Health New England

AMENDMENT 01-2022 – GIC Active

This is an Amendment to your Health New England, Inc. Summary Plan Description (SPD). Please keep this Amendment with your SPD as it changes the terms of that SPD. Any language in the SPD that does not follow the terms of this Amendment no longer applies. This Amendment is effective January 1, 2022, unless noted below.

The SPD is amended as shown below.

Benefit, Program, or Requirement	Description

Emergency care	**Health New England (HNE) covers Emergency Care in accordance with the provisions of the federal "No Surprises Act."**
	• HNE covers Emergency Care in an Emergency Room with no Prior Approval. This includes care by In-Plan and Out-of-Plan providers.
	• Emergency care includes post-stabilization services unless:
	  • The member is medically able to be transferred to an In-Plan provider.
	  • The provider has met the notice requirement of the "No Surprises Act" and the member has consented to waiving balance billing protections.
	• Out-of-Plan Emergency Care is covered as if provided In-Plan.
	  • Utilization management will be the same for In-Plan and Out-of-Plan services.
	  • In-Plan member cost sharing will apply to both In-Plan and Out-of-Plan services.
	• Member cost sharing counts toward the In-Plan deductible (if the plan has one) and the In-Plan Out-of-Pocket Maximum.
	• An Out-of-Plan provider may not bill you more than your In-Plan Cost Sharing amount, which must be a recognized amount. Under the "No Surprises Act," a recognized amount is either the amount specified by state law or a qualifying amount based on a historic amount.

Benefit, Program, or Requirement	Description
Balance billing by Out-of-Plan Providers	**The federal "No Surprises Act"** creates a process which providers must follow in order to balance bill. Balance billing is the when the provider bills for the difference between the provider's charge and the allowed amount. The allowed amount is the maximum amount on which payment is based for covered services. Pursuant to 32A, Section 20, all GIC members have balance billing protection in Massachusetts. This applies in and out of network. *"Section 20. No physician or other provider of services, who treats or provides services to an individual covered by hospital, surgical, medical or catastrophic illness coverage offered by the commission under section four, four A, ten B, twelve or fifteen, shall charge to or collect from any insured or other beneficiary any amount in excess of that amount of compensation determined or allowed for a particular service by the insurer or by the administrator"* This process is the "notice and consent" process. An Out-of-Plan provider must notify a patient of its Out-of-Plan status and get written consent from the patient to receive the Out-of-Plan services. Before obtaining written consent, the provider must first advise the patient of the right not to be balance billed. The "notice and consent" process is **not** available for the following: • Emergency services • Certain ancillary services (emergency medicine, anesthesiology, pathology, radiology, neonatology, and diagnostic services including radiology and lab services) • Items and services due to unforeseen urgent medical need during a procedure for which notice and consent has previously been obtained • Any situation where there is no In-Plan provider available at the In-Plan facility to provide the service Violations of this balance billing protection can be reported to the Massachusetts Division of Insurance (DOI). You can submit a complaint at this website: https://www.mass.gov/how-to/filing-an-insurance-complaint. Or you may call (617) 521-7794.

Benefit, Program, or Requirement	Description
Provider directories	**Section 1 – Introduction – How to Find an In-Plan Provider** The following is removed from the SPD: **Health New England (HNE) Network** To find out what hospitals, doctors and providers are in the HNE network, please refer to your HNE Provider Directory, call HNE Member Services at the number at the bottom of this page, or check the HNE website at healthnewengland.org. Printed Provider Directories are updated annually and as needed throughout the year, and are available upon request. HNE's website is updated weekly. HNE and In-Plan Providers are free to join and leave HNE's Network at any time. Neither the Plan nor HNE can guarantee the continued participation of any specific provider or group of providers. HNE and In-Plan Providers are independent contractors. Neither the Plan nor HNE controls the methods HNE or In-Plan Providers use to perform their work or to provide services. **As part of the Enrollment Process, you may request a printed Provider Directory, free of charge. Provider Directories are updated annually and from time to time throughout the year. To obtain an updated Provider Directory, please contact HNE Member Services. Providers are also listed on HNE's website at healthnewengland.org.** **HNE's list of In-Plan Providers is subject to change without notice.** It is replaced with: HNE updates its paper plan provider directory each month. HNE's website provider directory is updated as required by federal guidelines. Providers are free to join or leave the network at any time. HNE cannot guarantee that any provider or group of providers will continue to be In-Plan Providers. Some In-Plan Providers may have left or joined the HNE network since the last directory was printed. For the most up-to-date list of In-Plan Providers go to healthnewengland.org. Or you can call Member Services. A Member Services representative will respond to your question within one business day. If you choose a provider based on information from HNE that is shown to be inaccurate, you will only have to pay In-Plan Cost Sharing. If you believe your choice of provider was based on inaccurate information, you can file a complaint with the Massachusetts Division of Insurance (DOI). You can submit a complaint at this website: https://www.mass.gov/how-to/filing-an-insurance-complaint. Or you may call (617) 521-7794.
Colorectal cancer screening	**Section 4 – Detailed Description of Covered Services – Preventive Care** Colorectal cancer screenings will be covered for members starting at age 45.

Benefit, Program, or Requirement	Description
Telehealth services	**Section 4 – Detailed Description of Covered Services – Telehealth Services for:** • **Outpatient Care** • **Behavioral Health and Substance Abuse Disorder** The following replaces the text for "Other Telehealth Services." **Services Delivered via Telehealth** HNE covers certain services delivered via telehealth. Services are typically for the purpose of evaluations, follow-up care, or treatment of a specific condition. To be covered, services must meet certain criteria. • Services must be equivalent to in-person services. • Services must be provided in real-time. Services are not covered if medical information is stored and forwarded to be reviewed at a later time without the patient being present. • Services must be provided using secure electronic means. The technology used must meet or exceed HIPAA privacy requirements. • Providers must be eligible to perform and bill the equivalent face to face services. Providers must be licensed in the state in which they are performing the services. • All services that are provided must be documented and retained in the HNE Member's permanent medical record. • Applicable cost sharing for telehealth visits may apply. **Clarification**
Treatment of PANDAS/PANS	**Section 4 – Detailed Description of Covered Services – Other Outpatient Care** The following is added under Other Services: **Treatment of PANDAS/PANS** Health New England covers the treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome (PANDAS/PANS). Treatment includes, but is not limited to, the use of intravenous immunoglobulin therapy (IVIg). Prior Approval is required for IVIg. Member cost sharing applies to these services.
Services not covered	**Section 5 – Exclusions and Limitations – Exclusions** The following are considered experimental/investigational. They are added to the list of services Health New England does not cover. • Absorbable Nasal Implant for the Treatment of Nasal Valve Collapse (i.e Latera) • Cryoablation for the treatment of chronic rhinitis (i.e. Clarifix) **Clarification**

Benefit, Program, or Requirement	Description

Services requiring Prior Approval	**Section 6 – Claims, Prior Approval and Appeals Procedures – Services that Require Prior Approval**
	
	The following is added to the list of services and procedures that require Prior Approval.
	• These CAR-T treatments are covered with Prior Approval:
	  • Tecartus for the treatment of relapsed or refractory Mantle Cell Lymphoma
	  • ABECMA for the treatment of relapsed or refractory Multiple Myeloma
	
	Effective February 1, 2022

Continued treatment (transitional care)	**Section 14 – Continuation of Coverage Options - Continued Treatment (Transitional Care)**
	
	The following are added to the times when HNE will allow you to continue to receive coverage for care after your doctor leaves HNE's network.
	• **If a provider who is treating a Member with a serious or complex condition disenrolls.** If this occurs HNE will allow a member to see the provider:
	  • Through the current period of active treatment, or
	  • Up to (90) days after the provider is disenrolled, whichever is shorter
	  Serious or complex condition is defined to include:
	  • Acute illness – serious enough to require specialized medical treatment to avoid a reasonable possibility of death or potential harm; or
	  • Chronic illness or condition – a life threatening, degenerative, disabling or congenital condition that requires specialized medical care over a prolonged period of time
	  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 providers treating a Member in an institutional or inpatient setting disenroll.** If this occurs HNE will allow a Member receiving an active course of treatment to continue:
	  • Through the current period of active treatment, or
	  • Up to 90 days after the specialist leaves HNE, whichever is shorter
	  You will not be allowed to continue to see these providers if disenrolled for reasons relating to quality or for fraud.
	
	• **If providers treating a member scheduled to have non-elective surgery disenroll.** If this occurs HNE will allow the member to continue to see the provider:
	  • Until the member is no longer a continuing care patient, or
	  • For up to 90 days after the specialist is disenrolled, whichever is shorter

Benefit, Program, or Requirement	Description
	You will not be allowed to continue to see these providers if disenrolled for reasons relating to quality or for fraud. The following is added to the SPD: • **If a provider who is treating pregnant Members is involuntarily disenrolled.** If this occurs, HNE will permit you to continue treatment with your provider through the first postpartum visit. 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 care applies to medical providers and to behavioral health and substance abuse disorder providers.

All other terms and conditions of this SPD remain in full force and effect.