    - Summer camp
    - Premarital exams

Treatment of medical complications that are the result of preventive services or procedures is covered subject to Member Cost Sharing. This is the case even if the preventive service or procedure was not subject to member Cost Sharing. All services must be Medically Necessary.

You must have Prior Approval from HNE for:

- Neuropsychological Testing
- Partial Hospital Program (PHP) and Intensive Outpatient Program (IOP)
- Repetitive Transcranial Magnetic Stimulation (rTMS)
- Family Stabilization Team

Your Rights under the Massachusetts Mental Health Parity Laws and the Federal Mental Health Parity and Addiction Equity Act **(MHPAEA)**

You may have rights under state and federal mental health parity laws. Both laws say that health plans must cover treatment for behavioral health and substance use disorders in the same way that they cover treatment for medical conditions. This means that Copays, Coinsurance and Deductibles for behavioral health conditions must be the same as those for medical conditions. Also, behavioral health office visit Copays must not be greater than primary care visits. The methods we use to review coverage for behavioral health or substance use disorder benefits are comparable to those we use to review medical benefits. Clinical standards may permit a difference in how benefits are reviewed.

If you think HNE is not covering treatment for behavioral health and substance use disorders in the same way that we cover treatment for medical conditions, you may file a complaint with the Division of Insurance (DOI) Consumer Services Section.

You may file a written complaint by using the DOI's Insurance Complaint Form. You may request a copy of the form by phone or by mail. You also can find the form on the DOI's webpage at: http://www.mass.gov/ocabr/consumer/insurance/file-a-complaint/filing-a-complaint.html

You may also submit a complaint by telephone by calling (877) 563-4467 or (617) 521-7794.

If you submit a verbal complaint, you must follow up in writing. You must include the following information on the Insurance Complaint Form:

1. Your name and address
2. The nature of your complaint

3. Your signature authorizing the release of any information to help the DOI with its review of the complaint.

A parity complaint is not the same as an appeal under your Plan. You may still need to file an appeal with HNE. Filing an appeal with HNE may be necessary to protect your right to continued coverage of treatment while you wait for an appeal decision. See the appeal procedures outlined in Section 6 of this Member Handbook for more information about filing an appeal.

Dental Services

You Pay in Your PCP's Office: ..... $20 per visit
You Pay in a Specialist's Office:.....Tier 1: $30 per visit
.....Tier 2: $60 per visit
You Pay in an Outpatient Surgical Setting: ..... $250 §
You Pay at an Emergency Room: ..... $100 per visit
You Pay for Inpatient Care: ..... $275 per admission † ‡

HNE covers only the limited dental services described below. No other dental services are covered.

A. Surgical Treatment of Non-Dental Conditions of the Oral Cavity:

This benefit addresses surgical treatment of non-dental conditions, such as lesions, cysts, tumors of the jaw and gums, reduction of a dislocated or fractured jaw or facial bone, and diseases of the mouth.

B. Emergency Dental Care:

HNE covers the initial Emergency dental care needed due to a traumatic injury to sound, natural teeth. You must receive all services, except for suture removal, within 72 hours of injury. Coverage is limited to initial first aid (trauma care), reduction of swelling, pain relief, covered non-dental surgery and non-dental diagnostic x-rays. HNE does not cover follow-up care or restorative treatment. You must report Emergency dental care to HNE if *not* received in a hospital emergency room (for example, at a walk-in clinic or physician's office).

What is Covered:

HNE covers the following services under the emergency dental care benefit:

- Extraction of teeth when needed to avoid infection of teeth damaged in an injury
- One follow-up visit if treatment results in extraction of teeth
- Suturing and suture removal
- Reimplanting, repositioning and stabilization of dislodged or partly dislodged natural teeth
- Medication received from the provider

C. Dental Procedures:

HNE covers the following procedures only when the Member has a serious medical condition that makes it essential that he or she be admitted to a general hospital as an inpatient or to a surgical day care unit or ambulatory surgical facility as an outpatient in order for the dental care to be performed safely:

- Extraction of seven or more teeth
- Gingivectomies (including osseous surgery) of two or more gum quadrants
- Excision of radicular cysts involving the roots of three or more teeth

§ Maximum of four outpatient surgery Copays per Policy Year.

† Maximum of one inpatient admission Copay per quarter.

‡ If you have paid an inpatient Copay for an admission and are then readmitted to a hospital within 30 days of discharge from the previous admission, the Copay for the readmission can be waived if both admissions occur during the same Policy Year. See page 11 for details.

- Removal of one or more impacted teeth

Serious medical conditions include, but are not limited to, hemophilia and heart disease. *Your PCP must authorize, and submit to HNE for Prior Approval, all inpatient and surgical day care admissions.*

What is not covered:

Services that are not covered under the dental benefit include, but are not limited to, the following:

- Fillings, crowns, implants, caps, or bridges
- Braces
- Root canals
- Dentures
- Periodontics and orthodontics
- Dental treatment of temporomandibular joint syndrome (TMJ). Dental treatment of TMJ is defined as conservative, nonsurgical intervention. This may include, but is not limited to: therapeutic splints, oral appliances, or corrective dental treatments (for example, crowns, bridges, braces and prosthetic appliances).
- Orthognathic surgery in conjunction with orthodontic work
- Removal of impacted teeth to prepare for or support orthodontic, prosthodontic, or periodontal procedures
- Removal of non-impacted wisdom teeth

OTHER SERVICES

A. Home Health Care (Requires HNE's Prior Approval): **You Pay… $0**

HNE only covers Medically Necessary home health care services provided in conjunction with a physician-approved home health services plan. A licensed home health agency must provide the services. Care must be provided in the Member's home. (A hospital, skilled nursing, or rehabilitation facility is not considered to be the home.) The home must also be the best place to get Covered Services. Your PCP must arrange all home health care. HNE must approve the appropriateness and Medical Necessity of home health care before services begin. HNE will regularly review these factors.

What is Covered:

HNE covers the following only if they are Medically Necessary:

- Physical, occupational, and speech therapy (the visit limit described in Outpatient Care/Short-term Rehabilitation does not apply when provided as part of the home health benefit)
- Skilled nursing services provided by licensed professionals
- Durable medical equipment and supplies
- Medical social services
- Nutritional counseling
- Services of a home health aide

What is not Covered:

Services that are not covered under the home health benefit include, but are not limited to, the following:

- Disposable supplies such as bandages
- Custodial Care, unskilled home health care, and homemaking, whether at home or in a facility setting
- Private duty or block nursing and personal care attendants
- Long-term care

B. Hospice Services (Requires HNE's Prior Approval): **You Pay… $0**

HNE covers hospice services provided by a hospice provider for terminally ill Members with a life expectancy of six months or less. Members can continue to receive hospice care for as long as they are certified by their doctor and the hospice director as terminally ill and having a life expectancy of six months or less. After the first six months HNE will request documentation of continued certification. Care may be provided at home or on an inpatient basis. HNE will only cover inpatient care when skilled nursing care is Medically Necessary. Covered Services include, but are not limited to: physician services, nursing care, social services, volunteer services, and counseling services.

C. Durable Medical and Prosthetic Equipment, and Medical and Surgical Supplies
(All items require Prior Approval; your provider is responsible for obtaining the necessary Prior Approval):
You Pay… 20% Coinsurance

Please call Member Services with questions about whether a particular item is covered.

HNE covers certain durable medical equipment (DME), medical and surgical supplies and prostheses. These items must be prescribed by a physician.

To be covered, DME must meet the following criteria:

1. It is primarily and customarily used in the treatment of an illness or injury or for the rehabilitation of a malformed body part. (This does not apply to prostheses.)
2. It is able to withstand repeated use.
3. It is primarily intended for activities of daily living.
4. It is not intended primarily for sports-related purposes.
5. It is appropriate for home use (i.e., not hospital or physician equipment).

6. It should not serve the same purpose as equipment already available to a Member. (HNE may make an exception if the equipment contributes to important clinical decisions and will supply the level of precision needed.)
7. It should not be more costly than a medically appropriate alternative.

HNE will only cover one item of each type of equipment that meets the Member's need. No back-up items are covered.

What is Covered:

- HNE covers DME, and some medical and surgical supplies. There is no annual dollar limit for these items. For each item HNE covers, the Member must pay the Coinsurance amount. The Member Coinsurance for DME does not apply to Oxygen from In-Plan Providers.
- HNE may decide whether to purchase or rent the equipment. HNE may take back the equipment if your doctor decides you no longer need it, or if your membership ends. HNE covers the cost to repair and maintain covered equipment. This is subject to the Member Coinsurance for DME. Some repairs and maintenance requires Prior Approval.
- HNE covers prosthetic limbs. There is no annual limit for the purchase of prosthetic limbs. ***Prior Approval from HNE is required for these items.***
- HNE covers certain high cost equipment in full. HNE provides coverage for the full cost of this equipment with no Member Coinsurance required. For a list of these items, see below or contact Member Services. ***Prior Approval from HNE is required for these items.***

HNE Covers items such as those listed below:

- Breast prostheses (related to mastectomy as required by law)
- Canes/Crutches/Walkers
- Certain diabetic equipment and supplies (See Diabetic-related items)
- Certain types of braces or splints
- Certain wound care supplies (requires Prior Approval)
- Compression stockings
- Hospital beds
- Infusion pumps
- Ostomy supplies
- Oxygen and related supplies (not subject to Copay)
- Respiratory equipment and related supplies
- Wheelchairs

What is not Covered:

- Arch supports, orthotic devices and corrective shoes and shoe inserts (except those for diabetic foot care)
- Articles of special clothing, mattress and pillow covers, including hypo-allergenic versions
- Bed pans and bed rails
- Bidets
- Bath/shower chairs
- Certain disposable items or dressing supplies (for example, alcohol wipes, sterile water, saline solution, tape, Band-Aids, adhesive remover, topical anesthetics)
- Comfort or convenience items such as telephone arms, air conditioners, and over bed tables
- Dehumidifiers, humidifiers, air cleaners or purifiers, HEPA filters and other filters, and portable nebulizers
- Elevators, ramps, stair lifts, chair lifts, strollers, and scooters
- Exercise or sports equipment
- External urinary catheters
- Heating pads, hot water bottles, and paraffin bath units

- Any Home adaptations (This includes but not limited to home improvement and home adaptation equipment, for example, bathroom grab bars.)
- Hot tubs, saunas, Jacuzzis, swimming pools, or whirlpools
- Incontinence products
- Repair or replacement of equipment or devices as a result of loss, negligence, willful damage, or theft
- Safety equipment (e.g., car seats, safety belts, harnesses or vests)
- Saunders Lumbar Hometrac®
- Items that are considered experimental, investigational, or not generally accepted in the medical community
- Items that do not meet the coverage rules listed above

HNE will notify you of any change to the list of what is covered or is not covered. HNE will provide you with an amendment to this Member Handbook, which shows the change.

D. <u>Ambulance and Chair Van Services</u>: **You Pay… $0 after Deductible for Emergency Ambulance**
$25 per day per Member for Non-Emergency Ambulance

Member is responsible for a maximum of one ambulance or chair van transport Copay per day. HNE covers ambulance and chair van services as follows:

- **Emergency Transportation** - HNE covers transportation in a medical Emergency (i.e., where a prudent layperson could reasonably believe that an acute medical condition requires immediate care to prevent serious harm). HNE covers transportation services from the place where a person is injured or stricken by disease to the nearest hospital where treatment can be given. HNE will also cover transport from one hospital to another hospital when the first hospital does not have the required services and/or facilities to treat the Member.
- **Air Ambulance - HNE covers air ambulance services in the case of a life threatening Emergency or when** otherwise approved by HNE.
- **Non-Emergency Transportation (requires Prior Approval)** - HNE covers ambulance or chair van services for a Member from a hospital setting to their home, or to a skilled nursing facility, if the Member cannot be safely or adequately transferred without endangering their health. All non-emergency transportation services must be pre-approved by HNE.

<u>What is not Covered</u>:

- HNE does not cover transportation by ambulance or by chair van for patient convenience or for non-clinical reasons.
- HNE does not cover transportation to or from a doctor's office, clinic, or other place for medical care that can be planned ahead of time.
- HNE does not cover ancillary supplies when billed as separate line items as a part of ground ambulance services from Out-of-Plan Providers. Examples of these supplies and services are:
    - Drugs
    - ECG tracing
    - Intubation
    - Measuring of oxygen in the blood

E. Reconstructive or Restorative Surgery: **You Pay… $275 per inpatient admission † ‡**
$250 per outpatient surgery §

HNE covers reconstructive surgery to repair, improve, restore or correct bodily function caused by an accidental injury, congenital anomaly or a previous surgical procedure or disease.

As required by the Women's Health and Cancer Right Act of 1998, HNE will provide coverage, following a mastectomy, for:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses (subject to the 20% Coinsurance for DME and prosthetics)
- Any physical complications resulting from the mastectomy, including lymphedemas

Coverage will be provided in a manner determined in consultation with the attending physician and the patient.

The Plan will not cover reconstructive or restorative surgery for dental procedures, procedures for cosmetic purposes only or treatment for complications resulting from non-covered cosmetic procedures.

F. Kidney Dialysis: **You Pay… $0**

The Plan covers kidney dialysis on an inpatient or outpatient basis, or at home. If you are entitled to or eligible for benefits under Medicare, federal law permits Medicare to be the primary payer for dialysis after a certain time period, generally 30 months after you become entitled to or eligible for Medicare. After this time period has elapsed, the Plan will be the secondary payer for dialysis. You should apply for Medicare to make sure you get full coverage for dialysis when Medicare is the primary payer.

G. Human Organ Transplants and Bone Marrow Transplants (Requires HNE's Prior Approval):
You Pay… $275 per inpatient admission †‡

What is covered:
HNE covers the following organ transplants when Medically Necessary:

- Autologous bone marrow transplants for the following diagnoses:
  - Acute leukemia in remission
  - Resistant non-Hodgkin's lymphomas
  - Advanced Hodgkin's disease
  - Recurrent or refractory neuroblastoma
- Allogeneic or autologous bone marrow transplants for multiple myeloma, aplastic anemia, leukemia, severe combined immunodeficiency disease, Wiskott-Aldrich Syndrome, and cases of metastatic breast cancer which meet the coverage eligibility requirements established by the Massachusetts Department of Public Health. HNE does not cover bone marrow or stem-cell harvest or rescue and related treatments, except for these diseases.
- Cornea transplant. Contact lenses following a cornea transplant are covered for up to one year, if Medically Necessary.
- Heart transplant
- Heart/lung transplant
- Lung transplant
- Kidney transplant
- Liver transplant

† Maximum of one inpatient admission Copay per quarter.

‡ If you have paid an inpatient Copay for an admission and are then readmitted to a hospital within 30 days of discharge from the previous admission, the Copay for the readmission can be waived if both admissions occur during the same Policy Year. See page 11 for details.

§ Maximum of four outpatient surgery Copays per Policy Year.

- Human leukocyte antigen testing or histocompatibility locus antigen testing for a Member when necessary to establish such Member's bone marrow transplant donor suitability. HNE covers the costs of testing for A, B, or DR antigens, or any combination thereof.

A member only needs to be tissue typed once during his or her lifetime. Tissue typing is similar to blood typing. Like blood type, tissue type does not change. All other uses of HLA testing are covered when Medically Necessary.

In the case of bone marrow transplants, if a covered bone marrow transplant is not available from an In-Plan Provider, HNE will pay for services rendered by an Out-of-Plan Provider. You must get Prior Approval before receiving services from an Out-of-Plan Provider.

HNE covers the above services at transplant Centers of Excellence. If an HNE Member is the recipient of a human organ transplant and the donor's costs are not covered by any other insurance. HNE will cover the donor charges for no more than 90 days post-operatively or until the HNE Member's coverage ends, whichever happens first. HNE does not cover the charges for an HNE Member who is donating an organ to a non-HNE member. This applies whether or not the services are covered by the recipient's plan.

What is not Covered:

The following are not covered under the transplant benefit:

- Human organ transplants that are not listed above or that are experimental or unproven
- Transportation and lodging expenses for a Member and/or his or her family
- Artificial or animal to human organ or tissue transplant

H. Nutritional Support (Requires HNE's Prior Approval): **You Pay… $0**

HNE covers specific nutritional support as described below.

What is Covered:

HNE covers the following when Medically Necessary and ordered by an In-Plan Doctor:

- Nutritional support, including enteral tube feedings, when the Member has a permanent impairment involving the gastrointestinal tract that prevents adequate oral nutritional intake.
- Parenteral nutrition and total parenteral nutrition
- Special medical foods that are taken orally and prescribed for:
    - Phenylketonuria (PKU)
    - Tyrosinemia
    - Homocystinuria
    - Maple syrup urine disease
    - Propionic acidemia
    - Methylmalonic acidemia in a Dependent child
    - Protection of an unborn fetus of a pregnant Member with PKU
- Non-prescription enteral formulas for home use that are Medically Necessary for the treatment of malabsorption caused by:
    - Crohn's disease
    - Ulcerative colitis
    - Gastroesophageal reflux
    - Gastrointestinal motility
    - Chronic intestinal pseudo-obstruction
    - Allergic enteropathy, including allergic colitis
    - Low protein food products for inherited disease of amino acids and organic acids.

What is not Covered:

- Dietary supplements
- Specialized infant formulas unless the Member's medical condition meets the clinical criteria noted above for malabsorption

- Vitamins and/or minerals taken orally to replace intolerable foods, supplement a deficient diet, or provide alternative nutrition for conditions such as:
    - Hypoglycemia
    - Allergies
    - Excessive weight
    - Gastrointestinal disorders

These products are not covered even if they are required to maintain weight or strength.

I. Cardiac Rehabilitation: **You Pay… $20 per visit**

HNE covers the multidisciplinary, Medically Necessary treatment of persons with documented cardiovascular disease. HNE covers such care when received in a hospital or from another In-Plan Provider, and when the care meets standards issued by the Commissioner of Public Health. Such standards will include, for example, outpatient treatment, if the treatment is started within 26 weeks after the diagnosis of the disease. Phase IV of cardiac rehabilitation is not covered under this benefit. Phase IV begins following the completion of Phase III and is designed to maintain the patient's rehabilitated cardiovascular health.

J. Nurse Anesthetists and Nurse Practitioners: **You Pay… Copay will be equal to the Copay for the provider's supervising doctor**

HNE covers services provided by a certified registered nurse anesthetist or nurse practitioner that participates with the Plan, if the following conditions are met:

1. The service rendered is within the scope of the certified registered nurse anesthetist's license or the nurse practitioner's authorization to practice by the Board of Registration in Nursing.
2. HNE covers the identical services when rendered by other licensed providers of health care.

K. Scalp Hair Prostheses (Wigs): **You Pay… $0**

HNE covers scalp hair prostheses (wigs) worn for hair loss due to the treatment of any form of cancer or leukemia. HNE covers one prosthesis per Year. You must send your request for reimbursement to the HNE Member Services Department. The request must include proof of payment and a written statement from your physician that the wig is Medically Necessary.

L. Coronary Artery Disease/Change of Heart Program: **You Pay… 10% of cost of program**

Coverage for this program will be provided to Members with documented coronary artery disease, diabetes or high cholesterol to help participants reduce disease risk factors through lifestyle changes. *The program must be approved by your PCP.*

M. Hearing Aids: **You Pay… See below**

Members age 21 and under *(Requires Prior Approval)*:

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

Coverage for Members over 21 years old:

- HNE will reimburse Members for the purchase or repair of hearing aids at 100% for the first $500 and 80% coverage for the next $1,500 per person every two Years.
- You can obtain hearing aids and repairs from any provider.
- For reimbursement, you pay the provider and submit itemized bills with proof of payment to Member Services at HNE.

N. Treatment of Cleft Lip and Cleft Palate (Requires Prior Approval):

HNE covers the treatment of cleft lip and cleft palate for Members age 18 and younger as follows:

Coverage includes:

- Medical, dental, oral and facial surgery
- Surgical management and follow-up care by oral and plastic surgeons
- Orthodontic treatment and management
- Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy
- Speech therapy
- Audiology
- Nutrition services
- The services above are covered when prescribed by the treating physician or surgeon who certifies that the services are:
    - Medically Necessary
    - Related to the treatment of the cleft lip or the cleft palate
- Dental or orthodontic treatment not related to the management of a cleft lip or cleft palate is not covered.
- The payment responsibilities and other requirements that are a part of this plan apply to this coverage.

O. Hormone Replacement Therapy: **You Pay… applicable prescription drug Copay**

HNE covers hormone replacement therapy (HRT) services for peri- and postmenopausal women.

P. Clinical Trials (Clinical Research Studies) (Requires Prior Approval):

HNE covers patient care services provided as part of a qualified clinical trial studying potential treatment(s) for cancer. Patient care services include items and services provided when you are enrolled in a qualified clinical trial consistent with your diagnosis and the study protocol. Coverage is subject to all pertinent provisions of the Plan, including medical necessity review, use of participating providers, preapproval reviews, and provider payment methods.

HNE covers patient care services provided within the trial only if it is a qualified clinical trial, according to state law:

- The clinical trial is to study potential treatments for cancer.

The clinical trial has been peer reviewed and approved by one of the following:

- The United States National Institutes of Health (NIH)
- A cooperative group or center of the NIH
- A qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants
- The United States Food and Drug Administration (FDA) pursuant to an investigational new drug exemption
- The United States Departments of Defense or Veterans Affairs
- With respect to Phase II, III and IV clinical trials only, a qualified institutional review board

The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that experience.

With respect to Phase I clinical trials, the facility must be an academic medical center (or an affiliated facility) at which the clinicians conducting the trial have staff privileges.

The member meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial.

The member has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards.

The available clinical or pre-clinical data provide a reasonable expectation that the member's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial.

The clinical trial does not unjustifiably duplicate existing studies.

The clinical trial must have a therapeutic intent and must, to some extent, assume the effect of the intervention on the member.

The following services for cancer treatment are covered under this benefit:

- All services that are medically necessary for treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the Plan.
- The allowed cost, as determined by the Plan, of an investigational drug or device that has been approved for use in the clinical trial studying potential treatments for cancer to the extent it is not paid for by its manufacturer, distributor or provider, regardless of whether the FDA has approved the drug or device for use in treating your particular condition.

What is not Covered:

There is no coverage for any clinical research trial other than a qualified clinical trial studying potential treatments for cancer.

Patient care services do not include any of the following:

- An investigational drug or device, except as noted above
- Non-health care services that you may be required to receive as a result of participation in the clinical trial
- Costs associated with managing the research of the clinical trial
- Costs that would not be covered for non-investigational treatments
- Any item, service, or cost that is reimbursed or furnished by the sponsor of the clinical trial
- The costs of services that are inconsistent with widely accepted and established national or regional standards of care

- The costs of services that are provided primarily to meet the needs of the trial including, but not limited to, covered tests, measurements, and other services that are being provided at a greater frequency, intensity, or duration.
- Services or costs that are not covered under the Plan

Q. Gender Reassignment Operations and Treatments (Requires Prior Approval):

Gender Reassignment Surgery requires Prior Approval. You may access and view the clinical review criteria used by HNE for benefit decisions related to Gender Reassignment 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.

R. Tobacco Cessation/Counseling: **You Pay… See below**

HNE will provide for GIC members the following tobacco cessation program options:

- Counseling for tobacco dependence/smoking cessation up to and including a maximum of 300 minutes per Policy Year. The counseling can be telephonic or face-to-face and may be completed in either individual or group sessions.
- Nicotine replacement is currently available over-the-counter. Prescribed nicotine replacement will require a co-payment

S. Special Programs and Discounts:

By joining HNE, you may have access to special programs and discounts, such as discounts on complementary Alternative Medicine such as acupuncture and massage therapy (see the *"Definitions"* section of this Member Handbook).

HNE also has a reimbursement program for qualifying fitness costs, Weight Watchers® programs, community supported agriculture (Farm Share Programs).

Please contact HNE for the most current listing of all of HNE's special programs and discounts, as these programs and discounts may change from time to time.

SECTION 4 – EXCLUSIONS AND LIMITATIONS

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- Some services are not covered.
- Some services that are covered have specific limitations.
- HNE covers Medically Necessary treatment that is needed due to complications resulting from a non-covered service. Such coverage is provided consistent with the terms of this Member Handbook.

HNE excludes all services, supplies, and other items of care not specifically included in this Member Handbook. Coverage is subject to the terms and conditions of this Member Handbook. For example, services must be Medically Necessary. HNE does not limit or exclude coverage for pre-existing conditions. **Please also see the descriptions of individual benefits for services that are limited or partly excluded.**

HNE excludes or has limitations on the following services and supplies:

1. Acne-related services, such as the removal of acne cysts, injections to raise acne scars, cosmetic surgery, dermabrasion or other procedures to plane the skin. (Benefits are provided for outpatient medical care to diagnose or treat the underlying condition identified as causing the acne.)
2. Acupuncture
3. ALCAT test for food sensitivity
4. All medical, hospital, or other health care services or supplies provided by an Out-of-Plan Provider, unless approved by an In-Plan Doctor *and* HNE in accordance with HNE policies and rules. HNE covers services or supplies rendered by Out-of-Plan Providers in cases of an Emergency Medical Condition. See "Emergency Care" in the *"How to Obtain Benefits"* section of this Member Handbook.
5. Alternative medicine (see the *"Definitions"* section of this Member Handbook)
6. Ancillary services such as vocational rehabilitation, behavioral training, sleep therapy, employment counseling, training and/or educational therapy for learning disabilities, or other educational services such as educational testing.
7. Any costs associated with any form of surrogacy, including gestational carriers
8. Any services that are the legal liability of Workers' Compensation Insurance or other third party insurer.
9. Any services provided by the Veterans Administration for service-connected disabilities to which Members are legally entitled and for which facilities are reasonably available.
10. Arch supports, foot orthotic devices, and corrective shoes and shoe inserts, except as required by law.
11. Cardiac Rehabilitation Phase IV (see page 43)
12. Care or treatments provided by family members
13. Chiropractic care
14. Cold Therapy Devices
15. Cologuard® genetic test for colorectal cancer screening
16. Contact lenses are covered only for: cataract after extraction, keratoconus; aphakia, or following a cornea transplant, for up to one year, if Medically Necessary. A lens applied as a bandage lens following an eye injury or to treat a diseased cornea is covered.
17. Corrective intraocular lenses
18. Cosmetic or beautifying surgeries, procedures, drugs, services, or appliances. See page 62.
19. Diagnostic tests analyzed in functional medicine laboratories such as Genova Diagnostics

20. Dietary supplements
21. Educational service or testing, except services covered under the benefit for early intervention services described in the "Covered Benefits" section of this Member Handbook.
22. Elective treatment or surgery not required by your medical condition, according to the judgment of the Plan.
23. Experimental implants are not covered. Non-experimental implants are covered only when Medically Necessary due to a functional defect of a bodily organ and when the implant will serve to restore full normal function. (Note: This refers to implants. Coverage and exclusions for transplants are described in the "Covered Benefits" section of this Member Handbook.)
24. Extracorporeal Shock Wave Therapy (ESWT) for Chronic Plantar Fasciitis
25. Eyeglasses and contact lenses following cataract surgery. (Reimbursement is limited to one pair per Policy Year in which cataract surgery is performed, up to a limit of $250.)
26. Fees to a donor or program for donation of sperm/egg(s)
27. Holistic treatments (see definition of Alternative Medicine in the "Definitions" section of this Member Handbook).
28. INJEX™/ROJEX™ needle-free system
29. Intradiscal Electrothermal Therapy (IDET)
30. Items not listed or listed as "not covered" on the DME and medical and surgical supplies list
31. Laser hair removal
32. Laser vision correction surgery
33. Litholink services
34. Marijuana for medical use
35. Medical care that HNE's Medical Director determines is experimental, investigational, or not generally accepted in the medical community. Experimental means any medical procedure, equipment, treatment or course of treatment, or drugs or medicines that are considered to be unsafe, experimental, or investigational. This is determined by, among other sources, formal or informal studies, opinions and references to or by the American Medical Association, the Food and Drug Administration, the Department of Health and Human Services, the National Institutes of Health, the Council of Medical Specialty Societies, experts in the field, and any other association or federal program or agency that has the authority to approve medical testing or treatment.
36. Medical expenses incurred in any government hospital or facility or for services of a government doctor or other government health professional.
37. Neurobiofeedback
38. Nutritional supplements except as described under "Nutritional Support" in the "Covered Benefits" section of this Member Handbook
39. Orthoptics and orthoptic training
40. Postoperative Disposable Ambulatory Regional Anesthesia (PDARA)
41. Provider charges for shipping or copying medical records or for failing to keep an appointment
42. Pulmonary Rehabilitation Phase III exercise maintenance program
43. Reduction mammoplasty for male gynecomastia
44. Routine foot care, which 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.

HNE covers routine foot care if you are a diabetic.

45. Saunders Lumbar Hometrac®
46. Sclerotherapy, radiofrequency ablation, joint and ligamentous injections (Prolotherapy) for non-symptomatic varicose veins
47. Services and treatment not in keeping with national standards of practice, as determined by the Plan's Medical Director or his/her designees, including but not limited to: nutritional based therapies, non-abstinence based substance abuse care, crystal healing therapy, rolfing, regressive therapy, EST, and herbal therapy.
48. Services by Health Diagnostic Laboratory, Inc.
49. Services provided under MGL Chapter 71B in Massachusetts (referred to as "Chapter 766"). Services provided under Section 10-76A-d of the General Statutes in Connecticut. These services include, for example:
    - Adaptive physical education
    - Educational services or testing, except services covered under the benefit for early intervention services
    - Services for problems of school performance
    - Physical and occupational therapy
    - Psychological counseling
    - Speech and language therapy
    - Transportation

    Seek a Chapter 766 or Section 10-76A-d evaluation if you believe your child may be disabled. This includes:

    - Physical disability
    - Mental retardation
    - Learning problems
    - Behavioral problem

    Members must try to obtain benefits available under state law.
50. Services or supplies, other than those referred to in item 51 below, which are paid for, or with respect to which benefits are actually provided, under any law of a government (national or otherwise) except where such payments are made or such benefits are provided under a plan specifically established by a government for its own civilian employees and their dependents.
51. Services or supplies which are furnished or paid for, or with respect to which payments are actually provided, under any law of a government (national or otherwise) by reason of the past or present service of any person in the armed forces of a government.
52. Services, supplies, or medications that are primarily for the Member's personal comfort or convenience, or for the comfort or convenience of anyone else on behalf of the Member. This includes, among other things, services, supplies, or other items obtained from Out-of-Plan Providers based solely on the location or hours of operation of the provider.
53. Services received after the date that coverage ends
54. Services rendered outside the HNE Service Area, when the Member could have foreseen the need for such services before leaving the HNE Service Area. This exclusion will apply unless HNE has approved such services in advance.
55. Special duty or private duty nursing and attendant services
56. Specialty clothing appropriate to specific medical conditions
57. Sperm or egg banking not connected with approved Infertility treatment for an active cycle
58. Tinnitus masker
59. Toric lenses
60. Travel, transportation and lodging expenses for a Member and/or a Member's family as a course of treatment or to receive consultation or treatment.
61. Ultraviolet lights and cabinets

62. Vocational rehab, including job retraining, or vocational and driving evaluations focused on job adaptability, or therapy to restore function for a specific occupation.
63. Weight control programs that are not sponsored by HNE. (Please contact HNE Member Services for information on programs that are sponsored by HNE, such as our fitness club/Weight Watchers reimbursement program and our grocery store tour program.)

LIMITATIONS AND PARTIAL EXCLUSIONS

HNE places specific limitations or partial exclusions on the following services and supplies:

- Non-experimental implants are covered only if:
    - The implant is Medically Necessary due to a functional defect of a bodily organ; and
    - The implant will serve to restore full normal function

(Note: This refers to implants. Coverage and exclusions for transplants are described in Section 3 of this Member Handbook.)

- Contact lenses are covered only:
    - for cataract after extraction
    - for keratoconus
    - for aphakia
    - following a cornea transplant, for up to one year, if Medically Necessary
    - for bandage lenses for corneal abrasion or eye injury
- HNE provides reimbursement for eyeglasses after cataract surgery. Reimbursement is limited to $250 for one pair of glasses per Policy Year. Glasses must be purchased within six months of the cataract surgery.
- Reconstructive or restorative surgery is only covered when the surgery is a Medically Necessary service and it is:
    - Part of the treatment of a disease
    - In connection with a mastectomy
    - Needed to correct a birth defect to restore essential bodily functions

HNE will consult with you and your doctor to decide coverage. The Plan will not cover reconstructive or restorative surgery for dental services or for cosmetic purposes only.

COSMETIC SERVICES

HNE does not cover cosmetic services, or follow up treatment for cosmetic services. The primary purpose of cosmetic or beautifying surgeries, procedures, drugs, services, or appliances is to improve, alter or enhance appearance or self-image. They are not necessary to maintain or restore an essential bodily function, or they are performed for psychological or emotional reasons. If a non-approved cosmetic procedure is performed at the same time as an approved service, HNE may deny the non-approved treatment. HNE covers Medically Necessary treatment due to complications from the non-covered services.

Below are some examples of procedures that are considered cosmetic in nature and are not covered:

- Botox injections for cosmetic purposes
- Breast implants
- Chemical exfoliation for acne
- Chemical Peel
- Chin implant (Not covered except for correction of deformities that are secondary to disease, injury or congenital defect.)
- Collagen implant (e.g. Zyderm)
- Correction of diastasis recti abdominis
- Dermabrasion for removal of acne scars
- Earlobe repair to close a stretched or torn ear pierce hole

- Electrolysis for hirsutism
- Excision of excessive skin on thigh, leg, hip, buttock, arm, forearm or hand, submental fat pad or other areas
- Excision or repair of keloid
- Grafts, fat
- Otoplasty
- Reduction of labia minora
- Removal of spider angiomata
- Rhytidectomy (Facelift)
- Salabrasion (Tattoo removal)
- Scar revision
- Suction assisted lipectomy

This list is not exhaustive, and any procedure considered cosmetic in nature will be excluded.

SECTION 5 – CLAIMS AND UTILIZATION MANAGEMENT PROCEDURES

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- Some procedures require HNE's Prior Approval. Procedures requiring Prior Approval are listed in this section.
- HNE also performs retrospective and concurrent reviews as part of its Utilization Management program.

UTILIZATION MANAGEMENT PROGRAM

The purpose of HNE's Utilization Management program is to review certain claims to determine if they are Covered Services and if they are Medically Necessary and appropriate. There may be times when a service is not approved. When this occurs, coverage for the services may be denied. A utilization management denial may be made only on the basis of whether it is Medically Necessary or appropriate or if it is not a Covered Service under the Plan. HNE knows that there is a risk of under-utilization of necessary health care services. It therefore states that:

- HNE's utilization management programs have been designed to ensure that medical decision-making is based on the appropriateness of care and services and the existence of coverage.
- HNE encourages all clinicians and administrative staff who are involved in utilization management review to work collaboratively to help Members obtain access to appropriate health care resources.
- HNE does not provide compensation or other financial incentive or reward to its In-Plan Providers or staff who conduct utilization management review that is based on the quantity or type of denial decisions rendered.

PROCEDURES THAT REQUIRE HNE'S PRIOR APPROVAL

In order to obtain coverage for certain services and procedures, your Primary Care Provider or treating In-Plan Provider is required to get HNE's Prior Approval. Your Primary Care Provider or treating In-Plan Provider must get HNE's Prior Approval if you plan to have any of the following services or procedures:

- Abdominal panniculectomy (removal of fat and skin from the abdomen)
- Autologous Chondrocyte Transplant
- Behavioral health and substance use disorder services (for Prior Approval, call HNE's Health Services department at (800) 842-4464 ext. 5028):
    - Partial Hospitalization Program (PHP and Intensive Outpatient Program (IOP)
    - Neuropsychological testing
    - Repetitive Transcranial Magnetic Stimulation (rTMS)
    - Family Stabilization Team (FST) treatment
- Biofeedback for urinary incontinence
- Cancer clinical trials
- Cardiac monitoring (long term 30-days)
- Chair van services and non-emergency ambulance trips
- Cochlear implants
- Computed Tomography (CT scans or CAT scans)
- Corrective surgery of the palate, uvula, or related structures for obstructive sleep apnea
- Dermal injections for treatment of facial lipodystrophy syndrome
- Durable medical equipment
- Endothelial Keratoplasty – External
- Eyelid surgery

- Female breast reduction surgery
- Gastric Stimulator for specific diagnoses
- Gender reassignment operations and treatments
- Genetic testing (for example: BRCA and Colaris tests)
- Home Health Care-Skilled home care services, including for example:
    - Home infusion
    - Home perinatal monitoring
    - Home skilled nursing care
    - Home physical, occupational and speech therapy
- Hospice services
- Hospital and anesthesia services for dental procedures for Members with a serious medical condition
- Human organ transplants and bone marrow transplants
- Implantable miniature ocular telescope
- Infertility treatment: Members must meet the requirements of HNE's Infertility Protocol. You may call HNE Member Services for a copy of the Protocol.
- INFUSE® Bone Graft – External
- Infusion therapy is when a drug is delivered through a needle or catheter into a vein. Some drugs can be delivered by a subcutaneous infusion. (That is, delivered through a needle that is place into the fatty tissue just below the skin's first layer.) Some high cost infusion drugs require Prior Approval. These drugs are not a part of your prescription drug benefit. They are part of your medical benefit. To find out if a certain drug requires Prior Approval, your provider can check the pharmacy "Drug Lookup" on healthnewengland.org.
- Injectable drugs (Some injectable drugs require Prior Approval. These are not a part of your prescription drug benefit. They are part of your medical benefit. HNE is responsible for these drugs' Prior Approval. To find out if an injectable drug requires Prior Approval, check HNE's Drug Formulary on healthnewengland.org or call HNE Member Services.)
- Magnetic Resonance Angiogram (MRA)
- Magnetic Resonance Imaging (MRI)
- Mandibular Advancement Device for obstructive sleep apnea
- Medical supplies
- Mobi-C Artificial Cervical Disc
- Nuclear Cardiac Imaging in a doctor's office
- Nutritional Support (see the *"Covered Benefits"* section of this Member Handbook)
- Oncogene typing associated with treatment for breast cancer
- Orthognathic surgery (jaw surgery)
- Orthotics
- Outpatient Hyperbaric Oxygen (HBO) therapy
- Photochemotherapy and Phototherapy[1] for covered diagnoses after the first 36 visits
- Positron Emission Tomography (PET) scans
- Preimplantation Genetic Diagnosis (PGD)
- Prosthetic limbs
- Proton Beam Therapy
- Radiofrequency ablation for chronic spinal pain
- Reduction Mammoplasty
- Rhinoplasty
- Sacral nerve stimulation for urinary incontinence
- Scleral lenses
- Services from Out-of-Plan Providers
- Speech therapy after the initial evaluation
- Spinal cord stimulation

[1] For continued treatment you must have Prior Approval every three months. Prior Approval will only be given if your doctor has recorded that your condition has improved.

- Spinal Muscular Atrophy (SMA)
- Stretta® treatment for gastroesophageal reflux disease (GERD)
- Surgical management of morbid obesity
- Testing for the Transmembrane Activator and CAML Interactor *(TACI)* gene
- Total Ankle Replacement (TAR)
- Total Hip Resurfacing
- Any other services listed in this Member Handbook that indicate that Prior Approval is necessary

HNE will notify you of any changes to this list through our Member newsletter or through a direct mailing.

Prior Approval Process
To request Prior Approval, your treating doctor must submit a Prior Approval Request Form to HNE either by mail or by fax.

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

- A Covered Service
- Medically Necessary
- To be provided in the appropriate setting
- In keeping with generally accepted medical practice
- Available within the HNE network
- Consistent with HNE's 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 we get all needed information. This information includes the results of any face-to-face clinical evaluation or second opinion required. If HNE approves coverage, we 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
- 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 (800) 310-2835 to know its status or outcome. You may call HNE's Health Services Department if you want a copy of the clinical criteria HNE uses to make its decision.

The *"Covered Benefits"* section of this Member Handbook tells you if a particular item needs Prior Approval. You may also call Member Services.

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

CONCURRENT REVIEW PROCEDURES

HNE may approve certain procedures and services, such as inpatient hospital stays for specified procedures and ongoing courses of treatment. However, HNE will then review the Medical Necessity and appropriateness of the procedure during your stay or during the course of your treatment. This is called "concurrent review." In doing this, if HNE decides to terminate or reduce your coverage, we will notify you in writing prior to the reduction or termination of the service.

In the case of a decision to approve an extended stay or additional services, we will notify your provider by telephone within one working day, and send written or electronic confirmation to you and your provider within one working day thereafter. A written or electronic notification will include the number of extended days or the next review date, the new total number of days or services approved, and the date of admission or initiation of services. In the case of an Adverse Determination, we will notify your provider by telephone within 24 hours, and send written or electronic notification to you and your provider within one working day thereafter. The service shall be continued without liability to you until you have been notified of the determination.

If you decide to appeal our decision, HNE will continue to cover the services until your appeal is completed. Any request to extend the course of treatment involving urgent care will be decided and communicated within 24 hours after receipt. For this to occur, the request must be made at least 24 hours prior to the expiration of the course of treatment.

RETROSPECTIVE REVIEW PROCEDURES

Retrospective review is an initial review of any service that was already received by a Member. If HNE determines that the service was not Medically Necessary or appropriate, HNE may deny the claim for benefits. HNE will notify you of any claims denied on this basis within thirty (30) days of HNE's receipt of the claim.

WRITTEN NOTIFICATION OF AN ADVERSE DETERMINATION

If we decide not to approve coverage based upon medical necessity and appropriateness, we will send you and your provider a written notification of the Adverse Determination. The written notice will include a substantive clinical reason that is consistent with generally accepted principles of professional medical practice.

We 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 HNE, if any
- Reference and include applicable clinical practice guidelines and review criteria
- Offer your doctor or treating practitioner the opportunity for a case discussion or reconsideration (see below)
- Provide you with a clear, concise and complete description of HNE's grievance process and the procedures for obtaining external review pursuant to 105 CMR 128.400

CASE DISCUSSION AND RECONSIDERATION PROCESSES

If your doctor or treating practitioner disagrees with an Adverse Determination, he or she may request a case discussion with an HNE physician reviewer. This discussion may result in the reversal of HNE's decision. Your doctor or treating practitioner may also request a reconsideration of our decision from a clinical peer reviewer. This will be conducted 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 on your behalf. The case discussion and reconsideration processes are not prerequisites to the HNE grievance process or an expedited appeal. For more information, see the *"Inquiries and Grievances"* section of this Member Handbook.

SECTION 6 – INQUIRIES AND GRIEVANCES

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- If you have a complaint about the care you have received or about HNE's service, we want to know.
- If you are not satisfied with any aspect or action of HNE, you may have the right to appeal.

INQUIRY PROCESS

An "inquiry" is any communication that requests redress of an HNE action, omission, or policy. If you have an inquiry:

- Please call us. We will review your inquiry and respond by phone or letter within three business days.
- We will then ask you if you are satisfied with our response. If you tell us that you are not satisfied, we will offer to start a review of your complaint through the internal grievance process.
- We can start this review process over the telephone. If you choose not to start a grievance during our call, we will send you a letter to explain your right to have your inquiry processed as an internal grievance. If your concern is about a provider or provider office, HNE may share the details of your concern with that provider or office.
- The inquiry process is not used to review Adverse Determinations. Adverse Determinations must be reviewed through the internal grievance process, which is described below.

INTERNAL GRIEVANCE PROCESS

This section describes key terms, how to submit a grievance, and what to expect from HNE. A "grievance" is any oral or written complaint about any aspect or action of HNE relative to the Member or about quality of care or Plan administration. Grievances also include benefit appeals and appeals of Adverse Determinations or clinical appeals. The following chart describes the different types of grievances and the timeframes within which HNE must respond to your grievance. Please note that the time limits in this section may be waived or extended if both HNE and the Member agree. All time frames begin on the date that HNE receives your grievance, on the date you notify HNE that you are not satisfied with the response to an inquiry, or on the day immediately following the three-business day period for processing inquiries, if HNE was unable to address your inquiry within that time. Any grievance not properly acted on by HNE within the specified time limits (which include any agreed-upon extensions) will be resolved in favor of the Member. Any agreement to waive or extend time limits shall state the new time limits that apply and will not be longer than 30 calendar days from the date of the signed agreement.

	Overview: Grievances and Decision Time Frames Please note that this chart is for quick reference only. Refer to the explanations in this section for further detail.		
Type of Grievance	**Example**	**HNE will acknowledge within:**	**HNE 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
Complaint (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 that was 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.		
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
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 a hospital	48 hours	72 hours

SUBMITTING YOUR GRIEVANCE

You must submit your grievance within 180 calendar days after you receive notice that HNE has denied your claim for services. You may submit your grievance by telephone, in person, by mail, or by electronic means. 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 us by:

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

Fax: (413) 233-2685

Telephone: (413) 787-4004 or (800) 310-2835 (TTY: 711)

For complaints and appeals only, if you are faxing information on a billing issue, please fax to Member Services at (413) 233-2655.

Your authorized representative may also submit the grievance on your behalf. If you submit a grievance by mail, HNE will send a written acknowledgement of receipt of your grievance within five business days. If you submit your grievance orally, HNE will put your grievance in writing and send a copy to you within 48 hours. If your grievance is about a clinical denial, we may ask you to sign a form releasing your medical or treatment information to HNE.

REVIEW PROCESS

HNE 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 subordinates of anyone involved in the initial decision.

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 we need records from Out-of-Plan Providers, HNE may need to ask you to submit 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, we will also ask you to agree, in writing, to an extension of up to 30 business days after you return the release to issue a decision. If you choose not to sign the release, or if HNE does not receive a signed release within the required time limit (refer to the Overview chart above), we may, at our 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, HNE may offer you a reconsideration. HNE 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 HNE offers you a reconsideration based on these facts, HNE will agree in writing on a new time period for review, but in no event greater than 30 business 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 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.

If a grievance is filed concerning the termination of ongoing coverage or treatment that HNE previously approved, HNE will continue to cover the disputed service or treatment through the completion of the internal grievance process regardless of the final decision. HNE will not continue to cover medical care that was terminated pursuant to a specific time or episode-related exclusion.

Expedited Review Process: For Urgent, Inpatient, or Immediately Needed Services
HNE 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, HNE 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 the patient absent action within the 48-hour time period.

You have the right to file an expedited external review at the same time as you file an expedited appeal request with HNE. You can find more information about expedited external reviews later in this section.

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 a Member with a terminal illness appeals 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 timeframes 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 HNE's 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 hearing within five business days. You and/or your authorized representative may attend the conference. HNE will authorize its representative at the conference to decide your grievance.

OUR 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
- Reference and include the specific plan provisions on which the decision was based
- Specify alternative treatment options covered by HNE, 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 HNE'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 we notify you of our final decision. You must submit the request within 120 days after you receive HNE's 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 received 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. HNE 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. HNE will abide by the decision of the IRO.

SECTION 7 – ELIGIBILITY

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- To be eligible as a Member you normally must live in the HNE Service Area.
- Eligibility depends on the terms of the Group Insurance Commission contract.
- Dependent coverage normally ends at age 26.
- HNE may require reasonable evidence of eligibility from time to time.

The Group Insurance Commission determines the eligibility of any person enrolling in this plan. For additional eligibility details, refer to the GIC Regulations at: http://www.mass.gov/anf/employee-insurance-and-retirement-benefits/coordinator-information/gic-regulations. HNE may require proof of eligibility from time to time.

RESIDENCY REQUIREMENT

You must live within the HNE Service Area. This rule does not apply to a Dependent child who is enrolled as a full-time student.

SUBSCRIBERS

To be eligible as a Subscriber, you must meet the Group Insurance Commission's eligibility rules and be either:

- An employee or retiree of the Commonwealth of Massachusetts, certain municipalities or other entities that participate in the GIC.
- A participant in the Group Insurance Commission's Retired Municipal Teacher Program and Elderly Governmental Retiree Program, who is not eligible for Medicare.
- A Qualified Beneficiary as defined by applicable laws and regulations concerning continuation of health insurance coverage.
- A surviving spouse of an eligible employee or retiree insured with GIC coverage at the time of death.

DEPENDENTS

To enroll as a Dependent, you must meet the GIC's eligibility rules and be either:

- The employee's or retiree's spouse or a divorced spouse who is eligible for Dependent coverage pursuant to Massachusetts General Laws Chapter 32A as amended.
- An unmarried child who upon becoming 19 years of age is mentally or physically incapable of earning his or her own living, proof of which must be on file with the GIC.
- A child, stepchild, adoptive child or eligible foster child up to age 26.
- A full-time student at an accredited educational institution at age 26 or over may elect to continue GIC coverage.

ADOPTED DEPENDENTS

When can I enroll a child whom I have adopted or am trying to adopt?
Adopted children must be enrolled within 60 days of placement in the home. Complete a GIC Enrollment Form and send it to the GIC along with a letter from the adoption agency that states the date the child was placed in the home.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

What is a Qualified Medical Child Support Order?
A medical child support order is an order from the appropriate state court requiring a group health plan to provide coverage for a participant's child. QMCSO provisions do not define the term "child" or provide a maximum age limit. An order is qualified if it:

- Creates or recognizes the recipients' rights to receive benefits
- Provides the name and last known mailing address of the participant and each alternate recipient
- Provides a reasonable description of coverage
- Provides the period covered by the order
- Describes the plans to which the order applies
- Does not require the plan to provide any type of benefit that is not normally available

If a QMCSO is received by the Group Insurance Commission and the order qualifies, the GIC will comply with all state medical child support laws on eligibility and enrollment

CONTINUED DEPENDENT COVERAGE

What happens when my full time Student Dependent turns 26?
A dependent child who reaches age 26 is no longer eligible for coverage under this Plan. Dependents age 26 or over who are full-time students at accredited educational institutions may continue to be covered. However, you must pay 100% of the individual premium. The student must also submit an application to the GIC no later than 30 days after his or her 26th birthday. If this application is submitted late, your dependent may apply during the GIC's annual enrollment period. Full-time students age 26 and over are not eligible for continued coverage if there has been a two-year break in their GIC coverage.

What happens if my full-time Student Dependent goes to a school out of the HNE Service Area? Will HNE still cover him/her?
Dependents attending and residing at school outside of the HNE Service Area are covered for:

- Follow-up visit after an:
    - ER visit
    - Urgent Care Visit
- Non-routine Medical Office Visit **for urgent care**
    - Includes Diagnostic Lab and X-Ray
- Allergy Injections
- Outpatient Behavioral Health Visits
- Outpatient Short-term Rehabilitation Services

All services require Prior Approval by HNE. **NOTE**: Emergency services do not require Prior Approval.

DISABLED CHILD DEPENDENTS

What happens if my child is disabled when he or she turns 26?
A physically or mentally disabled child age 26 and older who was incapable of self-support before his/her 19th birthday may obtain Handicapped Dependent Coverage. Application must be made to the GIC to obtain this coverage. Coverage is subject to GIC approval and the insured parent's continued coverage with the GIC. If approved, disabled children receive their own identification numbers but are part of the family.

DEATH OF A SUBSCRIBER

In the event of the death of the subscriber, the surviving spouse and/or eligible dependent children may be able to continue coverage under this health care program. Surviving spouse coverage ends upon remarriage.

OPTION TO CONTINUE COVERAGE AFTER A CHANGE IN MARITAL STATUS

What happens if I divorce? Is my former spouse still eligible for coverage?
Your former spouse will not cease to qualify as a dependent under the Plan solely because a judgment of divorce or separate support is granted. (For the purposes of this provision, "judgment" means only a judgment of absolute divorce or of separate support.) Massachusetts law presumes that he or she continues to qualify as a dependent, unless the divorce judgment states otherwise.

If you get divorced, you must notify the GIC within 60 days and send the GIC a copy of the following sections of your divorce decree: Divorce Absolute Date, Signature Page, and Health Insurance Provisions. **If you or your former spouse remarries, you must also notify the GIC. If you fail to report a divorce or remarriage, the Plan and the GIC have the right to seek recovery of health claims paid or premiums owed for your former spouse.**

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

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

If your former spouse moves out of the HNE Service Area, he or she will no longer be eligible for Health New England coverage.

In addition, federal law permits continuation of group health care coverage for divorced spouses. See the *"Continuation of Coverage Options"* section of this Member Handbook.

What happens if I remarry? Is my former spouse still eligible for coverage?
If you remarry and your divorce judgment allows the continuance of health care coverage after your remarriage, your former spouse may continue coverage under an individual policy with a separate premium for that policy. Coverage ends if your former spouse remarries. If your former spouse moves out of the HNE Service Area, he or she will no longer be eligible for Health New England coverage.

In addition, federal law mandates continuation of group health care coverage for divorced spouses. See the *"Continuation of Coverage Options"* section of this Member Handbook.

SECTION 8 – HOW TO ENROLL AND WHEN COVERAGE BEGINS

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- You may enroll within 60 days of a qualifying event or within 10 days of date of hire.
- You may enroll during the Annual Enrollment Period.
- The Group Insurance Commission sets your Effective Date of coverage.
- HNE will not provide any coverage before the set Effective Date.
- There are special rules for late enrollments.

SUBSCRIBER ENROLLMENT

Who can enroll?
Eligible employees and retirees can enroll in the Plan. If you are retired and eligible for, and/or enrolled in, Medicare Part A & Part B, you may not enroll in this plan. Please see Health New England's Member Handbook for Group Insurance Commission Medicare Enrolled Retirees.

When can a Subscriber enroll?
A Subscriber can enroll in the Plan within 10 days of date of hire, within 60 days of a qualifying event or during the Annual Enrollment Period.

Are there any times when I can enroll outside the above time period?
Yes. Under the Health Insurance Portability and Accountability Act (HIPAA), if you did not enroll in the Plan when first eligible, you will be allowed to enroll yourself and your eligible Dependents at a later date if any of the below conditions are met:

- You did not enroll in HNE because you had COBRA continuation coverage under another plan when you otherwise became eligible to enroll in HNE, and that coverage has since been "exhausted"
- You did not enroll in HNE because you had other insurance coverage when you otherwise became eligible to enroll in HNE, and you subsequently lost your eligibility for that coverage

If you meet the above conditions, you must apply for enrollment to the Group Insurance Commission within 60 days from the loss of coverage.

Special Enrollment Rights Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)
You and your eligible Dependents also may enroll in the Plan at a later date if you meet any of the following conditions:

- You or your Dependent were covered under a Medicaid plan or state child health plan and that coverage terminated due to a loss of eligibility
- You or your Dependent become eligible for assistance from a Medicaid plan or state child health plan, with respect to coverage under the Plan

In both cases, you must request special enrollment through the GIC within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

APPLICATION FOR COVERAGE

You must apply to the GIC for enrollment in the Plan. To obtain the appropriate forms, active employees should contact their GIC Coordinator, and retirees should contact the GIC.

What happens if I am already enrolled but wish to add a new spouse or new dependent?
You must complete an enrollment form to enroll or add dependents. Additional documentation may be required, as follows:

Newborns: copy of hospital announcement letter or the child's certified birth certificate

Adopted children: photocopy of proof of placement letter or adoption

Foster children ages 19-26: photocopy of proof of placement letter or court order

Spouses: copy of certified marriage certificate

HOW DO I ENROLL?

To enroll in HNE you must meet the eligibility requirements of the *"Eligibility"* section of this Member Handbook. You must submit the GIC enrollment forms to your Group Insurance Commission Coordinator at your work site if you are an active employee, or directly to the Group Insurance Commission if you are a retiree.

What happens if I am pregnant, have a procedure or visit already scheduled, or have a chronic condition?
Please contact our Health Services Department. A nurse clinical liaison will talk with you about the transition of your care. *This is especially important if you are seeing a provider who is not an In-Plan Provider. You should also read the "Continued Treatment (Transitional Care)" provisions in the "Disclosures Required by Law" section of this Member Handbook.*

SECTION 9 – TERMINATION

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- HNE may end your coverage for certain specified reasons.
- Your employer may end your coverage.
- If you lose your coverage, you may have the right to continue coverage under the Federal COBRA law or in HNE's Non-Group plan.

HOW THIS AGREEMENT MAY END

Termination of Participation

Your eligibility for Plan benefits ends as of the date specified by your employer.

HNE may cancel your coverage or refuse to renew your coverage only in the following circumstances:

1. As allowed by state or federal law.
2. The Commonwealth's agreement with Health New England ends and is not renewed.
3. If you commit misrepresentation or fraud. The effective date of termination may, at HNE's option, be any day after the date of the misrepresentation or fraud.
4. You commit an act of physical or verbal abuse that poses a threat to providers, other HNE Members, or HNE's employees or agents that is unrelated to your physical or behavioral condition. At HNE's option, the effective date of termination may be any day after the date of the abuse.
5. If you relocate outside the HNE Service Area.

What rights do I have when HNE ends my coverage?
HNE will provide for continuation of benefits to the full extent required under the law. See the *"Continuation of Coverage Options"* section of this Member Handbook. In addition, HNE will cooperate with the Group Insurance Commission to facilitate the availability of continued coverage as required by law.

SECTION 10 – CONTINUATION OF COVERAGE OPTIONS

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- If you lose your coverage, you may have the right to continue your coverage.
- If you lose your coverage, you have the right to receive evidence of HNE coverage.

SURVIVORS

In the case of the death of an employee or eligible enrolled retiree, the surviving spouse may continue health plan coverage until remarriage. The surviving spouse must apply to the Group Insurance Commission for this coverage within 60 days of the date of the employee or retiree's death. Former and legally separated spouses are not eligible for survivor coverage.

In the case of the death of a single or divorced employee or retiree, or the surviving spouse of a deceased employee or retiree, Dependent children may continue coverage through COBRA for up to 36 months. (See the *"Eligibility"* section of this Member Handbook) or until they become eligible for other group health coverage, whichever is earlier. Application for continued coverage must be made within 60 days of the death of the insured parent. Orphan coverage is available for some Dependents; please contact the GIC for more information.

CONTINUATION COVERAGE UNDER FEDERAL LAW (COBRA)

Under the federal law called COBRA (which stands for the Consolidated Omnibus Budget Reconciliation Act), if you lose Group health insurance coverage, you may have the right to temporarily continue coverage at your own expense. In general, you can continue coverage if you lose coverage for any of these reasons:

- The Subscriber leaves employment (except for gross misconduct), is laid off, or has his or her hours reduced
- A Spouse gets divorced from the Subscriber
- A child Dependent is no longer eligible as a Dependent (see the *"Eligibility"* section of this Member Handbook)
- A student Dependent is no longer a full-time student and is not eligible for coverage as a Dependent
- The Subscriber dies

Federal law determines the amount Members pay for coverage and the length of the continuation coverage. For more detailed information about your rights under COBRA, see Appendix A, Group Health Continuation Coverage under COBRA. You must notify the Group Insurance Commission within 60 days of the date of the event or the date on which coverage would end under the Plan because of the event, whichever is later.

CONTINUATION COVERAGE FOR DIVORCED SPOUSES UNDER STATE LAW

Massachusetts law (M.G.L. C. 32A S.11A) gives Members the right to continue health coverage if they lose their eligibility for coverage following a Divorce. The divorced spouse can also continue coverage under the COBRA law described in "Continuation Coverage under Federal Law," or he or she can convert to Non-Group coverage.

EMPLOYEES ON MILITARY LEAVE

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and

present members of the uniformed services, and applicants to the uniformed services. The GIC has more generous guidelines for benefit coverage that apply to person subject to USERRA, as set forth below:

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

Please see Appendix A for more details.

CONVERSION TO INDIVIDUAL (NON-GROUP) COVERAGE

Group Subscribers and Dependents who are no longer eligible for Group coverage, or who have exhausted their continuation coverage may be eligible to continue coverage by enrolling in individual (non-group) coverage through HNE, the Commonwealth Healthcare Connector, or Health Services Administrators. For more information, contact HNE Member Services or go online to healthnewengland.org.

YOUR HIPAA PORTABILITY RIGHTS

If you should terminate your GIC health plan coverage, you may need to provide evidence of your prior coverage in order to enroll in another group plan, to reduce a waiting period in another group health plan, or to get certain types of individual coverage, even if you have health problems. This notice describes certain HIPAA protections available to you under federal law when changing your health insurance coverage. If you have questions about your HIPAA rights, contact the Massachusetts Division of Insurance at (617) 521-7777 or the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272.

When you have the right to specially enroll in another plan. If you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees. In order to do so, however, you must request enrollment within 30 days of your group coverage termination. Marriage, birth, adoption or placement for adoption can also trigger these special enrollment rights. Therefore, should you have such a life event or your coverage end, you should request special enrollment in another plan as soon as possible if you are eligible for it.

You have the right not to be discriminated against based on health status. A group health plan may not refuse to enroll you or your dependents based on anything related to your health, nor can the plan charge you or your dependents more for coverage, based on health factors, than the amount it charges similarly situated individuals for the coverage.

When you have the right to individual coverage. If you are eligible for individual coverage, you have a right to buy certain individual health policies without being subject to a pre-existing condition exclusion period. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more
- Your most recent coverage was under a group health plan
- Your group coverage was not terminated because of fraud or nonpayment of premium
- You are not eligible for another group health plan, Medicare or Medicaid, and do not have any other health insurance coverage

Therefore, if you are interested in obtaining individual coverage and you meet the criteria to be eligible, you should apply for this coverage as soon as possible to avoid forfeiting your eligibility due to a 63-day break. Contact the Group Insurance Commission for a HIPAA Creditable Coverage Notice.

SECTION 11 – MEMBERS' RIGHTS AND RESPONSIBILITIES

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- As a Member of HNE, you have certain rights and responsibilities.

MEMBERS' RIGHTS

As a Member of HNE, you have certain *rights*. These are to:

a) Receive information on HNE, its services, In-Plan Providers, policies, procedures, and your rights and responsibilities. HNE will not release information that by law may not be given to Members or any third party. We will not disclose privileged information about In-Plan Providers.

b) Be treated with respect and recognition of your dignity and right to privacy.

c) Participate in health care decisions with your doctor or other health care provider.

d) Expect that your physician or other health care provider will fully and openly discuss appropriate Medically Necessary treatment options, regardless of the cost or benefit coverage. It does not mean that HNE covers all treatment options. If you are unsure about coverage, please contact HNE Member Services at (413) 787-4004 or (800) 310-2835 (TTY: 711).

e) Contact us with a grievance or complaint about HNE or a plan provider. See the *"Inquiries and Grievances"* section of this Member Handbook for instructions.

f) Refuse a treatment, drug, or other procedure recommended by your doctor or other health care provider as the law allows. Providers should tell you about any potential medical effects of refusing treatment.

g) Select a Primary Care Provider (PCP) who is accepting new patients.

h) Change your PCP. You may choose any Plan PCP except those who have notified HNE that they no longer accept new patients.

i) Have access, during HNE's business hours, to HNE Member Services representatives who can answer questions and help resolve problems.

j) Expect that your medical records and information on your relationship with your doctor will remain confidential in accordance with state and federal law and HNE policies.

k) Make recommendations regarding HNE's Member rights and responsibilities policies.

MEMBERS' RESPONSIBILITIES

As a Member of HNE, you have certain *responsibilities*. These are to:

l) Provide, as much as possible, the information your providers need to care for you. This includes information on your present and past medical conditions, as you understand them, before and during any course of treatment.

m) Follow the treatment plans and instructions for care that you have agreed on with your provider.

n) Read HNE materials to become familiar with your benefits and services. If you have questions, you should call Member Services at (413) 787-4004 or (800) 310-2835 (TTY: 711).

o) Follow all HNE policies and procedures.

p) Treat providers and HNE staff with the respect and courtesy that you expect for yourself.

q) Arrive on time for appointments or give proper notice if you must cancel or will be late.

r) Understand your health problems, an important factor in your treatment. If you do not understand your illness or treatment, talk it over with your doctor.

s) Participate in decision-making on your health care.

t) Inform HNE of any other insurance coverage you may have. This helps us process claims and work with other payors.

u) Notify the Group Insurance Commission (GIC) of status changes (such as a new address) that could affect your eligibility for coverage.

v) Help HNE and plan providers to get prior medical records. You agree that HNE may obtain and use any of your medical records and other information needed to administer the plan.

w) Consider the potential effects if you do not follow your provider's advice. When a service recommended by a plan doctor is covered, you may choose to decline it for personal reasons. For example, you may prefer to get care from Out-of-Plan Providers rather than plan Providers. In these cases, HNE may not cover substitute or alternate care that you prefer.

SECTION 12 – COORDINATION OF BENEFITS AND SUBROGATION

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- HNE has certain coordination of benefits, reimbursement and "subrogation" rights that are explained in this Section.
- You must cooperate with us and give us the information that we need to coordinate benefits or subrogate a claim.

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

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

Benefits under this Member Handbook will be coordinated to the extent permitted by law with other plans covering health benefits, including: all health benefit plans, governmental benefits (including Medicare), motor vehicle insurance, medical payment policies, and homeowner insurance.

HNE's rights under this section will remain even after this Member Handbook ceases to be in effect, but only as to services provided while the Member Handbook was in effect.

COORDINATION OF BENEFITS

What happens if I have other group health insurance?

When anyone has coverage with HNE and another Group health plan, it is known as "double coverage." You must tell us if you or a family member has double coverage. You must also send us documents about your other insurance if we ask for them. When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary. It pays benefits next. This process is known as "coordination of benefits." If we are the secondary payer, we may be entitled to receive payment from your primary plan. HNE decides which insurance is primary based on rules used throughout the insurance industry, or as required by law and applicable regulations. A copy of these rules is available upon request.

We will always provide you with the benefits described in this Member Handbook. However, HNE will only provide coverage under this Member Handbook to Members who have other health insurance coverage if they follow HNE policies and rules. For example, if you receive certain services without Prior Approval, HNE will not cover the services you receive. Except as indicated below, please show all your health insurance cards to doctors, hospitals, pharmacies, and other health care providers at the time of your visit.

Medicare Secondary Payer Mandatory Reporting Law

HNE is required to provide the Centers for Medicare and Medicaid Services (CMS) with information about your group health plan and its covered members. CMS is requiring this information to coordinate Medicare benefits and payments. To comply with the CMS requirements, you must provide Social Security numbers (SSNs) for yourself and your covered dependents upon request.

What happens if one of my Dependents or I am enrolled in Medicare?
You must tell us and the Group Insurance Commission if you or a family member is enrolled in Medicare Part A or B. Medicare rules determine who has the first responsibility to pay for medical care. When HNE provides benefits to a Medicare eligible Member, HNE will coordinate coverage with Medicare according to Medicare rules. **If you are an ACTIVE employee age 65 or over, present your HNE card (not your Medicare card) to ensure HNE is charged for the visit**. If you are still working and are age 65 or over, HNE is your primary health insurance provider; Medicare (if you have it) is secondary. You may need to explain this to your provider if he/she asks for your Medicare card.

What happens if I am entitled to benefits under another medical payment policy?
For Members who are injured and therefore entitled to benefits under the medical payment benefit of any other insurance policy, such as a homeowner's or auto insurance policy, such coverage will be primary to the coverage under this Member Handbook. When HNE provides benefits to a Member that the Member is eligible for under such other medical payment policy, HNE will work with the other carrier. If you are in a motor vehicle accident, you must use your auto insurance carrier's Personal Injury Protection (PIP) coverage before we will pay for any of your expenses. You must send any explanation of payment or denial letters from an auto insurance carrier in order for us to pay for a claim that is related to a motor vehicle accident. Member responsibility with the HNE plan such as copays, deductible and coinsurance does apply. If the other coverage entitles you to be directly reimbursed for certain medical expenses, you agree to allow the payment to be made directly to HNE.

What happens if I am injured at work? Will HNE pay for the services that I receive?
If HNE has information showing that services provided to a Member are covered under Workers' Compensation, employer's liability, or other program of similar purpose, or by a federal, state, or other government agency, HNE may suspend payment for such services until a determination is made whether payment will be made by such program. If HNE provides or pays for services for an illness or injury covered under Workers' Compensation, employer's liability, or other program of similar purpose, or by a federal, state, or other government agency, HNE will be entitled to recover its expenses from the provider of services or the party or parties legally obligated to pay for such services.

SUBROGATION

As an HNE Member, you agree to give HNE a right of subrogation and a right of reimbursement. These terms are explained in this section.

Who pays my medical bills if another party is responsible for my injuries or illness?
Sometimes, HNE pays medical bills for which another person (or his or her insurer) is legally responsible. HNE then has the right to make a claim against the third party to recover for the benefits and services provided. This is called subrogation.

For example, if you are in an accident and another party is liable for your injuries, HNE will file a lien to recover the amount paid or owed to the provider by HNE (which may differ from the provider's fee-for-services charges) for any benefits provided to you under this Member Handbook. HNE has a right to recover even if you do not receive full settlement. HNE's recovery is limited, however, to the amount you received by suit or settlement.

HNE also has the right to sue in your name at HNE's expense. If a suit brought by HNE results in an award greater than the provider's charges, HNE then has the right to recover costs of the suit and attorney's fees out of the excess.

What if I have already received payment for my injuries?
If you receive payment from another party for injuries caused by the acts or omissions of a third party, HNE has a right of reimbursement. The right of reimbursement arises only after you receive payment for your injuries from a third party or that party's insurer. HNE then has the right to request reimbursement for the benefits and services provided to you.

If you receive payment from a third party, HNE will seek reimbursement from you for the provider's charges for the benefits and services provided to you. HNE's right to reimbursement applies even if you did not receive full settlement for your injuries. HNE will not ask for more than you received by suit or settlement.

What are my responsibilities as a Member when HNE decides to subrogate?
As a Member, it is your duty to cooperate with HNE and provide HNE with any documents and information needed to help HNE receive its repayment. You must not do anything to hinder or prevent HNE from pursuing 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 HNE, including reasonable attorney fees, in enforcing its rights under this Member Handbook.

SECTION 13 – OTHER PLAN ADMINISTRATION PROVISIONS

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- HNE and its Providers are independent contractors.
- HNE may amend this Member Handbook at any time.

Amendments
This Member Handbook is effective as of July 1, 2018. If you would like to know if HNE has made any changes to this Member Handbook, please call HNE Member Services. HNE, with the agreement of the Group Insurance Commission (GIC), may amend this Member Handbook at any time if the amendments: (1) are not in violation of any law; (2) comply with applicable rules and regulations of the Massachusetts Division of Insurance; or (3) are required by law, regulation, or rule. These changes will apply to all agreements of this type, not just to this Member Handbook. These changes will be effective whether or not an individual Member in fact receives notice of the amendment. Changes will apply to all benefits or services provided after the Effective Date of the change.

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

Members and Other Third Parties
Except as specifically provided in this Member Handbook, this Member Handbook will not create any rights in a Member or any other person as a third party beneficiary of this Member Handbook.

Health New England and Providers
The relationship between HNE and its In-Plan Providers is a direct or indirect independent contractor relationship. As such, each party is at all times acting and performing as an independent contractor, and neither party will have or exercise any control or discretion over the method by which the other party shall perform such work or render or perform such services or functions. It is further expressly understood that no work, act, commission, or omission of any party, its employees, agents, or servants will be construed to make or render any party, its employees, agents or servants an employee, agent, servant, representative or joint venture with the other party.

Payment of Providers
HNE pays In-Plan Providers in a number of ways. For example, we may pay a set fee for each *service*, each *day* (of a hospital stay), or each *case*. We also may pay a set amount each month for each Member signed up with a provider or group of providers, regardless of whether the Member is actually treated. (This payment is called a *capitation* payment.) In many cases, HNE assigns providers to a grouping or "pool" of providers. In these cases, HNE puts a part of each payment to the provider into his/her pool until the end of the year. If the pool meets set goals or targets, HNE will pay some or the entire amount put aside, or the full amount plus a bonus. HNE does not base payments or bonuses on denials or coverage of services.

Members and Providers
The relationship of a Member to a provider is based solely on the provider-patient relationship. Each provider is solely responsible for all health care services furnished to a Member.

Agreement Binding on Members
By enrolling in the Plan, or receiving benefits or coverage under the Plan, you agree to all terms and conditions of this Member Handbook. Subscribers will be responsible for their Dependents' compliance with this Member Handbook. Minor Dependents of Subscribers will be bound by the actions of the Subscriber.

Waiver
No waiver occurs if HNE fails to enforce any provision of this Member Handbook. HNE may enforce the provision at a future date. Similarly, no waiver occurs if HNE fails to enforce any remedy arising from a default under the terms of this Member Handbook.

Severability
If any part of this Member Handbook is declared not enforceable or not valid, such invalidity or unenforceability will not affect any other section or clause of this Member Handbook. The remaining sections or clauses of this Member Handbook will remain in full force and effect.

Governing Law
This Agreement will be governed and construed according to the laws of the Commonwealth of Massachusetts.

Conformance with Law
Each party agrees to carry out all activities that are taken pursuant to this Member Handbook in conformance with all applicable federal and state laws, regulations, rules, and policies.

Notices
Any notice under this Member Handbook may be given by United States mail, postage prepaid, addressed as follows:

To HNE:	President and Chief Executive Officer Health New England, Inc. One Monarch Place Springfield, MA 01144-1500
To a Subscriber/Member:	To the latest address on file with HNE
To the Group:	Group Insurance Commission P.O. Box 8747 Boston, MA 02114-0998

Circumstances Beyond HNE's Control
HNE will try to arrange for services in the case of major disasters. However, HNE will not be liable for any failure to provide or arrange, or for delay in providing or arranging, services or supplies in the event of any of the following: natural disaster, war, riot, civil insurrection, strikes, epidemic, acts of terrorism, or any other Emergency or event caused by an act which is beyond the control of HNE.

SECTION 14 – NOTICE OF PRIVACY PRACTICES

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- 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.

Health New England (HNE) knows how important it is to protect your privacy at all times and in all settings. This Notice of Privacy Practices describes how HNE may collect, use and disclose your protected health information, and your rights concerning your 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.

State and federal law require us to maintain the privacy of your protected health information. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) also requires us to provide you this notice about our legal duties and privacy practices.

This notice takes effect July 15, 2019. We must follow the privacy practices described in this Notice while it is in effect. 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. This Notice replaces any other information you have previously received from us with respect to your PHI. Whenever we make an important change, we will publish the updated Notice on our website at http://healthnewengland.org/notice-of-privacy-practices. We will inform subscribers whenever we make a material change to the privacy practices described in this notice in one of our periodic mailings.

How does HNE protect my personal health information?

HNE has a detailed policy on confidentiality. All HNE employees are required to protect the confidentiality of your PHI. An employee may only access your information when they have an appropriate reason to do so. Each employee or temporary employee must sign a statement that he or she has read and understands the policy. On an annual basis, HNE will send a notice to employees to remind them of this policy. Any employee who violates the policy is subject to discipline, up to and including dismissal. If you would like a copy of HNE's Policy on Confidentiality, you may request a copy from HNE Member Services. In addition, HNE includes confidentiality provisions in all of its contracts with plan providers. HNE also maintains physical, electronic, and procedural safeguards to protect your information.

How does HNE collect protected health information?

HNE gets PHI from:

- Information we receive directly or indirectly from you, your employer or benefits plan sponsor through applications, surveys, or other forms (e.g., name, address, social security number, date of birth, marital status, dependent information, employment information and medical history).
- Providers 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 HNE use and disclose my protected health information?

HIPAA and other laws allow or require us to use or disclose 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: HNE uses and discloses protected health information 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 for these purposes:

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, which may involve:

- Determining your eligibility for benefits;
- Paying claims for services you receive;
- Making medical necessity determinations;
- Coordinating your care, benefits or other services;
- Coordinating your HNE coverage with that of other plans (if you have coverage through more than one plan to make sure that the services are not paid twice;
- Responding to complaints, appeals and external review requests;
- Obtaining premiums, underwriting, ratemaking and determining cost sharing amounts; and
- Disclosing information to providers for their payment purposes.

Health Care Operations: We will use and disclose your protected health information to support HNE's other business activities, including the following:

- Conducting quality assessment activities, or for the quality assessment activities of providers and other health plans that have a relationship with you;
- Developing clinical guidelines;
- Reviewing the competence or qualifications of providers that treat our members;
- Evaluating our providers' performance as well as our own performance;
- Obtaining accreditation by independent organizations such as the National Committee for Quality Assurance;
- Maintaining state licenses and accreditations;
- Conducting or arranging for medical review, legal services and auditing functions including fraud and abuse detection and compliance programs;
- Business planning and development, including the development of HNE's drug formulary;
- Operation of preventive health, early detection and disease and case management and coordination of care 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;

- Reinsurance activities; and
- Other general administrative activities, including data and information systems management and customer service.

Health Information Exchanges: We participate in secure health information exchanges ("HIEs"), such as those operated by Pioneer Valley Information Exchange and the Massachusetts statewide HIE ("Mass HIway"). HIEs help coordinate patient care efficiently by allowing health care providers involved in your care to share health information with each other in a secure and timely manner. Your health information will be accessed, used and disclosed via the HIEs in which Health New England participates for purposes of treatment, payment and health care operations.

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 to do so by state or federal law. For example, the HIPAA 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. 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.

Will HNE give my PHI to my family or friends?

We will only disclose your PHI to a member of your family (including your spouse), a relative, or a close friend in the following circumstances:

- You have authorized us to do.
- 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 for such a disclosure (whether in person or on a telephone call), we will either seek your verbal agreement to the disclosure or provide you an opportunity to object to it. 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.

Will HNE disclose my personal health information to anyone outside of HNE?

HNE 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, HNE may delegate certain functions, such as medical management or claims repricing, to a third party that is not affiliated with HNE. HNE may also share your personal health information with an individual or company that is working as a contractor or consultant for HNE. HNE's 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 HNE's 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.

HNE may also disclose information about you to your Primary Care Physician, other providers that treat you and other health plans that have a relationship with you, for their treatment, payment and some of their health care operations.

Will HNE disclose my personal health information to my employer?

In general, HNE 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 HNE 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 medical information, we must obtain your written authorization. A written authorization request will, among other things, 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.

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 of Personal Representative Form. You should return the completed form to HNE's Enrollment Department at One Monarch Place, Suite 1500, Springfield, MA 01144. 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. 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 HNE Legal Department. Please provide us with the specific information we need to fulfill your request. 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 HNE Request for Amendment form. Please contact the HNE 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 that you or your personal representative have authorized; or (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?

To exercise your rights under this Notice or to file a complaint with HNE, please call us at (413) 787-4004, toll-free at (800) 310-2835 (TTY: 711) or write to:

Privacy Officer - Compliance Department
Health New England
One Monarch Place, Suite 1500
Springfield, MA 01144-1500

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 at https://www.hhs.gov/ocr/complaints/index.html.

You will not be retaliated against for filing a complaint with us or the federal government.

SECTION 15 – DISCLOSURES REQUIRED BY LAW

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- This section contains information which the law requires HNE to disclose to its Members.

Quality Management Program
The HNE Quality Management Program is developed annually to address the quality and safety of clinical care and the quality of services provided to the Plan's Members. The written program description defines our quality management program structure, objectives, processes, and resources used to identify, review, measure, monitor, and evaluate the activities implemented by HNE to meet the goals of the program.

HNE also develops a Quality Management Work Plan annually. This is the listing of activities that are implemented to meet our program goals. Projects focusing on patient safety, behavioral health issues, utilization of services, Member and provider communications, confidentiality, disease management, prevention, and continuity of care for Members have been implemented. The time frame for completion of each project is very different. Some are very simple, can be completed in a matter of months, while others are ongoing, and will be followed by HNE throughout the year.

The Plan's Board of Directors has made the Quality Management Committee responsible for the performance of the Plan. The HNE 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 HNE network providers is also essential to the functioning of the Quality Management Program.

If you would like any information regarding the HNE Quality Management Program Description or Work Plan, please contact the Director of Quality Operations at (413) 233-3435. HNE will provide this information on request.

Summary Description of Process for Developing Clinical Guidelines and Utilization Review Criteria
HNE has a written program for how health care service 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 that it develops with the input of local practicing physicians. Physicians outside the HNE staff may be consulted to help make a decision of medical appropriateness. Non-physicians can make a decision to approve care or services. Only HNE 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 annually reviews its utilization review program.

Summary Description of HNE's Procedures in Making Decisions about the Experimental or Investigational Nature of Individual Drugs, Medical Devices, or Treatments in Clinical Trials
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 HNE.
- To evaluate drugs, HNE uses a pharmacy benefit manager. HNE's pharmacy benefit manager uses a committee of physicians and pharmacists to review new FDA-approved drugs that have been available in the United States for at least six months. Some of the criteria used to evaluate drugs are:
    - Safety

    - The potential effects of treatment under optimal circumstances
    - The actual effects of treatment under real life conditions
    - Potential health outcomes and resulting total cost of drugs and medical care, and potential savings available
    - Any restrictions needed to assure safe, effective, or proper use of the drug, patient outcome, or cost effectiveness
- The recommendations by Hayes HNE's pharmacy benefit manager are then screened by an internal HNE 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 HNE committee, which includes In-Plan physicians, for discussion at its next meeting. This allows for local practicing physician input.
- Recommendations will then go to the HNE Medical Policy Committee for final decision. The committee makes a decision based on its review of the recommendations and other HNE-specific data, such as:
    - Prevalence of disease(s) associated with proposed technologies
    - Benefits to HNE Members
    - Cost
    - Use of current technologies and projected use of new technology

HNE does not cover any experimental or investigational device or treatment unless it has been reviewed and approved by HNE's Medical Technology Assessment Committee.

Continued Treatment (Transitional Care)

Provider disenrollment and continuation of coverage requirements:

There are times when HNE will allow you to continue to receive coverage for care after your doctor disenrolls.

Those circumstances are:

- If your PCP leaves. HNE will notify you at least 30 days before the disenrollment of your PCP. HNE will permit you to continue to see your PCP for a period of 30 days after your PCP leaves HNE. HNE will also allow a Member who is in active treatment for a chronic or acute condition to continue to see his or her PCP through the current period of active treatment or up to 90 days after the PCP is leaves, whichever is shorter. You will not be allowed to continue to see your PCP if your PCP leaves for reasons related to quality or for fraud. It is important for you to have a PCP to help ensure you have access to care. If your PCP leaves, HNE will send you a letter to notify you of your new PCP. If you wish to change your PCP, you can do so by following one of these simple steps:
    - Go to our secure online portal at my.healthnewengland.org. Login or register as a member. You will be able to search our provider directory and select a new PCP online.
    - Call Member Services at (413) 787-4004 or (800) 310-2835, Monday – Friday, 8:00 a.m. to 6:00 p.m. Our representatives can provide up-to-date information on PCPs in your areas who are accepting new patients. They can also answer any other questions you may have.
- If your specialist disenrolls. HNE will notify you at least 30 days before the disenrollment. HNE will help you to select a new specialist if you would like. HNE will let a Member who is in active treatment for a chronic or acute condition to continue to see the specialist through the current period of active treatment or for up to 90 days after the specialist is disenrolled, whichever is shorter. You will not be allowed to continue to see this provider if he or she is disenrolled for reasons relating to quality or for fraud.
- If a provider who is treating pregnant Members is involuntarily disenrolled. If this occurs and you are in your second or third trimester of pregnancy, HNE will permit you to continue treatment with your provider through the postpartum period. You will not be allowed to continue to see this provider if he or she is disenrolled for reasons related to quality or for fraud.
- If a provider who is treating terminally ill Members is involuntarily disenrolled. If this occurs and you are terminally ill, HNE will permit you to continue treatment with your provider until your death. You will not be allowed to continue to see this provider if he or she is disenrolled for reasons related to quality or for fraud.

Transitional coverage for new Members:
HNE will provide coverage for a new Member to continue to see an Out-of-Plan Provider for up to thirty 30 days from the Effective Date of coverage if:

- The Member's employer only offers the Member a choice of carriers in which the physician is not a participating provider
- The physician is providing the Member with an ongoing course of treatment or is the Member's PCP.

With respect to an insured in her second or third trimester of pregnancy, this provision will apply to services rendered through the postpartum period. With respect to an insured with a terminal illness, this provision will apply to services rendered until death.

Requirements for transitional coverage:
In all of the above circumstances, HNE will only permit a Member to continue coverage if their provider agrees:

- To accept payment from HNE at the rates applicable to participating providers or at the rates considered payment in full prior to the notice of disenrollment.
- Not to require the Member to be responsible for Cost Sharing that exceeds the amount that could have been required if the provider participated with HNE or if the provider had not been disenrolled.
- To adhere to HNE's quality assurance standards and to provide HNE with necessary medical information related to the care provided.
- To adhere to HNE's policies and procedures, including obtaining Prior Approval and providing services pursuant to a treatment plan, if any, approved by HNE.

Nothing in this section will be construed to require the coverage of benefits that would not have been covered if the provider involved remained an In-Plan Provider.

Notice of Termination for Nonpayment of Premiums
HNE will not deny a Member's claim for covered health care services on the grounds that, prior to the date covered health care services were received, the employer's plan had been terminated for nonpayment of premiums, unless HNE has sent written notice of the termination to the Member prior to the date the covered health care services were received.

Pediatric Specialty Care
HNE will provide coverage of pediatric specialty care, including behavioral health care, by persons with recognized expertise in specialty pediatrics to Members requiring such services.

Physician Profiling Information
Physician profiling information, so called, is available from the Massachusetts Board of Registration in Medicine for physicians licensed to practice in Massachusetts. You can request a physician printout by calling (781) 876-8230 (or in Massachusetts only toll free (800) 377-0550). You can also find information about a Massachusetts licensed physician by visiting massmedboard.org.

HNE's Involuntary Disenrollment Rate
HNE's involuntary disenrollment rate is 0%.

SECTION 16 – DEFINITIONS

Advance Directive – A written statement that tells a Provider what to do if a Member can't make decisions about his or her healthcare.

Adverse Determination – (a) 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. **(b)** 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.

Affordable Care Act (ACA) – Federal law that reforms the healthcare system in the United States.

Agreement – This Member Handbook, any amendments, and the Group Insurance Commission contract between your Group and HNE.

Allowed Amount – Maximum amount on which payment is based for covered health care services.

Alternative Medicine – HNE defines Alternative Medicine as approaches to 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, a broad category of treatment systems such as special diets, homeopathic remedies, electromagnetic fields, therapeutic touch, chiropractic services (except certain specific Covered Services, if any, listed elsewhere in the Member Handbook), herbal medicine, acupuncture, homeopathy, naturopathy, hypnosis, and spiritual devotions or culturally based healing traditions such as Chinese, Ayurvedic, and Christian Science. Alternative Medicine is also referred to as complementary medicine or holistic medicine.

Annual Enrollment Period – That period of each contract year when, by agreement between HNE and the Group, eligible persons may enroll or when Members may transfer from the Plan to an available alternate health benefits plan without any lapse in coverage.

Applied Behavior Analysis (ABA) – 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.

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

Coinsurance – A percentage of the charge for certain Covered Services that must be paid by the Member.

Copay – The amount specified in this Member Handbook or any amendments to this Member Handbook that you are required to pay when receiving Covered Services.

Cost Sharing – The amount a Member pays for covered services. This can include Deductibles, Copays, and Coinsurance.

Covered Services – Medically Necessary Services and benefits to which you are entitled, as set forth in this Member Handbook.

Custodial Care – Custodial Care serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial Care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving Custodial Care, HNE considers the level of care and medical supervision required and furnished. The decision is not based on diagnosis, type of condition, degree of functional limitation, or rehabilitation potential.

Deductible – The cumulative dollar amount that the Member is required to meet for certain Covered Services before HNE pays benefits. The Deductible is applied on a Policy Year basis. For individual plans, payments made by the Subscriber apply to this amount. For family plans, payments made by each family member apply to this amount. You must pay any Copay or Coinsurance for a service. If the Deductible applies to that service, you must pay the difference between your Copay or Coinsurance amount and the amount of Health New England's contracted payment to the provider until the Policy Year Deductible is satisfied.

Dependent – Any person who meets the Dependent requirements of the "Eligibility" section of this Member Handbook, who is enrolled, and for whom HNE has received the premium specified in the Group Insurance Commission contract.

Diagnosis of Autism Spectrum Disorders – Medically Necessary assessments, evaluations including neuropsychological evaluations, genetic testing or other tests to diagnose whether an individual has 1 of the autism spectrum disorders.

Effective Date – The date on which coverage begins under this Member Handbook.

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

Employer Group Agreement – An Agreement between your Group and HNE that details premium rates, Effective Date, and other obligations.

Essential Health Benefits (EHB) – The categories of benefits that all health plans in the individual and small group market must provide. Under the Affordable Care Act (ACA), those categories are:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Behavioral health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Formulary – A list of preferred brand name drugs offered to Members for a higher Copay than generic drugs.

Group – The Commonwealth of Massachusetts Group Insurance Commission.

HAS – HNE Advisory Services, Inc., a Massachusetts corporation, which is wholly-owned subsidiary of HNE and which has entered into a contractual agreement with the Group Insurance Commission.

Health Care Agent – The person responsible for making healthcare decisions for a person who can't make his or her own healthcare decisions.

HNE Service Area – The area in which Health New England is authorized to operate as a managed care plan.

Hospital Services – Those Covered Services that are usually provided by acute care general hospitals in the HNE Service Area and which are prescribed or approved by an In-Plan Doctor.

Identification Card (ID Card) – The card that HNE issues to a Subscriber upon enrollment and which must be presented at the time of service.

Infertility – The condition of an individual who is unable to conceive or produce conception during a period of:

- One year if the female is age 35 or younger
- Six months if the female is over the age of 35

If a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy will be included in the calculation of the 1 year or 6 month period.

In-Plan Doctor – A licensed doctor or oral surgeon who has an existing agreement with HNE to provide certain Covered Services to Members. HNE and the In-Plan Doctor are independent entities, and neither party is the agent, employee, or servant of the other.

1. Primary Care Provider (PCP) – An In-Plan Doctor, physician assistant, or participating nurse practitioner who has been designated by HNE to be primarily responsible for providing or arranging for Covered Services to Members.
2. In-Plan Specialist – An In-Plan Doctor who is eligible to provide a specialty service and who has agreed with HNE to provide such services.

In-Plan Hospital – A licensed acute care general hospital that has agreed with, and been designated by, HNE to provide Hospital Services. HNE and the In-Plan Hospital are independent entities, and neither party is the agent, employee, or servant of the other.

In-Plan Provider – Any hospital, doctor, health care facility, agency, organization, pharmacy, or person that is properly licensed or otherwise authorized to furnish health care services and which has agreed with HNE to provide Medically Necessary services to HNE Members. HNE and the In-Plan Provider are independent entities, and neither party is the agent, employee, or servant of the other.

Medically Necessary Services – Those Covered Services and supplies that HNE's Medical Director determines are (a) essential for the treatment of a Member's medical condition, (b) in accordance with generally accepted medical practice, and (c) provided at an appropriate facility and at the appropriate level of care for the treatment of a Member's medical condition in accordance with generally accepted standards in the medical community.

Member – Any person who is enrolled in HNE and has a right to services under this Member Handbook.

Non-Formulary – Any brand name drug that is not listed on the Formulary.

Out-of-Plan Provider – Any licensed provider who is not an In-Plan Provider.

Out-of-Pocket Maximum – This amount is the most you pay for Cost Sharing during a policy period. A policy period is usually a year. Once you reach this amount your plan pays 100% of the Allowed Amount. Not all payments made by Members are counted towards the Out-of-Pocket Maximum. The Out-of-Pocket Maximum does not include, for example:

- Any part of the premium paid for the policy
- Any payment you make for non-covered services

Policy Year – The twelve-month period used in the application of the plan Deductible and the plan Out-of-Pocket Maximum. The Policy Year for this plan starts on July 1st and ends on June 30th of the following year.

Prior Approval – The process by which HNE reviews and approves coverage for certain services before the services are performed.

Qualified Beneficiary – Persons who are covered under a Group health benefit plan on the day before a COBRA Qualifying Event.

Qualifying Event – A loss of coverage that would make a Qualified Beneficiary eligible to receive continuation coverage under COBRA.

Spouse – A person who is legally married to the Subscriber, as defined and interpreted based on federal law or applicable state law.

Subscriber – A person who meets the eligibility requirements of the "Eligibility" section of this Member Handbook, who is enrolled, and for whom HNE has received the premium specified in the Group Insurance Commission contract.

Tier – A Copay level where the amount that the member must pay for a covered service or item depends on: a) the type of service or item; or b) the provider's Tier status. Generally, you pay more for a service or item at a higher numbered Tier, and less for a service or item at a lower numbered Tier. For example, the Tier 2 Copay is higher than the Tier 1 Copay.

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.

GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

GENERAL NOTICE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HOW AND WHEN DO I PAY FOR COBRA COVERAGE? If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period**. After you make your first payment, you will be required to pay for COBRA coverage for each

subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement**. Payments should be sent to the GIC's address on the bill.

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

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

YOUR COBRA COVERAGE RESPONSIBILITIES

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

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

If you have questions about COBRA coverage, contact the GIC's Public Information Unit at (617) 727-2310, ext. 1 or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at **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**.

2017.03-GIC-COBRA

Notice of Group Insurance Commission Privacy Practices

Effective September 3, 2013

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

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

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at www.mass.gov/gic.

Required and Permitted Uses and Disclosures

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

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

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

To Provide You Information on Health-Related Programs or Products: Such information may include alternative medical treatments or programs or about health-related products and services, subject to limits imposed by law as of September 23, 2013.

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

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

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

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

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

Your rights

You have the right to:

- Ask to see and get a copy of your PHI that the GIC maintains. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.
- Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. You must ask for this by in writing, along with a reason for your request. If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.
- Get a listing of those with whom the GIC shares your PHI. You must ask for this in writing. The list will not include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research;
- Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. You must ask for this in writing. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.
- Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. You must tell us in writing that you are in danger, and where to send communications.
- Receive notification of any breach of your unsecured PHI.
- Receive a separate paper copy of this notice upon request. (An electronic version of this notice is on our website at www.mass.gov/gic.)

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call (617) 727-2310, extension 1 or TTY for the deaf and hard of hearing at (617) 227-8583.

The Commonwealth of Massachusetts

YOU ARE RECEIVING THIS NOTICE AS REQUIRED BY THE NEW NATIONAL HEALTH REFORM LAW (ALSO KNOWN AS THE AFFORDABLE CARE ACT OR ACA)

On January 1, 2014, the Affordable Care Act (ACA) will be implemented in Massachusetts and across the nation. The ACA will bring many benefits to Massachusetts and its residents, helping us expand coverage to more Massachusetts residents, making it more affordable for small businesses to offer their employees' healthcare, and providing additional tools to help families, individuals and businesses find affordable coverage. This notice is meant to help you understand health insurance Marketplaces, which are required by the ACA to make it easier for consumers to compare health insurance plans and enroll in coverage. In Massachusetts, the state Marketplace is known as the Massachusetts Health Connector. While you may or may not qualify for health insurance through the Health Connector, it may still be helpful for you to read and understand the information included here.

Overview: When key parts of the national health reform law take effect in January 2014, there will be an easy way for many individuals and small businesses in Massachusetts to buy health insurance: the Massachusetts Health Connector. This notice provides some basic information about the Health Connector, and how coverage available through the Health Connector relates to any coverage that may be offered by your employer. You can find out more by visiting: **MAhealthconnector.org**, or for non-Massachusetts residents, **Healthcare.gov** or (1-800-318-2596; TTY: 1-855-889-4325).

What is the Massachusetts Health Connector? The Health Connector is our state's health insurance Marketplace. It is designed to help individuals, families, and small businesses find health insurance that meets their needs and fits their budget. The Health Connector offers "one-stop shopping" to easily find and compare private health insurance options from the state's leading health and dental insurance companies. Some individuals and families may also qualify for a new kind of tax credit that lowers their monthly premium right away, as well as cost sharing reductions that can lower out-of-pocket expenses. This new tax credit is enabled by §26B of the Internal Revenue Service (IRS) Code.

MASSACHUSETTS HEALTH CONNECTOR
the right place for the right plan

Open enrollment for individuals and families to buy health insurance coverage through the Health Connector begins Oct. 1, 2013, for coverage starting as early as Jan. 1, 2014. (And in future years, open enrollment will begin every Oct. 15.) You can find out more by visiting **MAhealthconnector.org** or calling **1-877-MA ENROLL** (1-877-623-6765).

Can I qualify for federal and state assistance that reduces my health insurance premiums and out-of-pocket expenses through the Health Connector?

Depending on your income, you may qualify for federal and/or state tax credits and other subsidies that reduce your premiums and lower your out-of-pocket expenses if you shop through the Health Connector. You can find out more about the income criteria for qualifying for these subsidies by visiting **MAhealthconnector.org** or calling **1-877-MA ENROLL** (1-877-623-6765).

Does access to employer-based health coverage affect my eligibility for subsidized health insurance through the Health Connector?

An offer of health coverage from the Commonwealth of Massachusetts, as the employer, could affect your eligibility for these credits and subsidies through the Health Connector. If your income meets the eligibility criteria, you will qualify for credits and subsidies through the Health Connector if:

- **The Commonwealth of Massachusetts does not offer coverage to you**, or
- **The Commonwealth of Massachusetts offers you coverage, but:**
  - The coverage the Commonwealth of Massachusetts provides you (not including other family members) would require you to spend more than 9.5 percent of your household income for the year; or
  - The coverage the Commonwealth of Massachusetts provides does not meet the "minimum value" standard set by the new national health reform law (which says that the plan offered has to cover at least 60 percent of total allowed costs)

If you purchase a health plan through the Health Connector instead of accepting health coverage offered by the Commonwealth of Massachusetts, please note that you will lose the employer contribution (if any) for your health insurance. Also, please note that the amount that you and your employer contribute to your employer-sponsored health insurance is often excluded from federal and state income taxes. Health Connector premiums have different tax treatment.

As part of considering whether the ACA and Marketplaces will affect you as an employee it is important to understand what the Commonwealth of Massachusetts offers you.

- The Commonwealth offers benefited employees health coverage through the Group Insurance Commission. To be eligible for GIC health insurance, a state employee must work a minimum of 18 ¾ hours in a 37.5 hour workweek or 20 hours in a 40 hour workweek. The employee must contribute to a participating GIC retirement system, such as the State Board of Retirement**,** a municipal retirement board, the Teachers Retirement Board, the Optional Retirement Pension System for Higher Education**,** a Housing, Redevelopment Retirement Plan, or another Massachusetts public sector retirement system (OBRA is not such a public retirement system for this purpose. Visit www.mass.gov/gic or see your GIC Coordinator for more information.

- Temporary employees, contractors, less-than-half time part time workers, and most seasonal employees are not eligible for GIC health insurance benefits. These employees may shop for health insurance through the Health Connector and may be eligible for advanced premium federal tax credits and/or state subsidies if their gross family income is at or below 400% Federal Poverty Level (which is approximately $46,000 for an individual and $94,000 for a family of four). Visit www.MAhealthconnector.org or call 1-877-MA-ENROLL for more information.

If there is any confusion around your employment status and what you are eligible for, please email healthmarketplacenotice@massmail.state.ma.us or contact your HR department or GIC Coordinator.

2017.03-GIC- ACAMarketplaceNotice

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

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

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

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

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

2017.03-GIC-USERRA

Important Notice from the Group Insurance Commission (GIC)
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Plan and your options under Medicare's prescription drug coverage. This information can help you decide whether or not to join a non-GIC Medicare drug plan. If you are considering joining a non-GIC plan, you should compare your current coverage – particularly which drugs are covered, and at what cost – with that of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage can be found at the end of this notice.

FOR MOST PEOPLE, THE DRUG COVERAGE THAT YOU CURRENTLY HAVE THROUGH YOUR GIC HEALTH PLAN IS A BETTER VALUE THAN THE NON-GIC MEDICARE PART D DRUG PLANS.

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

1. Medicare prescription drug coverage became available to everyone with Medicare in 2006. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The GIC has determined that the prescription drug coverage offered by your plan is, on average for all participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Part D drug plan.

When Can You Join A Medicare Part D Drug Plan?

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

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

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

- If you enroll in another Medicare prescription drug plan or a Medicare Advantage plan with or without prescription drug coverage, you will be disenrolled from the GIC-sponsored HNE plan. If you are disenrolled from HNE, you will lose your GIC medical, prescription drug, and behavioral health coverage.
- If you are the insured and decide to join a non-GIC Medicare drug plan, both you and your covered spouse/dependents will lose your GIC medical, prescription drug, and behavioral health coverage.
- If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available online at **www.socialsecurity.gov** or by phone at 1-800-772-1213 (TTY 1-800-325-0778).

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage….

Contact the GIC at (617) 727-2310, extension 1. **NOTE:** You will receive this notice each year and if this coverage through the Group Insurance Commission changes. You may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Updated: November 2015

2017.03-GIC-MedicarePtD

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

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

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

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

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

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

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507

ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

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

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

U.S. Department of Labor U.S. Department of Health and Human Services
Employee Benefits Security Administration Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa www.cms.hhs.gov
1-866-444-EBSA (3272) 1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 12/31/2019)

2017.03-GIC-CHIP

APPENDIX B – ADVANCE DIRECTIVES: PLANNING FOR FUTURE HEALTH CARE

Advance Directives: Planning for Future Health Care

If you can't make decisions about your health care, an Advance Directive can help. An Advance Directive is a written statement. It tells your health care provider what to do if you can't make decisions about your care. There are different kinds of Advance Directives.

Types of Advance Directives in Massachusetts

Healthcare Proxy

A healthcare proxy is a written document. It allows you to assign a healthcare agent (agent). Your agent can make healthcare decisions for you if you can't make them yourself. You can assign a family member, friend, attorney, or other person of your choice. It is also a good idea to identify a back-up agent, in case the original agent is unavailable.

Your agent should make decisions based on what he or she thinks you would want. If this is unknown, he or she should decide based on your medical best interest. Your agent may make healthcare decisions in ***any*** situation where you can't make decisions. It is not just for end of life situations. You also can limit the agent's decision-making power.

Choosing an agent is an important decision. Before signing a healthcare proxy, talk to your agent. Make sure he or she is willing to take on this role. Select someone who knows you and will honor your wishes. Discuss your wishes openly and in detail. That way, your agent can represent you well. It is important for your agent to know what you would want.

In Massachusetts, two witnesses must sign the healthcare proxy document for it to be legal. Your agent cannot be an "operator, administrator, or employee of a hospital, nursing home, rest home, etc. … where the principal is presently a patient."

Living Will

A living will is a written statement. It explains your wishes for medical treatment and end of life care if you can't communicate them directly. It may tell physicians when you wish treatment to be withheld or withdrawn. This includes situations when you do not want drastic life-saving steps taken.

There is no Massachusetts law specifically for living wills. However, if you have appointed a healthcare proxy, living will instructions are recognized as evidence of your wishes.

For more information about Advance Directives, you can contact:

The Massachusetts Commission on End of Life Care
250 Washington St, 4th Floor
Boston, MA 02108
Phone: (617) 636-3480
Fax: (617) 636-4017
www.endoflifecommission.org

There is no specific healthcare proxy form required in Massachusetts. However, easy-to-use sample forms that comply with Massachusetts law are available at the Massachusetts Medical Society website (www.mms.org), the Hospice and Palliative Care Federation of MA website (www.hospicefed.org/hospice_pages/proxy.htm), and the Central Massachusetts Partnership to Improve Care at the End of Life website (www.betterending.org).

If you have any questions or need help getting a health care proxy form, please call HNE Member Services or your attorney.

APPENDIX C – PRESCRIPTION DRUG PLAN

Express Scripts is the pharmacy benefit manager for your prescription drug benefit plan. The Express Scripts pharmacy network includes major chain pharmacies nationwide, many independent pharmacies, a mail order pharmacy and a specialty drug pharmacy.

If you have any questions about your prescription drug benefits, contact Express Scripts Member Services toll free at 855-283-7679.

About Your Plan

Prescription medications are covered by the plan only if they have been approved by the U.S. Food and Drug Administration (FDA). In addition, with the exception of the over-the-counter versions of preventive drugs, medications are covered only if a prescription is required for their dispensing. Diabetes supplies and insulin are also covered by the plan.

The plan categorizes medications into seven major categories:

GENERIC DRUGS

Generic versions of brand medications contain the same active ingredients as their brand counterparts, thus offering the same clinical value. The FDA requires generic drugs to be just as strong, pure and stable as brand-name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements help to assure that generic drugs are as safe and effective as brand-name drugs.

MAINTENANCE DRUG

A maintenance drug is a medication taken on a regular basis for chronic conditions such as asthma, diabetes, high blood pressure or high cholesterol.

NON-PREFERRED BRAND-NAME DRUG

A non-preferred drug is a medication that usually has an alternative, therapeutically equivalent drug available on the formulary.

PREFERRED BRAND-NAME DRUG

A preferred brand-name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a group of physicians and pharmacists, and has been selected by Express Scripts for formulary inclusion based on its proven clinical and cost effectiveness.

PREVENTIVE DRUGS

Preventive drugs consist primarily of drugs recommended for coverage by the U.S. Preventive Services Task Force, and as specified by the federal Patient Protection and Affordable Care Act. See "Preventive Drugs" on page C-6 for more information.

SPECIALTY DRUGS

Specialty drugs are usually injectable and non-injectable biotech or biological drugs with one or more of several key characteristics, including:

- ❑ Potential for frequent dosing adjustments and intensive clinical monitoring
- ❑ Need for intensive patient training and compliance for effective treatment
- ❑ Limited or exclusive product distribution
- ❑ Specialized product handling and/or administration requirements

OVER-THE-COUNTER (OTC) DRUGS

Over-the-counter drugs are medications that do not require a prescription. Your plan does not provide benefits for OTC drugs, with the exception of preventive drugs (all of which are covered only if dispensed with a written prescription).

Copayments and Deductible

One of the ways your plan maintains coverage of quality, cost-effective medications is a multi-tier copayment pharmacy benefit: Tier 1 (generic drugs), Tier 2 (preferred brand-name drugs), Tier 3 (non-preferred brand-name drugs), or drugs which require no copayments. The following charts show your deductible and copayment based on the type of prescription you fill and where you get it filled.

Table 1. Deductible for Prescription Drugs

Deductible (fiscal year July through June)	
For an individual	**$100 for one person**
For a family	**$200 for the entire family** No more than $100 per person will be applied to the family deductible. Multiple family members can satisfy the family deductible.

Table 2. Copayments for Prescription Drugs

Copayment for	**Participating Retail Pharmacy up to 30-day supply**	**Mail Order or CVS Pharmacy up to 90-day supply**
Tier 1 – Generic Drugs	$10	$25
Tier 2 – Preferred Brand-Name Drugs	$30	$75
Tier 3 – Non-Preferred Drugs	$65	$165
Other ▪ Orally-administered anti-cancer drugs ▪ Generic drugs to treat opioid use disorder (generic buprenorphine-naloxone, naloxone, and naltrexone products) ▪ Preventive drugs: Refer to the "Preventive Drugs" section below for detailed information	$0 Deductible does not apply	$0 Deductible does not apply

Table 2. Copayments for Prescription Drugs *(continued)*

Copayment for	Specialty drugs must be filled only through Accredo, a specialty pharmacy.
Specialty Drugs: Tier 1	$10 per 30-day supply
Specialty Drugs: Tier 2	$30 per 30-day supply
Specialty Drugs: Tier 3	$65 per 30-day supply
Orally-administered anti-cancer specialty drugs	$0 per 30-day supply

Specialty medications may be dispensed up to a 30-day supply; some exceptions may apply.

Copayment for	May be filled through mail order or any network pharmacy
ADHD Medications: Tier 1	$20 per 60-day supply
ADHD Medications: Tier 2	$60 per 60-day supply
ADHD Medications: Tier 3	$130 per 60-day supply

Limited to a 60-day supply per state statute

Out-of-Pocket Limit

This plan has an out-of-pocket limit that is combined with your medical and behavioral health out-of-pocket limit. Deductibles and copayments you pay for prescription drugs during the year count toward this limit. Once you reach the limit, your prescription drugs are covered at 100%. Payments for a brand drug when there is an exact generic equivalent and for drugs not covered by the plan do not count toward the out-of-pocket limit

Table 3. Out-of-Pocket Limit

Individual	$5,000
Family	$10,000

How to Use the Plan

After you first enroll in the plan, Express Scripts will send you a welcome packet and Express Scripts Prescription Card(s). Your Prescription Card(s) will be mailed to you with ID cards for you and your dependents (if any) along with a mail order form.

Show your new Prescription Card to your pharmacy so they can correctly process your prescription drug benefits.

Register at express-scripts.com. As a registered user, you can check drug costs, order mail order refills, and review your prescription drug history. You can access the site 24 hours a day.

FILLING YOUR PRESCRIPTIONS

You may fill your prescriptions for non-specialty drugs at any participating retail pharmacy, or through mail order from the Express Scripts Pharmacy[SM]. Prescriptions for specialty drugs must be filled as described in the "Accredo, an Express Scripts Specialty Pharmacy" subsection.

To obtain benefits at a retail pharmacy, you must fill your prescription at a participating pharmacy using your Express Scripts Prescription Card, with the exception of the limited circumstances detailed in the "Claim Forms" subsection.

SHORT-TERM MEDICATIONS – UP TO 30 DAYS

Filling Your Prescriptions at a Participating Retail Pharmacy

The retail pharmacy is your most convenient option when you are filling a prescription for a short-term prescription that you need immediately (for example, antibiotics for strep throat or painkillers for an injury). Simply present your Express Scripts Prescription Card to your pharmacist, along with your written prescription, and pay the required copayment. Prescriptions filled at a non-participating retail pharmacy are not covered.

You can locate the nearest participating retail pharmacy anytime online after registering at express-scripts.com or by calling toll free at 855-283-7679.

If you do not have your Prescription Card the pharmacist can also verify eligibility by contacting the Express Scripts Pharmacy Help Desk at 800-922-1557; TDD: 800-922-1557.

MAINTENANCE MEDICATIONS – UP TO 30 DAYS

After you fill two 30-day supplies of a maintenance medication at a retail pharmacy, you will receive a letter from Express Scripts explaining how you may convert your prescription to a 90-day supply to be filled either through mail order or at a CVS Pharmacy. You will receive coverage for additional fills of that medication only if you convert your prescription to a 90-day supply to be filled either through mail order or at a CVS Pharmacy, or if you inform Express Scripts that you instead prefer to continue to receive 30-day supplies at a participating retail pharmacy. Exceptions for this policy do apply to ADHD medications. Per state statute, prescriptions are limited to a 60-day supply.

Express Scripts will assist you in transitioning your maintenance prescription to either mail order or a CVS Pharmacy location.

MAINTENANCE MEDICATIONS – UP TO 90 DAYS

Filling 90-day Prescriptions Through the Express Scripts Pharmacy or CVS Pharmacy

You have the choice and convenience of filling maintenance prescriptions for up to a 90-day supply at the mail order copayment, either through the Express Scripts Pharmacy or at a CVS Pharmacy.

The Express Scripts Pharmacy is a convenient option for prescription drugs that you take on a regular basis for conditions such as asthma, diabetes, high blood pressure and high cholesterol. Your prescriptions are filled and conveniently sent to you in a plain, weather-resistant pouch for privacy and protection. They are delivered directly to your home or to another location that you prefer.

CVS Pharmacy is another option for getting your 90-day maintenance medications for the same copayment amount as mail order. Prescriptions can be filled at a CVS Pharmacy locations across the country.

Convenient for You

You get up to a 90-day supply of your maintenance medications – which means fewer refills and fewer visits to your pharmacy, as well as lower copayments. Once you begin using mail order, you can order refills online or by phone, or you can use your local CVS Pharmacy.

Using Mail Order from the Express Scripts Pharmacy

To begin using mail order for your prescriptions, just follow these three simple steps:

1. Ask your physician to write a prescription for up to a 90-day supply of your maintenance medication plus refills for up to one year, if appropriate. (Remember also to ask for a second prescription for an initial 30-day supply and take it to your local participating retail pharmacy.)
2. Complete a mail order form (contained in your Welcome Kit or found online after registering at express-scripts.com). Or call Express Scripts Member Services toll free at 855-283-7679 to request the form.
3. Put your prescription and completed order form into the return envelope (provided with the order form) and mail it to the Express Scripts Pharmacy.

Please allow 7-10 business days for delivery from the time your order is mailed. A pharmacist is available 24 hours a day to answer your questions about your medication.

If the Express Scripts Pharmacy is unable to fill a prescription because of a shortage of the medication, you will be notified of the delay in filling the prescription. You may then fill the prescription at a retail pharmacy, but the retail pharmacy copayment will apply.

ACCREDO, AN EXPRESS SCRIPTS SPECIALTY PHARMACY

Accredo is a full-service specialty pharmacy that provides personalized care to each patient and serves a wide range of patient populations, including those with hemophilia, hepatitis, cancer, multiple sclerosis and rheumatoid arthritis.

You will be required to fill your specialty medications at Accredo. This means that your prescriptions can be sent to your home or your doctor's office.

Specialty medications may be filled only at a maximum of a 30-day supply; some exceptions may apply. Many specialty medications are subject to a clinical review by Express Scripts to ensure the medications are being prescribed appropriately.

Accredo offers a complete range of services and specialty drugs. Your specialty drugs are quickly delivered to any approved location, at no additional charge. We ship to all 50 states using one of our preferred expedited carriers. We can also ship to a variety of alternate addresses, including physician's offices or to another family member's address. We do not ship to P.O. Boxes.

You have toll-free access to expert clinical staff who are available to answer all of your specialty drug questions. Accredo will provide you with ongoing refill reminders before you run out of your medications.

To begin receiving your specialty drugs through Accredo, call toll free at 855-667-8678.

ACCREDO PHARMACY SERVICES

- **Patient Counseling** – Convenient access to pharmacists and nurses who are specialty medication experts
- **Patient Education** – Educational materials
- **Convenient Delivery** – Coordinated delivery to your home, your doctor's office, or other approved location
- **Refill Reminders** – Ongoing refill reminders from Accredo
- **Language Assistance** – Language-interpreting services are provided for non-English speaking patients

Claim Forms

Retail purchases out of the country, or purchases at a participating retail pharmacy without the use of your Express Scripts Prescription Card, are covered as follows:

Table 4. Claims Reimbursement

Type of Claim	Reimbursement
Claims for purchases at a participating (in-network) pharmacy without a Express Scripts Prescription Card.	Claims incurred within 30 days of the member's eligibility effective date will be covered at full cost, less the applicable copayment. -or- Claims incurred more than 30 days after the member's eligibility effective date will be reimbursed at a discounted cost, less the applicable copayment.

Type of Claim	Reimbursement
Claim forms are available to registered users on express-scripts.com or by calling 855-283-7679.	

Other Plan Provisions

PREVENTIVE DRUGS

Coverage will be provided for the following drugs:[2]

Preventive Drugs	
Aspirin	Generic OTC aspirin ≤ 325mg when prescribed for adults less than 70 years of age for the prevention of heart attack or stroke and to help prevent illness and death from preeclampsia for females who are at high risk for the condition.
Bowel preparation medications	Generic and brand (Rx and OTC) products for adults ages 50 to 75 years old. Limited to 2 prescriptions at $0 copay each year.
Contraceptives	Generic and brand versions of contraceptive drugs and devices, and OTC contraceptive products, when prescribed for women less than 50 years old.
Folic acid supplements	Generic OTC and Rx versions (0.4mg – 0.8mg strengths only) when prescribed for women under the age of 51.
Immunization vaccines	Generic or brand versions prescribed for children or adults.
Oral fluoride supplements	Generic and brand supplements prescribed for children 6 months through five years of age for the prevention of dental caries.
Breast cancer	Generic prescriptions for raloxifene or tamoxifen are covered for the primary prevention of breast cancer for females who are at increased risk, age 35 years and older.
Tobacco cessation	All FDA-approved smoking cessation products prescribed for adults, age 18 and older.
Statins	Generic-only, single-entity, low-to-moderate dose statin agents for adults 40 to 75 years old.

Call Express Scripts at 855-283-7679 for additional coverage information on specific preventive drugs.

BRAND-NAME DRUGS WITH EXACT GENERIC EQUIVALENTS

The plan encourages the use of generic drugs. There are many brand-name drugs, such as Lipitor®, Ambien® and Fosamax®, for which exact generic equivalents are available. If you fill a prescription for a brand-name medication for which there is an exact generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand-name drug and the generic drug, plus the generic copayment. This amount does not count towards the out-of-pocket limit. Exceptions to this provision may apply to certain brand-name preventive drugs; contact Express Scripts for additional information.

PRESCRIPTION DRUGS WITH OVER-THE-COUNTER (OTC) EQUIVALENTS

Some prescription drugs have over-the-counter (OTC) equivalent products available. These OTC products have strengths, active chemical ingredients, routes of administration and dosage forms identical to the prescription drug products. Your plan does not provide benefits for prescription drugs with OTC equivalents. This provision is not applicable to preventive drugs.

2 This list is subject to change during the year. Call Express Scripts toll free at 855-283-7679 to check if your drugs are included in the program.

Some prescription drugs also have OTC product alternatives available. These OTC products, though not identical, are very similar to the prescription drugs. Your plan does not provide benefits for prescription drugs when OTC equivalents are available. This provision is not applicable to preventive drugs.

PRIOR AUTHORIZATION

Some drugs in your plan require prior authorization. Prior authorization ensures that you are receiving the appropriate drug for the treatment of a specific condition, in quantities approved by the FDA. For select drugs, prior authorization also includes a medical necessity review that ensures the use of less expensive first-line formulary prescription drugs before the plan will pay for more expensive prescription drugs. First-line formulary prescription drugs are safe and effective medications used for the treatment of medical conditions or diseases.

If a drug that you take requires prior authorization, your physician will need to contact Express Scripts to see if the prescription meets the plan's conditions for coverage. If you are prescribed a drug that requires prior authorization, your physician should call Express Scripts at 800-417-1764.

Table 5. Current Examples of Drugs Requiring Prior Authorization for Specific Conditions[2]

Topical Tazarotene Products	**Tazorac® 0.05% and 0.1% cream, gel - Allergan; Fabior 0.1% foam - Stiefel**
Topical Tretinoin	**Retin-A®, Retin-A® Micro® - Ortho; Avita® - Bertek Pharmaceuticals; Tretin·X™ - Triax; Atralin™ gel - Coria; other generic topical tretinoin products - various manufacturers) and Clindamycin Phosphate 1.2% and Tretinoin 0.025% gel (Ziana(R) - Medicis; Veltin(TM) - Stiefel)**
Testosterone - Topical	**Androderm, AndroGel, Axiron, Fortesta, Natesto, Striant, Testim, Vogelxo**
Testosterone - Injectable	**Aveed®, Depo® - Testosterone [testosterone cypionate injection, generics], Delatestryl®, Xyosted® [testosterone enanthate injection, generics], Testopel® [testosterone pellet]**
Glaucoma: Ophthalmic Prostaglandin	**(Lumigan, Xalatan[Generics], Travatan, Travatan Z, Zioptan)**
Compounds- Select Compounds	**A compounded medication is one that is made by combining, mixing or altering ingredients, in response to a prescription, to create a customized medication that is not otherwise commercially available.**
Diabetes GLP-1 Agonists	**Byetta, Bydureon, Trulicity, Victoza, Incretin Mimetics**
Rosacea	**Mirvaso, Rhofade cream**
Narcolepsy	**Nuvigil, Provigil**
Nutritional Supplements	**Nonprescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids**
Pain	**Fentanyl Transmucosal Drugs (Abstral, Actiq, Fentora, Onsolis, Subsys, Lazanda)**
	Lidoderm

2 This list is not all-inclusive and is subject to change during the year. Call Express Scripts toll free at 855-283-7679 to check if your drugs are included in the program.

Weight Management	**Adipex (phentermine], Bontril [phendimetrazine], Contrave (bupropion; naltrexone), Didrex [benzphetamine), Sanorex [mazindol], Suprenza [phentermine], Tenuate [diethylpropion], Xenical [orlistat], Belviq, Qsymia, Saxenda**
Dry Eyes	**Restasis, Xiidra**

Table 6. Current Examples of Top Drug Classes that May Require Prior Authorization for Medical Necessity[1]

Dermatological Agents	Insulins
Diabetic Supplies	Nasal Steroids
Epinephrine Auto-Injector Systems	Ophthalmic Agents
Erectile Dysfunction Oral Agents	Opioid Analgesics
Erythropoiesis-Stimulating Agents	Opioid Dependence Agents
Glaucoma	Osteoarthritis - Hyaluronic Acid Derivatives
Growth Hormones	Osteoporosis Therapy
Hepatitis C Agents	Proton Pump Inhibitors

Select drugs within these classes require prior authorization for medical necessity to ensure formulary alternative(s) within the class have been tried. If you are a registered user on express-scripts.com, refer to the National Preferred Formulary or call Express Scripts toll free at 855-283-7679 for additional information.

QUANTITY DISPENSING LIMITS

To promote member safety and appropriate and cost-effective use of medications, your prescription plan includes a drug quantity management program. This means that for certain prescription drugs, there are limits on the quantity of the drug that you may receive at one time.

Quantity per dispensing limits are based on the following:

- ❑ FDA-approved product labeling
- ❑ Common usage for episodic or intermittent treatment
- ❑ Nationally accepted clinical practice guidelines
- ❑ Peer-reviewed medical literature
- ❑ As otherwise determined by the plan

Examples of drugs with quantity limits currently include Cialis®, Imitrex®, and lidocaine ointment.[1]

DRUG UTILIZATION REVIEW PROGRAM

Each prescription drug purchased through this plan is subject to utilization review. This process evaluates the prescribed drug to determine if any of the following conditions exist:

- ❑ Adverse drug-to-drug interaction with another drug purchased through the plan;
- ❑ Duplicate prescriptions;

1 This list is subject to change during the year. Call Express Scripts toll free at 855-283-7679 to check if your drugs are included in the program.

- ❑ Inappropriate dosage and quantity; or
- ❑ Too-early refill of a prescription.

If any of the above conditions exist, medical necessity must be determined before the prescription drug can be filled.

Exclusions

Benefits exclude:[1]

- Dental preparations (e.g., topical fluoride, Arestin®), with the exception of oral fluoride
- Over-the-counter drugs, vitamins or minerals (with the exception of diabetic supplies and preventive drugs)
- Homeopathic drugs
- Prescription products for cosmetic purposes such as photo-aged skin products and skin depigmentation products
- Medications in unit dose packaging
- Impotence medications for members under the age of 18
- Injectable allergens
- Hair growth agents
- Special medical formulas and medical food products, except as required by state law
- Compounded medications-some exclusions apply. Examples include: Bulk powders, bulk chemicals, and proprietary bases used in compounded medications
- Drugs administered intrathecally, by or under the direction of health care professionals and recommended to be administered under sedation

Definitions

Brand-Name Drug – The brand name is the trade name under which the product is advertised and sold, and during a period of patent protection it can only be produced by one manufacturer. Once a patent expires, other companies may manufacture a generic equivalent, providing they follow stringent FDA regulations for safety.

Compounded Medication – A compounded medication is one that is made by combining, mixing or altering ingredients, in response to a prescription, to create a customized medication that is not otherwise commercially available. At least one of the ingredients must be a medication that can only be dispensed with a written prescription.

Copayment – A copayment is the amount that members pay for covered prescriptions. If the plan's contracted cost for a medication is less than the applicable copayment, the member pays only the lesser amount.

Deductible – A deductible is the dollar amount you must pay during a plan year before the copayments for covered prescriptions apply.

Diabetes Supplies – Diabetic supplies include needles, syringes, test strips, lancets and blood glucose monitors.

FDA – The U.S. Food and Drug Administration.

Formulary – A formulary is a list of recommended prescription medications that is created, reviewed and continually updated by a team of physicians and pharmacists. The Express Scripts National Preferred Formulary contains a wide range of generic and preferred brand-name products that have been approved by the FDA. The formulary applies to medications that are dispensed in either the retail pharmacy or mail-order settings. The formulary is developed and maintained by Express Scripts. Formulary designations may change as new clinical information becomes available.

Generic Drugs – Generic versions of brand medications contain the same active ingredients as their brand counterparts, thus offering the same clinical value. The FDA requires generic drugs to be just as strong, pure and stable as brand-name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements assure that generic drugs are as safe and effective as brand-name drugs.

Maintenance Drug – A maintenance drug is a medication taken on a regular basis for conditions such as asthma, diabetes, high blood pressure or high cholesterol.

Non-Preferred Drug – A non-preferred drug is a medication that has been reviewed by Express Scripts, which determined that an alternative drug that is clinically equivalent and more cost-effective may be available.

Out-of-Pocket Limit – The out-of-pocket limit is the most you could pay in copayments during the year for prescription drugs that are covered by Express Scripts. Once you reach this limit, you will have no more copayments for covered drugs. Payments for a brand drug when there is an exact generic equivalent and for drugs not covered by the plan do not count toward the out-of-pocket limit.

Over-the-Counter (OTC) Drugs – Over-the-counter drugs are medications that do not require a prescription. Your plan does not provide benefits for OTC drugs, with the exception of preventive drugs (all of which are covered only if dispensed with a written prescription).

Participating Pharmacy – A participating pharmacy is a pharmacy in the Express Scripts nationwide network. All major pharmacy chains and most independently-owned pharmacies participate.

Preferred Brand-Name Drug – A preferred brand-name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a group of physicians and pharmacists, and has been selected by Express Scripts for formulary inclusion based on its proven clinical and cost effectiveness.

Prescription Drug – A prescription drug means any and all drugs which, under federal law, are required, prior to being dispensed or delivered, to be labeled with the statement "Caution: Federal Law prohibits dispensing without prescription," or a drug which is required by any applicable federal or state law or regulation to be dispensed pursuant only to a prescription drug order.

Preventive Drugs – Preventive drugs consist primarily of drugs recommended for coverage by the U.S. Preventive Services Task Force, and as specified by the federal Patient Protection and Affordable Care Act.

Prior Authorization – Prior authorization means determination that a drug is appropriate for treatment of a specific condition. It may also mean determination of medical necessity. It is required before prescriptions for certain drugs will be paid for by the plan.

Special Medical Formulas or Food Products – Special medical formulas or food products means nonprescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. These products require prior authorization to determine medical necessity.

To access the benefit for special medical formulas or food products, call the Group Insurance Commission at 617-727-2310, extension 1.

Specialty Drugs – Specialty drugs are usually injectable and non-injectable biotech or biological drugs with one or more of several key characteristics, including:

- ❑ Requirement for frequent dosing adjustments and intensive clinical monitoring
- ❑ Need for intensive patient training and compliance for effective treatment
- ❑ Limited or exclusive product distribution
- ❑ Specialized product handling and/or administration requirements

Member Appeals

Express Scripts has processes to address:

- ❑ Inquiries concerning your drug coverage
- ❑ Appeals:
  - Internal Member Appeals
  - Expedited Appeals
  - External Review Appeals

All appeals should be sent to Express Scripts at the following address:

Complete the form and fax it to 877.328.9660 or mail to:
Express Scripts
Attn: Benefit Coverage Review Department
P.O. Box 66587

St Louis, MO 63166-6587

All calls should be directed to Express Scripts Member Services at 855-283-7679

To request an initial administrative coverage review, the member or his or her representative must submit the request in writing using a Benefit Coverage Request Form, which can be obtained by calling the Member Services phone number on the back of the prescription card.

INTERNAL INQUIRY

Call Express Scripts Member Services to discuss concerns you may have regarding your prescription drug coverage. Every effort will be made to resolve your concerns. If your concerns cannot be resolved or if you tell a Member Services representative you are not satisfied with the response you have received, Member Services will notify you of any options you may have, including the right to have your inquiry processed as an appeal. Member Services will also provide you with the steps you and your doctor must follow to submit an appeal.

INTERNAL MEMBER APPEALS

Requests for coverage that were denied as specifically excluded in this member handbook or for coverage that was denied based on medical necessity determinations are reviewed as appeals through the Express Scripts Internal Appeals Process. You may file an appeal request yourself or you may designate someone to act on your behalf in writing. You have 180 days from the date you were notified of the denial of benefit coverage or prescription drug claim payment to file your appeal. To request an initial administrative coverage review, the member or his or her representative must submit the request in writing using a Benefit Coverage Request Form, which can be obtained by calling the Customer Service phone number on the back of the prescription card.

1. You must submit a written appeal to the address listed above. Your letter should include:
   - ❑ Your complete name and address;
   - ❑ Your Express Scripts ID number;
   - ❑ Your date of birth;
   - ❑ A detailed description of your concern, including the drug name(s) being requested; and
   - ❑ Copies of any supporting documentation, records or other information relating to the request for appeal
2. The Express Scripts Appeals Department will review appeals concerning specific prescription drug benefit provisions, plan rules, and exclusions and make determinations. If you are not satisfied with an Appeals Department denial related to a plan rule or exclusion (i.e., non-medical necessity appeal), you may have the

right to request an independent External Review of the decision (refer to the "External Review Appeals" section for details on this process).

For denials related to a medical necessity determination, you have the right to an additional review by Express Scripts. Express Scripts will request this review from an independent practitioner in the same or in a similar specialty that typically manages the medical condition for which the prescription drug has been prescribed. If the second review is an adverse determination, you have the right to request an External Review of this decision (refer to the "External Review Appeals" section for details on this process).

3. For an appeal on a prescription drug that has not been dispensed, an Appeals Analyst will notify you in writing of the decision within no more than fifteen calendar days of the receipt of an appeal. For an appeal on a prescription drug already dispensed, an Appeals Analyst will notify you in writing of the decision within no more than thirty calendar days of the receipt of an appeal.

   A copy of the decision letter will be sent to you and your physician. A determination of denial will set forth:

   - ❑ Express Scripts understanding of the request;
   - ❑ The reason(s) for the denial;
   - ❑ Reference to the contract provisions on which the denial is based; and
   - ❑ A clinical rationale for the denial, if the appeal involves a medical necessity determination.

Express Scripts maintains records of each inquiry made by a member or by that member's designated representative.

Express Scripts recognizes that there are circumstances that require a quicker turnaround than allotted for the standard Appeals Process. Express Scripts will expedite an appeal when a delay in treatment would seriously jeopardize your life and health or jeopardize your ability to regain maximum function. If your request does not meet the guidelines for an expedited appeal, Express Scripts will explain your right to use the standard appeals process.

If your request meets the guidelines for an expedited appeal, it will be reviewed by a practitioner in the same or in a similar specialty that typically manages the medical condition for which the prescription drug has been prescribed. Express Scripts will notify you of its decision by telephone no later than 72 hours after Express Scripts' receipt of the request.

If the patient or provider believes the patient's situation is urgent, the provider must request the expedited review by phone at 800.753.2851.

EXTERNAL REVIEW APPEALS

In most cases, if you do not agree with the Appeals decision, you or your authorized representative have the right to request an independent, external review of the decision. Should you choose to do so, send your request within four months of your receipt of the written notice of the denial of your appeal to:

To submit an external review, the request must be mailed or faxed to MCMC, LLC, an independent third party utilization management company, at:
MCMC LLC
Attn: Express Scripts Appeal Program 300 Crown Colony Drive, Suite 203
Quincy, MA 02169-0929
(617) 375.7700, ext. 28253
(617) 375.7683

In some cases, members may have the right to an expedited external review. An expedited external review may be appropriate in urgent situations. Generally, an urgent situation is one in which your health may be in serious jeopardy, or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. The request must be received within 4 months of the date of the final internal adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the

deadline will be the next business day. For urgent external appeals urgent external review, the IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

If you request an external review, an independent organization will review the decision and provide you with a written determination. If this organization decides to overturn the Appeals decision, the service or supply will be covered under the plan.

If you have questions or need help submitting an appeal, please call Customer Care for assistance at (855) 283-7679

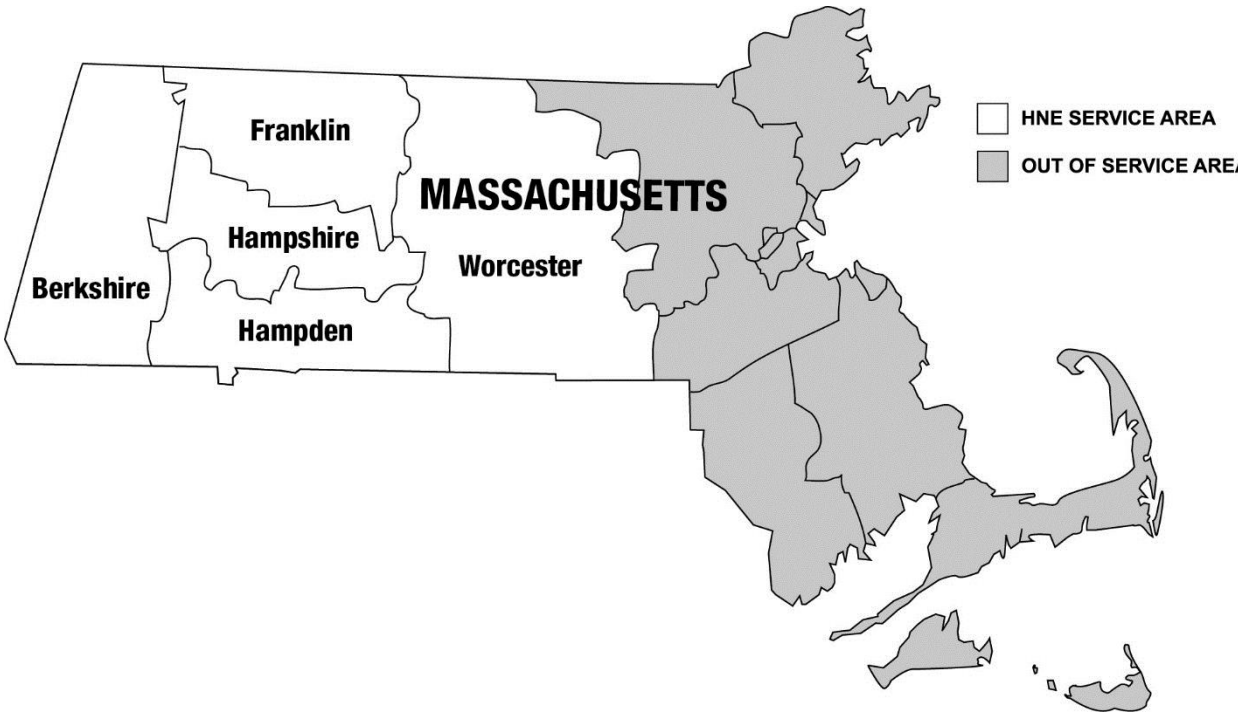
Health and Prescription Information

GIC authorizes health and prescription information about members be used by Express Scripts to administer benefits. As part of the administration, Express Scripts may report health and prescription information to the administrator or sponsor of the benefit plan. Express Scripts also uses that information and prescription data gathered from claims nationwide for reporting and analysis without identifying individual members.

NOTES:

Active GIC-HNE 2019 Handbook.doc
Print Date: 9/10/2019
Benefit Package SF

HEALTH NEW ENGLAND SERVICE AREA



Health New England

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