Health New England

HMO Thrive Gold Connector

HMO Health Plan

Small Group and Individual (Non-Group) Coverage

January 1, 2026

EXPLANATION OF COVERAGE

It is important to read any Amendments and Riders to your Explanation of Coverage (EOC).

We explain your coverage for prescription drugs, chiropractic care, and pediatric dental services in Riders to this Explanation of Coverage.

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 MA-ENROLL (TTY: 711) or visit the Connector website (mahealthconnector.org).

This health plan meets Minimum Creditable Coverage standards that are in effect January 1, 2026 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, 2026. 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.

Health New England

Notice Informing Individuals of Nondiscrimination and Accessibility

Health New England complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). 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 people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Health New England provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, you may contact Health New England's Section 1557 Coordinator at One Monarch Place, Suite 1500, Springfield, MA 01144-1500, Phone: (888) 270-0189, TTY: 711, Fax: (413) 233-2685, or email at **1557Coordinator@hne.com**.

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 Health New England at the above address, in person, by phone, fax, or email to **ComplaintsAppeals@hne.com**. If you need help filing a grievance, Health New England's Section 1557 Coordinator 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**.

This notice is available on Health New England's website at **healthnewengland.org/notice**.

Reviewed: June 2025

Notice of Availability of Language Services and Auxiliary Aids and Services (§ 92.11)

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.

English	ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call (800) 310-2835 (TTY: 711) or speak to your provider.
Spanish	ATENCIÓN: Si hablas español, tienes a tu disposición servicios gratuitos de asistencia lingüística. También dispone de recursos y servicios auxiliares gratuitos para proporcionar información en formatos accesibles. Llame al (800) 310-2835 (TTY: 711) o hable con su proveedor de atención médica.
Portuguese	ATENÇÃO: Se fala português, estão disponíveis para si serviços gratuitos de assistência linguística. Os recursos auxiliares e os serviços adequados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para (800) 310-2835 (TTY: 711) ou fale com o seu médico.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Geeignete Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten sind ebenfalls kostenlos verfügbar. Rufen Sie (800) 310-2835 (TTY: 711) an oder sprechen Sie mit Ihrem Anbieter.
Japanese	注意：日本語を話せる場合は、無料の言語支援サービスをご利用いただけます。アクセシブルな形式で情報を提供するための適切な補助手段やサービスも無料でご利用いただけます。（800）310-2835（TTY：711）までお電話いただくか、ご契約の医療機関にお問い合わせください。
Chinese Mandarin	注意：如果您讲中文普通话，我们提供免费的语言协助服务。还免费提供适当的辅助工具和服务，以可访问的格式提供信息。请致电（800）310-2835（TTY：711）或咨询您的医疗保健提供者。
Chinese Cantonese	注意：如果您講粵語，我們提供免費的語言協助服務。此外，我們還免費提供相應的輔助工具和服務，以無障礙的格式提供資訊。請致電（800）310-2835（TTY：711）或諮詢您的醫療保健提供者。
French Creole	ATANSYON: Si ou pale Kreyòl Franse, sèvis asistans lang gratis la disponib pou ou. Tout ekipman ak sèvis ki apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele (800) 310-2835 (TTY: 711) oubyen pale ak founisè ou.
Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Các dịch vụ và hỗ trợ bổ sung thích hợp để cung cấp thông tin ở các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Gọi (800) 310-2835 (TTY: 711) hoặc trao đổi với nhà cung cấp của bạn.
Russian	ВНИМАНИЕ: Если вы говорите по-русски, вам доступны бесплатные услуги языковой помощи. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также доступны бесплатно. Позвоните по телефону (800) 310-2835 (TTY: 711) или обратитесь к своему провайдеру.

Arabic	تنبيه :إذا كنت تتحدث العربية، تتوفر لك خدمات مساعدة لغوية مجانية .كما تتوفر مجانًا وسائل مساعدة وخدمات مناسبة لتقديم المعلومات بتنسيقات سهلة الوصول .اتصل على 800-310-2835 أو تحدث مع مقدم الخدمة. TTY: 711.
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Polish	UWAGA: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnych usług pomocy językowej. Odpowiednie pomoce i usługi pomocnicze, które zapewniają informacje w dostępnych formatach, są również dostępne bezpłatnie. Zadzwoń pod numer (800) 310-2835 (TTY: 711) lub porozmawiaj ze swoim lekarzem.
Hindi	ध्यान दें: अगर आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। सुलभ प्रारूप में जानकारी प्रदान करने के लिए उपयुक्त सहायक उपकरण और सेवाएँ भी निःशुल्क उपलब्ध हैं। (800) 310-2835 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Tagalog	PANSIN: Kung nagsasalita ka ng Tagalog, ang mga libreng serbisyo ng tulong sa wika ay magagamit mo. Ang mga naaangkop na pantulong na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din nang walang bayad. Tumawag sa (800) 310-2835 (TTY: 711) o makipag-usap sa iyong provider.
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Lao	ຂໍ້ຄວນລະວັງ: ຖ້າເຈົ້າເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ການຊ່ວຍເຫຼືອ ແລະການບໍລິການທີ່ເໝາະສົມໃນການສະໜອງຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ແມ່ນຍັງສາມາດໃຊ້ໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທຫາ (800) 310-2835 (TTY: 711) ຫຼືເວົ້າກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.
Albanian	KUJDES: Nëse flisni shqip, ju ofrohen shërbime falas për ndihmë gjuhësore. Ndihmat dhe shërbimet e përshtatshme ndihmëse për të ofruar informacion në formate të aksesueshme janë gjithashtu në dispozicion pa pagesë. Telefononi (800) 310-2835 (TTY: 711) ose flisni me ofruesin tuaj.
Greek	ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, διατίθενται δωρεάν υπηρεσίες γλωσσικής βοήθειας. Διατίθενται επίσης δωρεάν κατάλληλα βοηθητικά βοηθήματα και υπηρεσίες για την παροχή πληροφοριών σε προσβάσιμη μορφή. Καλέστε στο (800) 310-2835 (TTY: 711) ή μιλήστε με τον πάροχό σας.
Mon-Khmer, Cambodian	យកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ (ខ្មែរ) សេវាកម្មជំនួយភាសាឥតគិតថ្លៃអាចរកបានសម្រាប់អ្នក។ ជំនួយ និងសេវាជំនួយសមស្របដើម្បីផ្តល់ព័ត៌មានក្នុងទម្រង់ដែលអាចចូលប្រើបានក៏អាចរកបានដោយឥតគិតថ្លៃដែរ។ ទូរស័ព្ទទៅ (800) 310-2835 (TTY: 711) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។
Haitian Creole	ATANSYON: Si ou pale kreyòl Ayisyen, sèvis asistans lang gratis disponib pou ou. Gen èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòma aksesib ki disponib tou gratis. Rele (800) 310-2835 (TTY: 711) oswa pale ak pwofesyonèl swen sante w la.

Swahili	TAZAMA: Ikiwa unazungumza Kiswahili, huduma za usaidizi wa lugha bila malipo zinapatikana kwako. Usaidizi na huduma zinazofaa za kutoa taarifa katika miundo inayofikika zinapatikana pia bila malipo. Piga simu (800) 310-2835 (TTY: 711) au zungumza na mtoa huduma wako.

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If you have questions, please call Health New England Member Services at (413) 787-4004 or (800) 310-2835 (TTY: 711), Monday – Friday, 8 a.m. – 6 p.m. or visit healthnewengland.org.

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SECTION 1 – INTRODUCTION

WHAT'S IN THIS SECTION?

In this section, we describe what this book is and how to use it. We also tell you about Health New England. We describe our provider network. Our provider network is made up of the medical professionals with whom we are contracted to provide Covered Services to you. It includes doctors, hospitals, and other medical professionals and facilities.

Certain words in this book begin with a capital letter. They have a special meaning. We define these words in Section 15.

How to Use This Book

This Explanation of Coverage is called the "EOC" or "Agreement." In the EOC we talk about your coverage as a Member of Health New England. In this EOC, we call Health New England "HNE" or "the Plan." This EOC tells you what health care services HNE covers and how to get them. It is set up to help you find what you need to know about your coverage.

The Table of Contents lists each section of the EOC. It also lists where to find that section. At the beginning of each section there is a shaded box, like the box at the top of this page. Each box lists some of the important things to know about that section. You can find more details below the shaded box. In this EOC certain words have a special meaning. You can find definitions of these words in Section 15.

If you have any questions, please call us. HNE's phone numbers and web address are at the bottom of each page. Member Services help is available Monday – Friday, 8 a.m. – 6 p.m.

About Health New England (HNE)

HNE is licensed as a Health Maintenance Organization (an "HMO") in Massachusetts. An HMO is a health plan that requires you to get your care from specific doctors, hospitals, and other health care providers. We call these providers "In-Plan Providers."

HNE does not control the way In-Plan Providers do their work. These In-Plan Providers are independent contractors.

In-Plan Providers are part of the HNE network. There are three ways to find In-Plan Providers:

- You can check the Plan Provider Directory
- You can call HNE Member Services
- You can check healthnewengland.org

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.

To find out more about a doctor licensed in Massachusetts, you can call Physicians Profiles at (781) 876-8230. Toll free in Massachusetts only call (800) 377-0550. You can also visit http://www.mass.gov/check-a-physician-profile. Physicians Profiles is a service of the Board of Registration in Medicine. It provides information on residency, education, languages spoken, etc.

HNE has a specific service area. It includes in Massachusetts:

- Hampden County
- Hampshire County
- Franklin County
- Berkshire County
- Worcester County

How the Plan Works

If you are insured through a Group Contract

Your employer or union group (the "Group") maintains this group health insurance plan. The Plan provides health benefits to its eligible employees and their eligible Spouses and dependents. Benefits of the Plan are provided under an insurance contract entered into by the Group and HNE.

If you are insured with an Individual (Non-Group) Contract

The Plan provides health benefits to you and your eligible Spouse and dependents. Benefits of the Plan are provided under an insurance contract entered into by you as the Subscriber and HNE.

To find out if you and your Spouse and/or dependents are eligible to participate in the Plan, please read the eligibility information in Section 7 of this EOC.

You Must Enroll to Receive Benefits!

You must enroll to receive benefits under this Plan. We explain this in Section 7 and Section 8 of this EOC. Benefits under the Plan are described in this EOC. You must read the EOC to understand your benefits!

Premium Payments

If you are insured through a Group Contract, each month your employer pays HNE for your coverage. ***If are insured with an Individual (Non-Group) Contract****,* each month you pay for your coverage. This monthly payment is called the "Premium." The Premium covers many kinds of services. HNE covers checkups and other care to keep you healthy. We also cover hospital and other care when you are sick. When you use an In-Plan Provider, the bill is sent to HNE. For some services, such as doctors' visits, prescriptions, and emergency room visits, you pay a set dollar amount. This amount is called a "Copay."

Some Services Require Prior Approval

HNE must approve some kinds of care in advance. This is called "Prior Approval." One example is diagnostic imaging services. We list all of the services that require Prior Approval in Section 5 of this EOC. Your health care is covered only when it is Medically Necessary and appropriate.

Preexisting Conditions

This Plan does not limit or exclude coverage for preexisting conditions.

Exclusions

In this EOC we describe when benefits could be terminated, reduced, lost, or denied. We also list exclusions for certain medical procedures. Please read the booklet carefully.

Health New England In-Plan Providers

This HMO health plan requires you to get your care from specific doctors, hospitals, and other health care providers. We call these providers "In-Plan Providers." There may be exceptions to this requirement, for instance when there is no HNE In-Plan Provider available to treat you. See Section 2 of this EOC.

Your Payment Responsibilities

Deductible for Medical Services

For some services you will be responsible for a Deductible before the Plan pays benefits. A Deductible is the cumulative dollar amount that the Member is required to satisfy by paying out-of-pocket for certain Covered Services before HNE will pay benefits under this plan. After this Deductible has been satisfied, you will pay Copays or Coinsurance for some services. For certain other Covered Services the Deductible does not apply, but you may be responsible for Copays or Coinsurance. A Copay is a set dollar amount. Coinsurance is a percentage. Payments for services through the use of coupon programs do not count towards your Deductible.

If you have individual coverage (just for yourself), you must meet the Individual Deductible before the Plan begins paying benefits. 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. 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.

Deductibles are applied on a Calendar Year basis. A Calendar Year is the 12 month period beginning January 1 and ending December 31. The Summary of Benefit Chart in Appendix A shows your Copays and whether or not the Deductible applies.

Please remember that, in general, you must pay any Copay at the time you receive services. Hospitals and emergency rooms usually do not require that you pay the Copay at the time of your visit.

Out-of-Pocket Maximum

The amount of the Out-of-Pocket Maximum is shown in the Summary of Benefit Chart in Appendix A of this EOC. This amount is the most you pay for Cost Sharing for Essential Health Benefits during a policy period (usually a year). Once you reach this amount your plan pays 100% of the Allowed Amount. Not all payments you make are counted towards the Out-of-Pocket Maximum. The Out-of-Pocket Maximum does not include, for example:

- Any part if the premium paid for the policy
- Any payment you make for non-covered services
- Payments made for benefits which are not Essential Health Benefits (see the definition of Essential Health Benefits in Section 15)
- Any payment for drugs obtained through the use of a manufacturer drug coupon program

Explanation of Benefits

When HNE processes a claim for health care services, an Explanation of Benefits (EOB) is produced. This EOB shows how much the provider billed, how much HNE paid, and how much you owe the provider for Member Cost Sharing. It does not show whether or not you have paid the provider.

You can view EOBs on HNE's secure member portal. Visit healthnewengland.org and log onto the member portal "MyHNE." You can print an EOB from the portal. Or, if you wish to have EOBs sent to you, you can log onto the portal and change your mailing preferences. You can also request paper copies of your EOBs by calling Member Services at (800) 310-2835.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an Out-of-Plan provider at an In-Plan hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-Plan providers may bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than In-Plan costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care. For example, when you have an emergency or when you schedule a visit at an In-Plan facility but are unexpectedly treated by an Out-of-Plan provider.

You are protected from balance billing for.

Emergency services

If you have an emergency medical condition and get emergency services from an Out-of-Plan provider or facility, the most the provider or facility may bill you is your plan's In-Plan cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an In-Plan hospital or ambulatory surgical center, certain providers there may be Out-of-Plan. In these cases, the most those providers may bill you is your plan's In-Plan cost-sharing amount. This applies to:

- emergency medicine
- anesthesia
- pathology
- radiology
- laboratory
- neonatology
- assistant surgeon
- hospitalist
- intensivist services

These providers can't balance bill you. Also, they may not ask you to give up your protections not to be balance billed.

If you get other services at these In-Plan facilities, Out-of-Plan providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care Out-of-Plan. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections.

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles) that you would pay if the provider or facility was In-Plan. Your health plan will pay Out-of-Plan providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (Prior Approval).
  - Cover emergency services by Out-of-Plan providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an In-Plan provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or Out-of-Plan services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you can report this 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. You may also file a complaint with the federal government at https://www.cms.gov/nosurprises/consumers.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

Claims Payment Information

For In-Plan Providers, you do not have to submit claims to HNE. In-Plan Providers do this for you. Sometimes you may need to submit claims to HNE. An example may be if you receive Covered Services from an Out-of-Plan Provider in an emergency or with Prior Approval from HNE. Present your HNE ID Card. Most Out-of-Plan Providers will bill HNE directly. If possible, ask the Out-of-Plan Provider to send a standard medical claim form to HNE.

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

- Pay the Out-of-Plan Provider, ***or***
- If we do not pay the claim, tell the Out-of-Plan Provider the reason for non-payment, ***or***
- Ask the provider in writing for any additional information we need to pay the claim.

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

If the Out-of-Plan Provider will not bill HNE, you must make a claim to HNE. Send HNE a bill or claim which lists each service, the amount charged, the date and the diagnosis. In some cases, you may have to pay the Out-of-Plan Provider's bill before HNE can pay it. 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 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. You must pay any Copays that apply. HNE will pay you for the cost of Covered Services, less any applicable Deductible and Copays or Coinsurance.

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. Health New England uses clinical criteria to decide if some services or procedures are Medically Necessary. You may call HNE's Health Services Department if you want a copy of the criteria HNE uses to make such decisions.

Please note: With this HMO plan, 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.

If you receive Emergency services in a foreign country, you must have your bill translated into English. The amount you are billed must also be converted to U.S. dollar values. These dollar values must be the dollar value on the date you received the services.

SECTION 2 – HOW TO OBTAIN BENEFITS

WHAT'S IN THIS SECTION?

In this section, we describe how to get Covered Services. We also may refer to Covered Services as "benefits" or "covered benefits."

The first thing you must do is choose a Primary Care Provider or "PCP." You can change your PCP at any time. If you need care, call your PCP first. In an Emergency, you may go straight to the emergency room.

Most of the time, your PCP will provide your care, or arrange for services with In-Plan Providers. For mental health and substance abuse services, you can call the In-Plan Provider you choose. You do not need to call HNE or your PCP first. HNE must approve coverage for services from Out-of-Plan Providers before you get the services.

Always show your HNE ID Card when receiving services.

In an Emergency, you may go straight to the emergency room. If there is time, call your doctor first.

If you do not follow the rules described in this EOC, you may not be covered for some or all of the care you receive.

Choosing Your Primary Care Provider

We ask you to choose a PCP as soon as you join HNE. Your PCP is the first person you should call when you need medical care. A PCP may be:

- An In-Plan doctor
- A participating nurse practitioner of internal medicine, family practice, or pediatrics.
- 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 you can view it at healthnewengland.org.

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

- Call your PCP's office as soon as possible. Tell the staff you are a new HNE Member.
- Make an appointment to see your new PCP. That way, he or she can get to know you and begin taking care 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. See "If your Primary Care Provider Disenrolls" in Section 14 of this EOC for details on what will happen if your PCP disenrolls from HNE. Please note that HNE will 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 provider.

You may change your PCP by calling HNE Member Services. PCP changes take effect on the next business day after your request. You may change to any In-Plan PCP, except those who have notified HNE that they are not taking new patients.

Your PCP may request that you transfer to another In-Plan Provider. HNE does not allow transfers based on the amount of medical care a Member needs or the Member's physical condition. Your PCP must ask HNE to approve a transfer to a new PCP. Your PCP must send you a letter asking you to choose a new PCP.

Your HNE ID Card

You must present your HNE ID Card to get services. It provides information such as:

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

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

How to Get Medical Care from an In-Plan Provider

To get care from an In-Plan Provider, call your PCP. It is your PCP's responsibility to provide or arrange for most of your medical care. The services you receive must be Medically Necessary and provided by In-Plan Providers except in an Emergency.

Certain services and procedures also require Prior Approval by HNE. Please see Section 5 of this EOC for a list of these procedures.

How do I get non-emergency hospital care?

If you need hospital care, and it is not for an Emergency, your In-Plan Provider will make the arrangements for your hospital stay.

What if I need Non-Emergency care after normal business hours?

Because medical problems may occur at any time, we ask our PCPs to be on call 24 hours a day, seven days a week. 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:

1. Say that you are an HNE Member.
2. Give your name and phone number.
3. Describe your symptoms.
4. Ask for 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. When you go to your appointment, show your HNE ID Card, and pay your usual Copay. Your PCP is the best person to coordinate your care. He or she will discuss treatment options and help decide where you can get the services you need. The end of this section also describes how to get mental health or substance abuse services.

It is your responsibility to make sure that any doctor you see is an HNE In-Plan Doctor. This is true even if the doctor you see is recommended by an In-Plan Doctor. If you are not sure, check the Plan Provider Directory, visit healthnewengland.org, or call HNE.

Services at an HNE In-Plan Location

Medically Necessary services are covered at locations that are in HNE's In-Plan network of providers. Services by Out-of-Plan Providers at these locations will be covered at the In-Plan level of benefits if you did not have a reasonable opportunity to choose to have the services performed by an In-Plan Provider.

How to Get Medical Care from an Out-of-Plan Provider

HNE normally does not cover care you receive from an Out-of-Plan Provider. In general, HNE In-Plan Providers can provide most health care services. However, in some cases, there may be no HNE In-Plan Provider available to treat you. If this is the case, your treating In-Plan Provider can request HNE's approval to refer you to an Out-of-Plan Provider.

In order to see an Out-of-Plan Provider, you must first have the approval of HNE. 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 to treat you, HNE may approve treatment from an Out-of-Plan Provider. HNE will work with your PCP or treating In-Plan Provider to identify an appropriate Out-of-Plan Provider to treat you.

To start this process, your PCP or treating In-Plan Provider must submit a Prior Approval Request Form to HNE. The form should explain why services are not available from an In-Plan Provider. HNE will notify you and your doctor in writing of our decision to approve or not approve the services. If you have not received a response from HNE, call us. You should not make an appointment with the Out-of-Plan Provider before you receive HNE's response. For more details on the Prior Approval process, see Section 5 of this EOC.

Please note: HNE does not verify the credentials of Out-of-Plan Providers. Only In-Plan Providers go through HNE's credentialing process.

Out-of-Area Student Coverage

Dependents attending and residing at school outside of the HNE Service Area are covered for:

- Non-routine medical office visits **for urgent care**
    - Includes diagnostic lab and x-ray
- Follow-up visit after an:
    - ER visit
    - Urgent care visit
- Allergy injections
- Outpatient behavioral health visits
- Outpatient short-term rehabilitation services

All services listed above require Prior Approval by HNE. Note: Emergency services do not require Prior Approval.

How to Get Medical Care in an Emergency

HNE uses the definition of "Emergency" provided by Massachusetts law. This is the definition:

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

All Members may obtain health care services for an Emergency Medical Condition. If you believe that you need emergency care, you should seek care at once. This includes calling 911 or the local emergency number. No

Member will in any way be discouraged from using 911 or any similar pre-hospital emergency medical service system, or the local equivalent.

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

What should I do in an Emergency?

You always have coverage for care in an Emergency. 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 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 arrange for any follow-up care.

If you are admitted to a hospital as an inpatient directly from the ER, you will not have to pay the ER Copay. You will, however, have to pay the amount required by your Plan for the hospital admission. This amount is listed in "Appendix A, Your Payment Responsibilities." Please note: we will not cover non-emergency care you receive in an ER.

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 that are not received in a hospital emergency room. Examples are services at a walk-in clinic or doctor's office. You should also be aware that HNE will 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 will not cover care (including follow-up care) you receive outside the HNE Service area once you are medically able to return to the HNE Service Area.

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 EOC, including the rules for obtaining care in an Emergency. Remember that all follow-up care must be received from an In-Plan Provider. If you are not sure if a Provider that you are being referred to is an In-Plan Provider, please check your Provider Directory, visit healthnewengland.org, or call HNE Member Services.

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, 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 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 (TTY: 711). Our staff can help you choose a provider based on the nature of your concerns, your location, and appointment availability.

Inpatient Services

Most inpatient admissions do not require Prior Approval from HNE. The admitting facility must contact the HNE Health Services Department within one business day to obtain approval for continued stay. For information please call HNE's Health Services Department at (413) 787-4000, ext. 5028 or (800) 842-4464 ext. 5028 (TTY: 711).

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 this section of the EOC.

For detailed information on benefits for behavioral health and substance use disorder services, please see Section 3 of this EOC.

Cost Estimator for Services and Out-of-Pocket Costs

HNE can help you get information on estimated costs for health care services. You can also get an estimate of what you will pay for those services. Available information includes:

- The estimated or 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 the health care services are then provided, you will not be required to pay more than the estimated amount for Member responsibility. However, if unforeseen services arise out of the proposed admission, procedure or service, you may have additional cost sharing as required by your HNE plan.

To get cost estimates for health care services you can:

- Call Member Services toll free at (800) 310-2835. (TTY: 711)
- Email us at memberservices@hne.com
- Go to healthnewengland.org and log in to our member portal, MyHNE.

SECTION 3 – COVERED BENEFITS

WHAT'S IN THIS SECTION?

In this section, we provide details about what is covered. Think of it as the who, what, when, where, and why section. We describe what is covered. We describe where services are provided. We also describe any coverage limits or guidelines.

- To be covered, care must be:
  1. Listed as covered by HNE
  2. Medically Necessary
  3. Appropriate
  4. Provided by an In-Plan Provider
  5. Provided by an Out-of-Plan Provider with HNE's approval or in an Emergency
- Some care is not covered.

Each benefit is listed in bold. Benefit details follow each heading.

HNE covers the services in this section only if they are Medically Necessary and appropriate. Your PCP will provide or arrange most of your health care, following HNE policies and rules. HNE must provide Prior Approval for treatment by an Out-of-Plan Provider. The Emergency situations described in this EOC are the only exceptions.

All covered care is subject to the conditions in this EOC. This section describes HNE's coverage limitations and exclusions. HNE does not pay for medical care unless it is a Covered Service as described in this EOC. HNE also does not cover medical care unless provided as required by this EOC.

Inpatient Care

Acute Hospital Care

HNE covers hospital care. There is no limit on the number of days covered. Prior Approval from HNE is not required for acute hospital care. The admitting facility must contact the HNE Health Services Department within one business day to obtain approval for continued stay.

Inpatient Rehabilitation

(Prior Approval is required)

HNE covers this service in a licensed rehab facility. HNE covers up to 60 days per Calendar Year. HNE covers this service only when you need daily inpatient rehab care. HNE will review your care during your stay. (Concurrent Review is described in Section 5 of this EOC.)

Skilled Nursing Facility

(Prior Approval is required)

HNE covers this service in a licensed skilled nursing facility. HNE covers up to 100 days per Calendar Year. HNE covers this service only when you need daily inpatient skilled nursing care. HNE will review your care during your stay. (Concurrent Review is described in Section 5 of this EOC.)

Long Term Acute Care (LTAC)

(Prior Approval is required)

HNE covers Long Term Acute Care (LTAC). LTAC hospitals are designed for extended stay members with chronic conditions that no longer need intensive diagnostic care. LTAC hospitals provide specialized care to treat complex medical conditions in patients who require long-term highly skilled nursing and rehabilitation care.

What is Covered

Admission to a hospital, skilled care, or rehab facility includes, but is not limited to:

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

What is Not Covered

- Personal or comfort items, including telephone and television charges
- 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 your membership ends
- Unskilled nursing home care

Preventive Care

HNE covers preventive care according to you and your family's medical needs. Your PCP generally provides these services. For a list of preventive services covered by HNE, go to https://healthnewengland.org/preventive-care-services.

Routine Exams

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

Well Child 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

Routine Prenatal & Postpartum Care

HNE covers Routine prenatal and postpartum care. For more information see "Maternity Care" later in this section.

Routine Child and Adult Immunizations

HNE covers immunizations based on guidelines published by the Massachusetts Health Quality Partners (MHQP) or other state or 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. For a complete list of covered immunization vaccines please visit https://healthnewengland.org/preventive-care-chart.

What is Covered

- MHQP immunizations
- Vaccine for the prevention of shingles (herpes zoster) for members 50 years of age and older
- Some Non-Routine immunizations, such as for:
- Exposure to rabies
- Exposure to hepatitis
- Many travel immunizations

Routine Eye Exams

HNE covers one Routine eye exam each Calendar Year. **Important note**: Routine vision exams for children under age 19 will be covered with $0 copay only if you use an EyeMed In-Network provider. Routine vision exams by Health New England providers who are not EyeMed providers will not be covered for children under age 19. See Appendix D of this EOC for vision care benefits for children under age 19.

Annual GYN Exams

HNE covers one Routine GYN exam per Calendar Year. We cover a Pap smear (cytology) and pelvic exam. HNE covers follow-up care for GYN services.

Breast Cancer Screening

HNE covers the following services related to breast cancer:

- Screening mammograms
- Digital breast tomosynthesis
- Screening breast magnetic resonance imaging
- Screening breast ultrasound
- Diagnostic examinations for breast cancer

There is no coast for this care. Deductible will apply for members in High Deductible Health Plans.

Cervical Cancer Screening

HNE covers one Routine GYN exam per Calendar Year. Coverage includes a Pap smear (cytological screening) and pelvic exam.

Colorectal Cancer Screening

HNE covers the following for colorectal cancer screening.

- Fecal occult blood tests
- Cologuard® (Cologuard® tests will be limited to 1 every 3 Calendar Years.)
- One screening colonoscopy *or* sigmoidoscopy every five Calendar Years. This preventive services benefit is for only one procedure or the other (not one of each) every five Calendar Years. You will not have any Member Cost Sharing for the consultation prior to the screening, related *generic* preparation prescriptions or pathology services. For brand name prescriptions you will be responsible for any Member Cost Sharing your plan may have.

Colorectal cancer screenings will be covered for members starting at age 45.

Prostate Cancer Screening

HNE covers PSA tests for prostate cancer screening.

Heart and Vascular Diseases Screening

HNE covers heart and vascular diseases screenings for lipid disorders.

Infectious Diseases Screening

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

Lung Cancer Screening

HNE covers screening for lung cancer with low-dose computed tomography. The the screening is covered only for adults ages 50 to 80. Members must be in a high risk category for developing lung cancer.

Musculoskeletal Disorders Screening

HNE covers screening for osteoporosis.

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

Women's Preventive Health Services

HNE provides coverage for the preventive health services listed below. For services provided by an In-Plan provider, the services are covered in full. There is no Member Cost Sharing for these services when provided In-Plan.

- Well-woman 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. Coverage for contraceptive methods with no Member Cost Sharing is limited to:

- Certain contraceptive methods
- Certain generic prescription drugs
- Certain devices
- Breast feeding support, supplies, and counseling
- Screening and counseling for interpersonal and domestic violence

Pediatric Conditions Screening

HNE covers lead screening in accordance with Massachusetts law. HNE covers screening for phenylketonuria.

Nutritional Counseling

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

Behavioral Health Counseling to Promote a Healthy Diet and Physical Activity

HNE covers this counseling for the prevention of cardiovascular disease in adults who have known risk factors.

Depression Screening for Adolescents and Adults

HNE covers this screening as a part of your routine annual exam.

Tobacco Cessation Products and Services

The following are covered with no Member Cost Sharing.

- Certain tobacco cessation drugs and products. These include prescription drugs and over-the-counter products (with a prescription). See the Health New England Prescription Drug Formulary.
- Counseling for tobacco cessation.

Also, Health New England will reimburse each Member $50 for attending a tobacco cessation class or hypnosis session. Visit healthnewengland.org for a reimbursement form that has details and requirements. Or you can call Member Services at the number at the bottom of this page.

What is Not Covered

- Services required by a court or third party. 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.

Outpatient Care

HNE covers the outpatient services and supplies listed below.

PCP Office Visits (Non-Routine)

HNE covers Non-Routine office visits with your PCP.

Specialist Office Visits

HNE covers care you receive from specialists. See Section 5 of this EOC for a list of services that require Prior Approval.

Obstetrics/Gynecology

All female Members may receive the services listed below from an In-Plan obstetrician, gynecologist, certified nurse midwife, or family practitioner:

- Annual preventive GYN health exams, this includes Covered Services which your provider determines to be Medically Necessary
- Maternity care
- Evaluations and health care services for GYN conditions

You may schedule these visits yourself. (See also *Preventive Care* and *Maternity Care*.)

Foot Care

Unless you are a diabetic, HNE does not cover podiatry care for "Routine" foot care. This includes care of corns, calluses, and trimming of nails. HNE covers Non-Routine podiatry services available from an In-Plan podiatrist. This includes treatment of podiatric diseases and conditions.

Second Opinions

HNE covers second opinions from an In-Plan Provider.

Telehealth Services

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 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.

Telehealth Services through Teledoc®

HNE covers phone or online video consultations through Teladoc®. You can 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. You will not pay a Copay for consultations. If your plan has a Deductible, that Deductible may apply. See the Summary of Benefit Chart in Appendix A to find out if a Deductible could apply.

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) Teladoc or (800) 835-2362, or visit Teladoc.com. You will need to set up an account with Teladoc before your first consultation. To set up an account visit Teladoc.com and click "Set Up Account." You do not need to wait until you want a consultation before setting up an account.

Hearing Tests

HNE covers hearing tests.

Diabetic Related Items

HNE covers the items and services below to diagnose or treat diabetes. These items are covered when ordered by an In-Plan Provider. This applies whether the diabetes is:

- Gestational
- Insulin-dependent
- Insulin-using
- Non-insulin-dependent

Outpatient Services

HNE covers outpatient diabetes training and education. This includes medical nutritional therapy and nutritional counseling.

Lab/Radiological services

HNE covers lab tests including glycosylated hemoglobin, HbAlc tests, urinary protein/microalbumin, and lipid profiles.

Durable Medical Equipment (DME)

(Prior Approval is required)

You must have Prior Approval for all covered:

- Durable Medical Equipment
- Medical supplies
- Orthotics

The In-Plan Provider who supplies these items is responsible for obtaining the Prior Approval.

HNE covers the following DME for diabetics:

- Blood glucose monitors.
- Continuous glucose monitoring devices
- Voice synthesizers for blood glucose monitors for use by the legally blind. (If approved, these items are not subject to Coinsurance.)
- Visual magnifying aids for use by the legally blind.
- Insulin pumps. (If approved, insulin pumps and insulin pump supplies are not subject to Coinsurance.)
- Therapeutic/molded shoes and shoe inserts. Coverage for footwear and inserts is limited to one of the following per Calendar Year:
- One pair of custom molded shoes (including inserts provided with those shoes) and two additional pairs of inserts; or
- 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.

Diabetic Supplies

HNE covers the items below. Some diabetic supplies can be obtained at a pharmacy or from a DME supplier. If you obtain diabetic supplies from a DME supplier, you must have Prior Approval.

- Blood glucose monitoring strips
- Urine glucose strips

- Ketone strips
- Lancets
- Insulin
- Insulin pens
- Needles and syringes
- Prescribed oral diabetes drugs that influence blood sugar levels (covered only if your plan has prescription drug coverage)

Group Diabetic Education Series

HNE covers Group Diabetic Education services. This is a specific program for people newly diagnosed with diabetes or who have uncontrolled diabetes. A Registered Nurse certified in diabetes education and a Registered Dietician teach these classes. Those in the class learn about:

- Self-management techniques
- Medical testing
- Prescription medication and insulin

Emergency Room Care

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.

See Section 2 of this EOC for information about how to obtain Emergency Care. If you need follow-up care after being treated in an emergency room, you must call your Primary Care Provider. You PCP will provide or arrange for the care you need. All follow-up care must be provided by In-Plan Providers.

What is Not Covered

- Follow-up care that is not provided by In-Plan Providers
- Visits to an ER that are not for emergency care
- Medical care outside of the HNE Service Area that you could have foreseen was needed when you were in the HNE Service Area
- Care from an Out-of-Plan Provider once you are medically able to return to the HNE Service Area

Observation Room

If you are in a hospital in observation status:

- HNE will pay for the observation room charges.
- Member Cost Sharing applies for services provided while you are in observation.
- You must pay the ER Copay or Coinsurance.

Diagnostic Testing

HNE covers some services to diagnose illness, injury, or pregnancy. Some service, such as sigmoidoscopies, endoscopies, colonoscopies, arthroscopies, needle aspirations, and biopsies, are covered under the outpatient surgical services and procedures benefit.

Sleep Studies

(Studies in Facilities Requires Prior Approval)

Prior Approval of sleep studies will be reviewed by eviCore. You or your doctor can contact eviCore at (888) 693-3211. For Prior Approval of related devices and supplies, see Durable Medical Equipment in the "Covered Benefits" section. If you have any questions, please call Member Services at the number at the bottom of the page.

HNE covers sleep studies, including home sleep studies. 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

Genetic Testing

(Requires Prior Approval)

Requests for Prior Approval of genetic testing will be reviewed by eviCore. You or your doctor can contact eviCore at (888) 693-3211. If you have any questions, please call Member Services at the number at the bottom of the page.

HNE covers medically necessary genetic testing per medical policy Examples of genetic testing are:

- Testing for the breast cancer gene (BRCA)
- Testing for Lynch syndrome
- Testing for Huntington's Chorea

HNE limits certain genetic tests to once per lifetime of the member. These are tests where the results will never change on subsequent testing.

Lab Services

HNE covers lab services when they are done in your In-Plan Doctor's office or other In-Plan lab.

What is Not Covered

- Diagnostic tests analyzed in functional medicine labs such as Genova Diagnostics

Radiological Services

HNE covers X-rays, ultrasound, and mammography.

Diagnostic Imaging

(Requires Prior Approval)

Requests for Prior Approval of these diagnostic imaging procedures will be reviewed by eviCore. You or your doctor can contact eviCore at (888) 693-3211. If you have any questions, please call Member Services at the number at the bottom of the page.

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

- Computerized Tomography (CT) scans
- Positron Emission Tomography (PET) scans
- Magnetic Resonance Imaging (MRI)

- Magnetic Resonance Angiograms (MRA)
- Nuclear Cardiac Imaging done in all outpatient settings, including outpatient facilities and doctors' offices

You do not need Prior Approval for diagnostic imaging services provided in the emergency room or during an inpatient admission.

Radiation Therapy and Chemotherapy

HNE covers radiation therapy and chemotherapy.

Outpatient Short Term Rehabilitation Services

These services include physical and occupational therapy (PT and OT). HNE only covers short-term therapy for rehab. There is a limit during each Calendar Year. The limit is 60 visits per Calendar Year for physical or occupational therapy.

The Calendar Year limit does not apply to services that are part of a home health plan. The limit also does not apply when services are provided to treat autism spectrum disorder. Services that are part of a home health plan and services provided to treat autism spectrum disorder require Prior Approval. Your medical condition must improve during your course of therapy for coverage to continue.

HNE covers Day Rehab Services. HNE covers half day and full day sessions. HNE covers up to 15 days of Day Rehab Services per lifetime per condition. Half days and full days are counted as "one day" towards this benefit.

HNE covers treatment for acute episodes of an illness related to your chronic condition. Your medical condition must improve during your therapy for coverage to continue.

What is Not Covered

- Rehab treatment for non-acute chronic conditions
- Maintenance treatments designed:
    - To retain health or bodily function
    - 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 that are covered by MGL Chapter 71B in Massachusetts (referred to as Chapter 766) or C.G.S.A. § 10-76a through 10-76g, inclusive, in Connecticut, unless such services are Medically Necessary (as defined in Section 15 of this EOC) and meet Health New England's clinical criteria for such services. Members should obtain services available under Massachusetts law (by seeking a Chapter 766 evaluation) or under Connecticut law. See Section 7 of this EOC.

Early Intervention Services

HNE covers Early Intervention (EI) services. These services must be delivered by certified EI specialists. These specialists work in EI programs and are certified by the Department of Public Health. Coverage is for Members from birth until age 3. There is no visit limit for EI services.

Autism Spectrum Disorders and Down Syndrome

Autism Spectrum Disorder

HNE covers medically necessary care 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 is required)
- Genetic testing (Prior Approval is required)
- Other tests to diagnose ASD (some services 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 (ABA) 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 Pharmacy Rider of your EOC 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.

Down Syndrome

HNE covers Medically Necessary care to diagnose and treat Down Syndrome. This includes:

- Habilitative or Rehabilitative care: professional, counseling and guidance services and treatment programs, including, but not limited to, applied behavior analysis supervised by a board certified behavior analyst, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of an individual
    - Applied behavior analysis includes the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including in the use of direct observation, measurement and functional analysis of the relationship between environment and behavior (Prior Approval required)
- Therapeutic Care: Services provided by licensed or certified speech pathologists, 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 and Down Syndrome. All services are subject to applicable Copays, Coinsurance, and Deductibles.

What is Not Covered

- Services related to ASD and Down Syndrome provided under an individualized education program, whether provided by school personnel or by third-party contractors or vendors at the direction of school personnel.

Surgical Services and Procedures at an Outpatient Facility

(Some procedures require Prior Approval)

HNE covers the following outpatient surgical services. These are part of the Surgical Services and Procedures benefit:

- Outpatient or ambulatory surgery and related services
- Certain procedures, such as sigmoidoscopies, colonoscopies, arthroscopies, needle aspirations, and biopsies

What you pay for Surgical Services and Procedures at an outpatient facility depends on your HNE plan as explained below. See the Summary of Benefit Chart in Appendix A of the EOC for your responsibility for Surgical Services and Procedures at an outpatient facility.

If the Summary of Benefit Chart shows a $0 Copay for Surgical Services and Procedures at an Outpatient Facility

You will not pay a Copay for surgical services in an ambulatory care facility or the outpatient department of a hospital.

If the Summary of Benefit Chart shows Coinsurance (a percentage) for Surgical Services and Procedures at an Outpatient Facility

You will pay Coinsurance (a percentage of HNE's Allowed Amount) for surgical procedures done in an outpatient surgical facility.

If the Summary of Benefit Chart has a Copay (dollar amount) other than $0 Copay for Surgical Services and Procedures at an Outpatient Facility

The Copay you pay for services in an outpatient facility is based on the type of service you receive. Some surgical services and procedures are simpler than others. The simple procedures are minimally invasive. They are minor in terms of time, preparation, or expertise needed to do them. Others are more complex. They may require the skills of a specialist.

In general, you do not have to pay a Surgical Services and Procedures Copay for services that are:

- Simple, minor, or involve a small, localized area of the body
- Closed treatments
- Done while the surface or local area is anesthetized (instead of complete anesthesia)
- Biopsies which are not extensive or invasive
- Injections
- Done using imaging guidance
- Screening colonoscopies and sigmoidoscopies (preventive, one every five Calendar Years)

These services require you to pay a Surgical Services and Procedures Copay when done in an outpatient facility:

- Services that are complicated, clinically complex, deep, or involve an extensive area of the body
- Services that are complicated or involved and/or may require the skills of a clinical specialist
- Services that involve open treatment
- Services that require general anesthesia (more than just the area of surgery)
- Biopsies that are extensive or invasive
- Non-preventive scope procedures (such as endoscopies and colonoscopies)
- Some IVF procedures

HNE Member Services can tell you if the Copay applies to a specific procedure. Please contact HNE Member Services at the number below.

Certain outpatient surgical services require Prior Approval by HNE. We list these in Section 5 of this EOC. HNE will only approve these services if they meet HNE's clinical review criteria.

Allergy Testing and Treatment

HNE covers testing, antigens, and allergy treatments.

Hormone Replacement Therapy

HNE covers hormone replacement therapy (HRT) services for peri- and postmenopausal women. HRT drugs are covered only if your plan includes a prescription drug benefit.

Clinical Trials

(Requires Prior Approval)

HNE may cover patient care items and services provided in a clinical trial for cancer or another life threatening disease, as long as required by Massachusetts or federal law and per our medical policy. Please discuss with your provider if you are considering entering a clinical trial. HNE Member Services can give you more information about what would be covered in a clinical trial.

What is not Covered

- An investigational drug or device paid for by its manufacturer, distributor, or provider
- Non-health care services that you may need when enrolled in the clinical trial
- Costs associated with the research associated with 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 which are inconsistent with widely accepted and established national or regional standards of care
- The costs of services which are provided primarily to meet the needs of the trial. This includes but is not limited to, tests, measurements, and other services which are typically covered but which are being provided at a greater frequency, intensity, or duration.
- Services or costs that HNE does not cover

Family Planning Services and Infertility Treatment

Family Planning Services

HNE covers family planning services. This includes pregnancy testing and genetic counseling.

What is Covered

- Outpatient contraceptive services. This includes consultations, exams, and medical services that are provided on an outpatient basis. HNE covers services related to the use of all contraceptive methods approved by the Food and Drug Administration (FDA) to prevent pregnancy.
- Birth control drugs, devices, implants, procedures, and injections approved by the FDA. There are some contraceptives which require you to have coverage for prescription drugs with HNE.
- Counseling and diagnostic services for genetic problems and birth defects
- Family planning information and consultation
- Pregnancy testing
- Sterilizations

What is Not Covered

- Reversal of voluntary sterilization

You may have Member Cost Sharing for the treatment of medical complications that are the result of preventive services or procedures. This is the case even if you did not have Member Cost Sharing for the preventive service or procedure. For example, the insertion and removal of a birth control device is covered as a preventive service with no Member Cost Sharing. Treatment of medical complications that are a result of the insertion or removal of the device are subject to Member Cost Sharing. All services must be Medically Necessary.

Abortion

HNE covers abortion as allowed by Massachusetts Law (Chapter 127 of the Act of 2022). There is no member cost share for abortion and related services per Massachusetts law.

Abortion related services include the following.

- Pre-operative evaluation and examination
- Pre-operative counseling
- Laboratory services, including pregnancy testing, blood type, and Rh factor
- Rh (D) immune globulin (human)
- Anesthesia (general or local)
- Post-operative care
- Follow up
- Advice on contraception or referral to family planning services

Infertility Treatment

(Requires Prior Approval)

HNE covers all non-experimental infertility procedures. This includes, but is not limited to:

- Artificial Insemination / Intra-Uterine Insemination (AI/IUI)
- 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)
- Assisted Hatching
- Cryopreservation of eggs during an active IVF cycle or as Medically Necessary (in the case of impending or possible loss or damage of reproductive tissue because of medical treatments (chemo or radiation))
- Preimplantation Genetic Diagnosis (PGD)

There are limits to the benefits and there are some exclusions. This is defined in the terms of HNE's Infertility Policy. You can view the policy on healthnewengland.org. Or you can call Member Services to have a copy mailed to you, free of charge.

What is Not 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.
- Any costs associated with any form of surrogacy, including gestational carriers.

Fertility Preservation Services

(Requires Prior Approval)

HNE covers fertility preservation services, including, but not limited to, coverage for procurement, cryopreservation and storage of gametes, embryos or other reproductive tissue, when the enrollee has a diagnosed medical or genetic condition that may directly or indirectly cause impairment of fertility by affecting reproductive organs or processes.

Maternity Care

Only an In-Plan Provider can provide prenatal care. Also, an In-Plan provider must arrange all inpatient care.

Important Notice of Rights

Massachusetts law gives you the right to stay in the hospital for at least 48 hours after giving birth. If you have a cesarean section, you may stay at least 96 hours. If you have any questions about your rights under this law, talk to your doctor or nurse, or call the Office of Patient Protection at (800) 436-7757.

The state 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. If you have a cesarean section you have the right to stay in the hospital with your baby for at least 96 hours after giving birth. If this time period ends between 8:00 PM and 8:00 AM, you have the right to stay in the hospital until after 8:00 AM, 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 Office of Patient Protection at (800) 436-7757. If you feel your rights have been denied under this law, you may file an appeal within the Office of Patient Protection at (800) 436-7757. TDD/TTY (800) 439-2370. Filing an appeal will prevent you from being discharged while the appeal is being considered.

What is Covered

- Prenatal and postpartum care, including:
    - Breast feeding consultation
    - Parent education
    - Screenings for postpartum and major depressive disorders
    - Donor human milk and donor human milk derived products for hospitalized infants up to six months
    - Universal postpartum home visiting services
- Diagnostic tests
- Child delivery
- Routine nursery charges. These include services commonly given to healthy newborns. To have HNE cover your child after birth, you must enroll your child as a Member within 30 days of birth.
- Newborn hearing screening
- One home visit. More than one home visit if Medically Necessary. (A registered nurse, physician, or certified nurse midwife provides the first home visit. A licensed health care provider covers additional visits.)
- Doula services, including:
    - Antepartum and Postpartum visits (limited to 16 total hours per pregnancy
    - Attendance for support and delivery

Member Cost Sharing for inpatient maternity care applies to care at an In-Plan birthing center.

What is Not Covered

- Routine maternity (prenatal and postpartum) care when you are traveling outside of the HNE Service Area

- Delivery out of the HNE Service Area after the 37th week of pregnancy. HNE also will not cover delivery out of the service area if you have been told that you are at risk for early delivery.
- Home deliveries

Emergency Dental Services and Non-Dental Oral Surgery

HNE covers only the limited dental services listed below.

Surgical Treatment of Non-Dental Conditions of the Oral Cavity

HNE covers surgical treatment of non-dental conditions. This includes:

- Lesions
- Cysts
- Tumors of the jaw and gums
- Disease of the mouth

Emergency Dental Care

HNE covers the first Emergency dental care for traumatic injury to sound, natural teeth. You must get all services, except for suture removal within 72 hours of injury. HNE does not cover follow-up care. We also do not cover care to restore your teeth or gums. You must report Emergency dental care to HNE unless you get the care in a hospital ER. What is Covered

- Surgery to treat non-dental conditions
- Removal of impacted teeth (If you have impacted teeth removed in an oral surgeon's office, you do not need Prior Approval. If it is done in an outpatient facility, you must have Prior Approval for the facility and anesthesia charges.)
- Emergency dental care needed due to an injury to sound natural teeth, including:
    - Having teeth removed 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 and stabilization of dislodged natural teeth
    - Medication received from the provider
- Surgical treatment of temporomandibular joint syndrome (TMJ). Prior Approval is required.
- Some medical conditions can complicate dental care. They may require a person to get dental care in a hospital or surgical day care facility. If you have such a condition, for some specific kinds of dental care, HNE covers the hospital and anesthesia services you need. HNE will not cover the dental care. Examples of "medical conditions that can complicate dental care" are bleeding disorders and serious heart or lung disease. Your doctor must approve these services. HNE must approve your hospital or day surgery admission.
    - In some cases HNE covers hospital and anesthesia services for small children. The coverage is available only if:
    - It is related to dental procedures
    - It is for children aged 6 and under
    - The child has behavioral or medical conditions
    - The conditions require close monitoring in a controlled situation
    - As part of your hospital stay, you must pay the costs of services related to the dental procedure for:
    - Physician
    - Dental
    - Surgical assistant
    - Radiology

What is Not Covered

- Braces
- Dental treatment of temporomandibular joint syndrome (TMJ). Dental treatment of TMJ is defined as conservative, nonsurgical intervention. This may include, for example, therapeutic splints, oral appliances, or corrective dental treatments such as crowns, bridges, braces and prosthetic appliances.
- Dentures
- Services for dental conditions, including but not limited to tooth decay and gum disease
- Fillings, crowns, implants, caps, or bridges
- Jaw surgery in connection with orthodontics
- Periodontics and orthodontics
- Removal of wisdom teeth if teeth are not impacted
- Root canals

Other Services

COVID-19

Health New England will cover the following services related to COVID-19

- Emergency Services
- Inpatient Services
- Cognitive rehabilitation services
- Diagnostic and laboratory services
- Medically Necessary testing
- Immunizations

This applies to both In-Plan and Out-of-Plan provider.

Home Health Care

(Requires Prior Approval)

HNE only covers home health care services that are:

- Approved by your physician as part of a home health service plan
- Provided by a licensed home health agency
- Provided in the Member's home. The home must also be the best place to get Covered Services.

To be covered as Home Health Care, care cannot be provided in:

- A hospital
- A skilled nursing facility
- A rehab facility

Your PCP must arrange all home health care under a home health care plan. Before care begins, HNE must agree that the care is Medically Necessary. HNE will continue to review the home health care. (We describe "Concurrent Review" in Section 5 of this EOC.)

What is Covered

- Physical, occupational, and speech therapy (the visit limit for physical and occupational therapy does not apply when provided as part of the home health benefit)
- Skilled nursing services provided by licensed professionals
- Durable medical equipment (DME) and supplies (no Coinsurance applies for DME that is part of an approved home health plan)
- Medical social services
- Nutritional counseling

- Services of a home health aide

What is Not Covered

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

Hospice Services and Palliative Care

(Requires Prior Approval)

HNE covers hospice services for Members who are terminally ill. These services must be provided by a hospice provider. During the hospice care, the PCP and hospice director must certify that the Member is terminally ill and is expected to live six months or less. After six months of hospice care, HNE will ask for continued proof of this. Hospice care may be provided at home or in a hospice.

For hospice care, Covered Services include:

- Physician services
- Nursing care
- Social services
- Volunteer services
- Counseling services

HNE will only cover inpatient care when skilled nursing care is Medically Necessary.

HNE also covers palliative care. The goal of palliative care is to improve the quality of life for members with a serious illness. This illness can be curable, chronic, or life threatening.

Durable Medical Equipment, Prosthetic Equipment, and Medical and Surgical Supplies

(Prior Approval is required)

You must have Prior Approval for *all covered*:

- Durable Medical Equipment
- Hearing aids
- Medical supplies
- Orthotics
- Oxygen and related supplies
- Prosthetics (including wigs worn for hair loss due to treatment of cancer or leukemia)

The In-Plan Provider who supplies these items is responsible for obtaining Prior Approval.

Prior Approval is **not** required for items you receive in:

- A hospital
- A rehab facility
- An outpatient surgical center

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 standards:

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 the 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. HNE will not cover replacement of a DME item just because a newer model is available. For example, we do not cover equipment upgrades or accessories whose sole purpose is to integrate an insulin pump and an interstitial glucose monitor through wireless communication. We do not consider this to be Medically Necessary.

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 Coinsurance. The Summary of Benefit Chart lists what you will pay for Coinsurance. The Member Coinsurance for DME does not apply to oxygen from In-Plan Providers. The Member Coinsurance does not apply to items that are part of a home health care plan approved by HNE.

- 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. HNE will not cover repairs to any items that are not covered by your plan. We will not cover repairs to an item that has been obtained through another payer after HNE has denied coverage for the item. If a warranty was issued with the item, repair or replacement under that warranty will take precedence over HNE's coverage for repair or replacement.

- HNE covers prosthetic limbs. There is no annual limit for the purchase of prosthetic limbs. The Coinsurance the Member must pay is listed in the Summary of Benefit Chart in this EOC.

- HNE covers certain high cost equipment from In-Plan providers with no Member Coinsurance required. For a list of these items, see below or contact HNE Member Services.

HNE covers items such as:

- Automatic blood pressure monitors (Prior Approval is not required when prescribed by a doctor and supplied by an In-Plan DME provider. Limited to one per Calendar Year.)
- Breast prostheses (related to mastectomy as required by law)
- Canes/crutches/walkers
- Certain diabetic equipment and supplies (see Diabetic-Related Items in this section of the EOC)
- Certain types of braces or splints
- Certain wound care supplies (requires Prior Approval)
- Compression stockings (limited to 3 pairs per Calendar Year)
- External urinary catheters
- Hospital beds

- Infusion pumps
- Limb prostheses (artificial arms and legs)
- Ostomy supplies (including adhesives and adhesive removers)
- Oxygen and related supplies (not subject to Coinsurance)
- Power Operated Vehicles (POV) if medical criteria are met
- Respiratory equipment and related supplies
- Wheelchairs

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

What is Not Covered

- Arch supports, corrective shoes, and 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, retail strollers, and retail scooters
- Exercise or sports equipment
- Eyeglasses and contact lenses (unless specifically covered in your EOC)
- Heating pads, hot water bottles, and paraffin bath units
- Home adaptations (This includes but is not limited to home improvement and home adaptation equipment, for example, bathroom grab bars.)
- Home lumbar traction
- 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, retail safety belts, retail harnesses or retail vests)
- Tinnitus masker
- Items that are considered Experimental, investigational, or not generally accepted in the medical community
- Items that do not meet the coverage rules listed above

If you do not see your specific items on the lists above, please call HNE Member Services.

HNE will notify you of any change to:

- This list
- What is covered
- What is not covered

An amendment to this EOC will be provided by HNE and will show the change.

Ambulance and Transportation Services

HNE covers ambulance and transportation services as follows:

- **Emergency Transportation –** HNE covers transportation for an Emergency Medical Condition (as defined in Section 15 of the EOC). 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. For ground ambulance services, HNE covers only the ambulance transport and mileage. HNE will not cover ancillary supplies or services *when billed as separate line items* as a part of ground ambulance services. Examples of these supplies and services are: ECG Tracing, drugs, intubation, and measuring of oxygen in the blood.

- **Air Ambulance –** HNE covers air ambulance services in the case of a life threatening emergency or when otherwise pre-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.

What is Not Covered

- HNE does not cover transportation by ambulance or by chair van for patient convenience or for non-clinical, non-medical 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.

Kidney Dialysis

HNE covers kidney dialysis on an inpatient or outpatient basis, or at home. Some people with kidney disease, who have "end stage renal disease" or ESRD, are eligible for Medicare at any age. If you have ESRD, you should enroll in Medicare. Medicare may pay some medical costs HNE does not cover. Starting 30 months after you are enrolled in Medicare with ESRD, Medicare pays first for dialysis, and HNE pays second. You should apply for Medicare to make sure you get the most complete coverage.

Nutritional Support

(Requires Prior Approval)

Nutritional support items must be obtained from an In-Plan Provider, unless there is no In-Plan Provider who can supply them. If an item is not available from an In-Plan Provider, you may obtain the item from an Out-of-Plan Provider.

Some providers submit claims to HNE for nutritional support items. Some providers may not submit a claim form. If the provider will not submit a claim form, pay the provider and submit the itemized paid receipts to HNE. HNE will repay you for covered items. When you send the receipts in to HNE, circle the nutritional items on the receipt. Also, be sure to include the Member's name and HNE ID number on the receipt.

HNE covers the following when ordered by an In-Plan Provider:

- Nutritional support, including enteral tube feeding, when the Member has a permanent impairment involving the gastrointestinal tract that prevents adequate or 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 academia 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
- Special 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

The items above are not covered even if they are required to maintain weight or strength.

Cardiac Rehabilitation

HNE covers the multidisciplinary treatment of persons with documented cardiovascular disease. HNE covers such care when it 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. Phases III and IV of cardiac rehabilitation are not covered under this benefit. Phases III and IV are exercise programs designed to maintain the patient's rehabilitated cardiovascular health.

Nurse Anesthetists and Nurse Practitioners

HNE covers services provided by a certified registered nurse anesthetist or nurse practitioner if the following conditions are met:

1. The service 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, and
2. HNE covers the identical services when rendered by other licensed providers of health care

Physician Assistants

HNE covers services provided by an In-Plan Physician Assistant if the following conditions are met:

1. The service is within the scope of the Physician Assistant's license, and
2. HNE covers the identical services when rendered by other licensed providers of health care

Wigs (Scalp Hair Prostheses)

HNE covers wigs (scalp hair prostheses) worn for hair loss due to the treatment of any form of cancer or leukemia. HNE covers one prosthesis per Calendar Year. Your Cost Sharing is shown in the Summary of Benefit Chart in Appendix A. Your cost will be less if you use a provider in the network of HNE's DME Benefit Manager, Northwood. A Northwood provider will submit a claim for you. Or, you can pay for a wig from any provider and submit a request to HNE Member Services for reimbursement. Requests for reimbursement must include:

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

Speech, Hearing, and Language Disorders

(Requires Prior Approval after the initial evaluation)

HNE covers the diagnosis and treatment of speech, hearing, and language disorders. Services must be provided by In-Plan speech-language pathologists or audiologists. HNE will not cover these services when available in a school-based setting.

Hearing Aids for Members Age 21 and Under

(Requires Prior Approval)

HNE covers hearing aids for Members age 21 and under as required by Massachusetts law.

- HNE covers the cost of one hearing aid per hearing impaired ear, every 36 months, up to a maximum of $2,000 for each hearing aid. The $2,000 limit applies to the hearing aid only. Related supplies and fittings are covered under the benefit for Durable Medical Equipment (DME).
- 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
- 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 Plan's Out-of-Pocket Maximum.
- HNE requires a written statement from the Member's treating physician that the hearing aid is Medically Necessary.

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 required by Massachusetts law.

- 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
    - Nutritional 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.
- Any Cost Sharing and other requirements that are a part of your plan apply to this coverage.

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.

Gender Affirming Care

The Plan covers gender affirming health care to treat Gender Dysphoria per HNE's clinical guidelines. To get a copy of HNE's guidelines for gender affirming surgery, please call HNE Member Services at (800) 310-2835. You can also find the guidelines on our website. Coverage includes the following.

- Behavioral health benefits
- Pharmaceutical coverage (e.g., for hormone replacement therapies)
- Coverage for medical visits or laboratory services
- Coverage for reconstructive surgical procedures related to sex reassignment
    - Medically necessary care is not limited by the number of surgeries
- Coverage of routine, chronic or urgent non-transition services

These benefits are on top of other benefits covered under the Plan. HNE does not consider gender affirming surgery to be reconstructive to correct a physical functional impairment or cosmetic services.

Treatment for HIV Associated Lipodystrophy Syndrome

Health New England covers medical and drug treatments to correct or repair disturbances of body composition caused by HIV associated lipodystrophy syndrome. These include, but are not limited to:

- Reconstructive surgery, such as suction assisted lipectomy
- Other restorative procedures
- Dermal injections or fillers for reversal of facial lipoatrophy syndrome

Member cost sharing will be the same as for other medical benefits under the plan.

Organ Transplants and Bone Marrow Transplants

(Requires Prior Approval)

What is Covered

- Autologous bone marrow transplants for a Member with metastasized breast cancer in accordance with the criteria of the Massachusetts Department of Public Health and for the follow diagnoses:
    - Acute leukemia 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 some cases of metastatic breast cancer which meet the coverage eligibility guidelines by the Massachusetts Department of Public Health. HNE does not cover bone marrow or stem cell harvest or rescue and related treatment, 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
- Human leukocyte antigen testing of histocompatibility locus antigen testing. This is covered for a Member when needed to establish the Member's bone marrow transplant donor suitability. HNE covers the costs of testing for A, B, or DR antigens, or any combination of those. 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 and the donor's costs are not covered by any other insurance, HNE covers 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

- 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
- Human leukocyte antigen testing for individuals who are not HNE Members

Pain Management Alternatives to Opioid Pain Products

Health New England covers the pain management alternatives to opioid pain products shown below.

Medication alternatives (a prescription is required):

- Non-steroidal anti-inflammatory drugs (i.e., ibuprofen or naproxen)
- Lidocaine patches

Non-medication alternatives:

- Acupuncture (may be limited to 12 visits per Calendar Year, depending on your plan)
- Chiropractic care
- Cognitive behavioral care
- Physical therapy (limited to 60 visits per Calendar Year)
- Recovery coaches and peer specialists if part of a licensed behavioral health treatment program, such as a licensed mental health clinic or outpatient hospital clinic and under the supervision of a licensed clinician, such as a licensed social worker, registered nurse, or clinical psychologist
- Transcutaneous electrical nerve stimulation (TENS) devices (Prior Approval is required)

You are responsible for any cost sharing your plan may have.

Wellness Services

Acupuncture
Health New England covers up to 12 visits per Calendar Year for acupuncture services. You must receive In-Plan services from an Optum Physical Health acupuncturist. You can find an In-Plan provider in HNE's provider directory. You are responsible for any Member Cost Sharing your plan may have.

Massage Therapy
Health New England will reimburse you for a total of two one hour visits for massage therapy, per family, per Calendar Year. The massage therapist you visit must be licensed to provide the type of service you receive. For reimbursement you must send us a completed Health New England "Massage Reimbursement Form" along with proof of your payment. For a reimbursement form, go to healthnewengland.org/forms. Only covered in the United States.

Behavioral Health and Substance Use Disorder Services

Some care may need Prior Approval. Prior Approval is not needed for emergency care. You do not need Prior Approval for medication management services with an In-Plan psychiatrist or clinical nurse specialist. There is no yearly limit to the number of these visits you may have.

HNE will cover one Behavioral Health screening each year, per Massachusetts law (Chapter 177 of the Acts of 2022). There is no cost share for the yearly screening.

Outpatient Behavioral Health Services

We cover Medically Necessary Outpatient Behavioral Health care. Providers must be licensed in the state in which you receive care based on medical policy.

Providers below may provide Behavioral Health care.

- Psychiatrists
- Psychologists
- Psychotherapists
- Licensed independent clinical social workers
- Mental health counselors
- Clinical specialists in psychiatric and mental health nursing
- Licensed marriage and family therapists providing services within the scope of practice allowed by law for these therapists
- Licensed alcohol and drug counselors who have a Massachusetts LADC-I level license
- Psychiatric collaborative care model
- Licensed Applied Behavioral Analysts (LABA)/ Board Certified Behavioral Health Analysts (Defined as a behavioral analyst credentialed by the Behavior Analyst Certification Board as a Board-Certified Behavior Analyst)
- Licensed supervised mental health counselor
- Licensed Physician Assistant who practices in the area of psychiatry
- Health care professional under the supervision of a licensed Behavioral Health Professional
- Recovery coaches and peer specialists if part of a licensed behavioral health treatment program, such as a licensed mental health clinic or outpatient hospital clinic and under the supervision of a licensed clinician, such as a licensed social worker, registered nurse, or clinical psychologist

Care may be done in the outpatient settings below.

- A licensed hospital
- A mental health or substance use clinic licensed by the Massachusetts Department of Public Health
- A public community mental health center
- A professional office
- Home-based services by a licensed professional acting within the scope of his or her license

Outpatient care does not have yearly, lifetime or visit/unit/Day limits. Outpatient behavioral health care includes the following.

- Applied Behavior Analysis (ABA) (Prior Approval is required)
- Community crisis counseling
- Diagnostic evaluation
- Electroconvulsive therapy
- Family and case consultation
- Individual, group, and family counseling
- Medication management services/visits
- Narcotic treatment services
- Neuropsychological assessment and psychological testing (Prior Approval is required)
- Recovery coaches and peer specialists if part of a licensed behavioral health treatment program, such as a licensed mental health clinic, substance use disorder clinic, or outpatient hospital clinic and under

supervision of a licensed clinician, such as a licensed social worker, registered nurse, or clinical psychologist

You do not need Prior Approval for visits with In-Plan Providers when care is for Outpatient behavioral health therapy or Outpatient substance use disorder care.

Intermediate Behavioral Health Services

We cover Medically Necessary Intermediate behavioral health care. Intermediate care is more in-depth than Outpatient care and less than Inpatient care. Intermediate care does not have any yearly, lifetime or visit/unit/Day limits. This includes the following.

- Acute residential treatment, such as community-based acute treatment (this is not a substance-use-specific service)
- 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
  - It is sometimes used as a step down from an inpatient hospitalization
  - HNE has clinical review criteria for admissions to CBAT programs
  - Your provider must notify HNE of the admission*
- Clinically managed detoxification services (This is 24 hour, seven days a week clinically managed detoxification services in a licensed non-hospital setting that includes 24 hour per day supervision, observation and support, and nursing care, seven days a week)
- Crisis stabilization
- Day treatment programs
- Intensive Outpatient Programs (IOP) and Partial Hospitalization Programs (PHP) To be covered, PHP and IOP services must meet certain requirements
  - They must offer clinically intensive programming within a state licensed health care facility
  - That facility must use evidence-based treatment modalities for at least a certain number of hours a day
  - At least three hours per day is required for IOP
  - At least five hours per day is required for PHP
- In-home therapy services, such as family stabilization team services
- Level 3 community-based detoxification services
- Medication Assisted Treatment (MAT) for substance abuse and related services (Member Cost Sharing may apply for these services)
- Clinical Stabilization Services (CSS) and Acute Treatment Services (ATS) for treatment of substance abuse
  - CSS is a 24 hour treatment program that usually follows an inpatient detoxification
  - ATS is a 24 hour a day medically monitored inpatient detoxification treatment setting that provides withdrawal management
  - Prior Approval is not required when you use an In-Plan facility licensed by the Massachusetts Department of Public Health
  - Your provider must contact HNE 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 days is a combined total for CSS and ATS

Inpatient Behavioral Health Services

We cover Medically Necessary 24-hour clinical intervention care and mental health acute care done in the places listed below. Providers must be licensed in the state in which you receive care based on medical policy.

- A facility under the direction and supervision of the Department of Mental Health

- A general hospital licensed to provide such services
- A private mental health hospital licensed by the Department of Mental Health
- A substance use facility licensed by the Massachusetts Department of Public Health
- A residential treatment center licensed by the Department of Mental Health (Prior Approval is required)

Most inpatient stays do not need Prior Approval from HNE. The location must call the HNE Health Services team within one business day to approve a continued stay. Notice to the plan is needed within 48 hours of admission. Clinical review is done at the same time to decide Medical Necessity. Inpatient care is performed on a nondiscriminatory basis. There are no visit limits on Medically Necessary outpatient visits or inpatient stays for conditions described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). This manual is published by the American Psychiatric Association. For information please call HNE's Health Services team at (413) 787-4000, ext. 5028, or (800) 842-4464, ext. 5028 (TTY: 711).

Inpatient and Intermediate Services for Child-Adolescent Behavioral Health Disorders

HNE covers care to treat mental, emotional or behavioral disorders described in the most recent edition of DSM in children and adolescents under the age of 19.

- This coverage is not limited to those disorders that substantially interfere with or limit the way the child functions or how they interact with others

These services cover two kinds of disorders: those that are biologically based, and those that are not. Services need Prior Approval, unless noted below.

A health care professional supervised by a licensed Behavioral Health Professional may perform care.

The options below are available to children and adolescents until age 19, and to their parents and/or caregiver, when Medically Necessary.

- Community-based acute treatment for children and adolescents (CBAT)
  - Mental health services provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to ensure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to: daily medication monitoring; psychiatric assessment; nursing availability; specialing (as needed); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed (Prior Approval not required)
  - This service may be used as an alternative to or transition from inpatient services
- Intensive Community Based Acute Treatment program (ICBAT)
  - Provides the same services as CBAT for children and adolescents but of a higher intensity, including more frequent psychiatric and psychopharmacological evaluation and treatment and more intensive staffing and service delivery (Prior Approval not required)
  - ICBAT programs have the capability to admit children and adolescents with more acute symptoms than those admitted to CBAT
  - ICBAT programs are able to treat children and adolescents with clinical presentations similar to those referred to inpatient mental health services but who are able to be cared for safely in an unlocked setting
  - Children and adolescents may be admitted to an ICBAT directly from the community as an alternative to inpatient hospitalization
  - ICBAT is not used as a step-down placement following discharge from a locked, 24-hour setting
- Family Stabilization Team (FST)
  - FST is an intensive family therapy model focused on youth who are most at risk for out-of-home placement due to behaviors in the home
  - Youth and family engage in intensive family therapy, as well as some individual skill building to improve functioning

- This service is implemented by a two-person team; a master's level clinician creates the treatment plan and provides the clinical interventions while a paraprofessional conducts skill building activities with individuals, dyads, or groups within the family system (this service may also be known as In-Home Therapy or IHT)

- Mobile Crisis Intervention (MCI)
  - MCI is used for acute exacerbation of mental health symptoms that may require stabilization in an out of home or diversionary level of care
  - MCI does an evaluation of need with the goal of maintaining community
  - MCI is able to provide support in the home, school, or a location in the community location, and to make the best recommendations for the appropriate services based on the unique needs of the youth in crisis
  - Specific referrals and warm hand-offs to community services such as medication clinics, IHT, or open access outpatient treatment can be made to divert an out of home placement
  - These services are available from In-Plan Emergency Service Providers
- Intensive Care Coordination (ICC)
  - ICC is a non-clinical service created to provide community-based care management to families who receive multiple services across multiple domains
  - ICCs are in place to help the family and their providers prioritize treatment goals and create a care plan for the family that takes into account the needs of all involved in the youth's care, such as education systems, Department of Children and Families, Department of Youth Services, probation, and community mental health providers
- In-Home Behavioral Services (IHBS)*
  - IHBS is a specific behavioral planning approach including a functional behavioral assessment, a behavioral intervention plan and parent training to alleviate specific behaviors causing functional intervention plan
  - This service is reserved for youth who do not respond to traditional talk therapy models
  - This is a two-person teamed approach with a master's-level clinician creating the behavior plan and a para professional helping to implement that plan
  - This is similar to applied behavior analysis (ABA); however, IHBS focused on parent training around plan updating and sustainability, a departure from the traditional ABA activities of table time or hand-over-hand based activities
- Family Partner*
  - Family Partner is a service provided to the parent/caregiver of a youth, in any setting where the youth resides, such as the home (including foster homes and therapeutic foster homes), and other community settings
  - Family Partner is a service that provides a structured, one-to-one, strength-based relationship between a Family Partner peer and a parent/caregiver
  - The purpose of the service is for resolving or ameliorating the youth's emotional and behavioral needs by improving the capacity of the parent/caregiver to parent the youth so as to improve the youth's functioning as identified in the outpatient or In-Home Therapy treatment plan or Individual Care Plan (ICP), for youth enrolled in Intensive Care Coordination (ICC), and to support youth in the community or to assist the youth in returning to the community
  - Services may include:
    - Education, assistance in navigating the child serving systems (such as DCF, education, mental health, juvenile justice)
    - Fostering empowerment, including linkages to peer/parent support and self-help groups
    - Assistance in identifying formal and community resources (e.g., after-school programs, food assistance, summer camps, etc.) support, coaching, and training for the parent/caregiver
- Therapeutic Mentor*
  - Therapeutic Mentoring Services are provided to youth in any setting where the youth resides, such as the home (including foster homes and therapeutic foster homes), and in other community settings

such as school, child care centers, respite settings and other culturally and linguistically appropriate community settings
    - Therapeutic mentoring offers structured, one-to-one, strength-based support services between a therapeutic mentor and a youth for the purpose of addressing daily living, social, and communication needs
    - Therapeutic Mentoring services include supporting, coaching, and training the youth in age-appropriate behavioral, interpersonal communication, problem-solving and conflict resolution, and relating appropriately to other children and adolescents, as well as adults, in recreational and social activities pursuant to a behavioral health treatment plan developed by an outpatient, or In-Home Therapy provider in concert with the family, and youth whenever possible, or Individual Care Plan (ICP) for youth with ICC
- All other emergency service programs

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; or
- The time the person's coverage ends under this EOC; or
- The time a person's coverage ends under an HNE plan replacing this EOC

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

Please note: services marked with an asterisk (*) may be accessed through Massachusetts Behavioral Health Partnership (MBHP). MBHP member services may be reached at (800) 495-0086, TTY: (617) 790-4130. It is available 24 hours a day, seven days a week. MBHP's clinical team may be reached at (800) 495-0086, TTY: (617) 790-4130. It is available 24 hours a day, seven days a week.

Additional Behavioral Health (Mental Health and/or Substance Use) Services

We cover Medically Necessary Outpatient, Intermediate, and Inpatient behavioral health care to diagnose and treat mental disorders. This includes the following.

- Biologically based mental disorders, such as schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia, panic disorder, obsessive-compulsive disorder, delirium and dementia, affective disorders, eating disorders, post-traumatic stress disorder, substance use disorders, autism, and other psychotic disorders or 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
- Rape-related mental or emotional disorders for victims of rape or victims of an assault with intent to commit rape are covered
- All other non-biologically based mental disorders

There are no visit limits on Medically Necessary Outpatient visits or Inpatient stays for these conditions.

Psychopharmacological services and neuropsychological assessment services

HNE covers these the same way as all other medical services.

Substance Use Disorder Services

HNE covers the Medically Necessary options below to diagnosis and treat substance use disorder per medical policy.

- Inpatient substance use disorder treatment
- Outpatient treatment provided by a physician or psychotherapist who spends a large part of their time treating substance abuse
- Inpatient Detoxification

Prior Approval from HNE is not needed for substance use disorder care from an In-Plan provider if the provider is certified or licensed by the Massachusetts Department of Public Health.

Screening of urine for opioids is a good way to monitor patients on prescribed drugs or to detect abuse of drugs. You may have 20 screenings per Calendar Year, done in a physician's office or an independent lab

without Prior Approval. More screenings need Prior Approval. You must also meet medical necessity standards outlined in Health New England's Drug Testing Medical Coverage Policy.

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-mental health care
- Christian Science practitioner and sanitarium stays
- Residential/custodial services (including group homes and halfway houses)
- Services required by a third party or court order
- Unlicensed and unaccredited residential treatment centers

You must have Prior Approval From HNE for:

- Partial hospitalization (PHP) and Intensive Outpatient Program (IOP)
- Neuropsychological testing
- Repetitive Transcranial Magnetic Stimulation (rTMS)
- Family Stabilization Team (FST)
- Residential Treatment Center**

- **Prior Approval is not needed for certain Medically Necessary substance use disorder treatments

Telehealth Services

HNE covers some care done through telehealth. This is typically for evaluations, follow-up care, or treatment of specific conditions. To be covered, care must meet certain standards.

- Cares must equivalent to in-person care
- Care 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 care that is provided must be documented and retained in the HNE Member's permanent medical record

Member Cost Sharing may apply.

Telehealth Services through Teladoc®

HNE covers phone and online video visits for behavioral health and substance use disorder issues through Teladoc®. Teladoc providers include the following.

- Psychiatrists
- Psychologists
- Therapists
- Social Workers

This is for members age 13 and older for non-emergency issues. All visits must be scheduled. Once you have set up an account, you can set up a visit online or with Teladoc's mobile app. You will be able to see profiles for providers in your state and set up a time to see the provider you pick.
To set up your account with Teladoc visit member.teladoc.com/hne. For general questions or for help in setting up your account, you can call Teladoc at (800) Teladoc or (800) 835-2362.

Member Cost Sharing applies.

Emergency care

If you need emergency care, follow the steps listed in Section 2 under "How to Obtain Care in an Emergency."

Disclosure of Information

HNE will not require consent to the release of information regarding services for behavioral disorders differently than for other medical conditions. Only licensed mental health professionals will decide the medical necessity of care described in this section.

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 mental health and substance use disorders in the same way that they cover treatment for medical conditions. This means that Cost Share for mental health conditions must be the same as those for medical conditions. Also, mental health office visit Copays must not be more than primary care visits. The methods we use to review coverage for mental 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 mental 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 information below on the Insurance Complaint Form.

- Your name and address
- The nature of your complaint
- 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 needed 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 EOC for more information about filing an appeal.

Special Programs and Discounts

HNE Members have access to special programs and discounts, such as discounts off the cost of some therapies like acupuncture and massage therapy.

HNE has a Wellness Reimbursement Program. The reimbursement offered is $300 for an individual plan and $600 for a family plan, per Calendar Year. The $600 payment for a family plan can be split among family members on the plan. The maximum for each member on the plan is $300. This reimbursement program applies to the services below.

- Qualifying fitness club memberships
- Weight Watchers
- School and town sports
- Aerobic/wellness classes
- Personal trainer fees
- Athletic event registration fees
- Golf (lessons and rounds of golf)
- Ski tickets
- Fitness equipment and devices (i.e., treadmill, workout videos)

- Nutrition classes and apps
- Mindfulness classes and apps
- Community supported agriculture (CSA) or farm shares
- Wellness and fitness apps
- Bike shares

For more information about our Wellness Reimbursement Program call member services or visit healthnewengland.org/wellness/reimbursement-programs.

Programs and discounts may change from time to time. Call HNE Member Services for a current listing of HNE's special programs and discounts.

SECTION 4 – EXCLUSIONS AND LIMITATIONS

WHAT'S IN THIS SECTION?

In this section, we describe services that are not covered. We call these "exclusions." We also describe services that have a benefit limit. Some benefit limits place a cap on the number of services that are covered. Other benefit limits only allow coverage of a service for certain conditions.

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

HNE does not limit or exclude coverage for pre-existing conditions. HNE will cover these pre-existing conditions to the same extent as for any other condition. Services must be Medically Necessary.

This section lists specific medical services. To describe the services, we use medical language. If you do not know what a certain exclusion means, call Member Services or talk to your doctor.

HNE covers Medically Necessary treatment that is needed due to complications resulting from a non-covered service. HNE covers such treatment consistent with the terms of this EOC.

Exclusions

HNE does not cover services and items listed below. This means they are "excluded" from coverage. HNE also does not cover services or items that are listed as "not covered" in this EOC.

HNE does not cover:

1. All services or supplies provided by an Out-of-Plan Provider, unless:
   - An In-Plan Doctor approves them ***and***
   - HNE approves them in advance ***or***
   - The services are provided to treat an Emergency Medical Condition (See "How to Obtain Care in an Emergency" in Section 2 of this EOC.)
2. All services provided outside the HNE Service Area when the Member could have foreseen the need for such services before leaving the HNE Service Area. This exclusion applies unless HNE has approved services in advance.
3. Absorbable nasal implant for the treatment of nasal valve collapse (i.e. Latera)
4. Any costs associated with any form of surrogacy, including gestational carriers
5. Any of the following types of programs/services that are not Medically Necessary and do not meet HNE's clinical criteria:
   - Recreational programs
   - Camps
   - Wilderness programs
   - Educational programs
   - Spas/resorts
   - Relaxation or lifestyle programs
   - Outdoor skills programs
   - Services provided in conjunction with or as part of the above program/services
6. Any service that Workers' compensation or other third party insurer is legally responsible to pay

7. Any services provided by the Veterans Administration for disabilities connected to military service. There also must be facilities which are reasonably available for these Members.
8. Services provided under MGL Chapter 71B in Massachusetts (referred to as "Chapter 766") or services provided under C.G.S.A. § 10-76a through 10-76g, inclusive in Connecticut, if such services are not Medically Necessary (as defined in Section 15 of this EOC) and do not meet Health New England's clinical criteria.. Such services can include the following:
   - Adaptive physical education
   - Physical and occupational therapy
   - Educational services or testing, except services covered under the benefit for Early Intervention services
   - Services for problems of school performance
   - Psychological counseling
   - Speech and language therapy
   - Transportation

   Members must try to obtain benefits available under state law. A member or parent should seek a Chapter 766 or Connecticut law evaluation if you believe your child may be disabled. This includes:
   - Physical disability
   - Intellectual disability
   - Learning problems
   - Behavioral problems
9. Alternative medicine. This includes 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:
   - Special diets
   - Homeopathic remedies
   - Electromagnetic fields
   - Therapeutic touch
   - Homeopathy
   - Naturopathy
   - Hypnosis
   - Herbal medicine
   - Holistic medicine
   - Non-standard labs
   - Chiropractic services (except certain specific Covered Services, if any, listed elsewhere in this EOC or riders to this EOC)
   - Spiritual devotions or culturally based healing traditions such as Chinese, Ayurvedic, and Christian Science
10. Care or treatments by family members
11. Cryoablation for the treatment of chronic rhinitis (i.e. Clarifix)
12. Dry needling (trigger point acupuncture)
13. Educational services or testing, except services covered under the benefit for Early Intervention services. These are examples of excluded services:
    - School or sports related physical exams
    - Services for problem of school performance
    - Job retraining
    - Vocational and driving evaluations
    - Therapy to restore function for a specific occupation
    - Transportation
14. Extracorporeal Shock Wave Therapy (ESWT) for chronic plantar fasciitis
15. EyeBox® Concussion Assessment
16. Eyeglasses, conventional contact lenses used for vision correction, laser vision correction surgery, orthoptics, vision therapy, corrective intraocular lenses for treatment of astigmatism (for example toric lenses) – See "Limitations and Partial Exclusions" later in this section for some exceptions. **Please note:** This plan covers certain vision services for Members under the age of 19. See Appendix D.

17. Foot orthotics (such as arch supports and shoe inserts) and corrective shoes (excluded except for diabetics)
18. Hearing aids or exams to prescribe, fit, or change them for Members over the age of 21
19. Hippotherapy (the use of horseback riding as a therapeutic or rehabilitative treatment)
20. Insertion of endobronchial valves
21. Intradiscal Electrothermal Therapy (IDET)
22. Litholink services
23. Marijuana for medical use
24. Medical care that an HNE Medical Director determines is not generally accepted in the medical community or is Experimental or investigational. (We define "Experimental" in Section 15.)
25. Medical expenses in any government hospital or facility. Services of a government doctor or other government health professional.
26. Postoperative Disposable Ambulatory Regional Anesthesia (PDARA) and Cold Therapy Devices
27. Pulmonary Rehabilitation Phase III exercise maintenance program
28. Charges to ship or copy Member medical records
29. Charges for failing to keep an appointment
30. Routine foot care for Members who do not have diabetes. This includes but is not limited to:
    - Cutting or removal of corns and calluses, plantar keratosis
    - Trimming, cutting, and clipping of nails
    - Treatment of weak, strained, flat, unstable or unbalanced feet
    - Other hygienic and preventive maintenance care considered self-care (i.e. cleaning and soaking the feet, and the use of skin creams to maintain skin tone)
    - Any service performed in the absence of localized illness, injury or symptoms involving the foot

    HNE covers Routine foot care if you are a diabetic.
31. Sales tax on health care services, DME or other items
32. Services by non-standard labs (for example Health Diagnostic Laboratory, Inc.)
33. Services, supplies, or medications primarily for personal comfort or convenience. This includes, for example, services or other items obtained from a provider based solely on location or hours of service.
34. Services you receive after the date your coverage ends
35. Serum immunoglobulin G allergy testing for food intolerance or food sensitivity
36. Special duty or private duty nursing and attendant services
37. Specialty clothing for specific medical conditions (for example compression vests for the treatment of behavioral issues associated with behavioral disorders)
38. Stretta® treatment for gastroesophageal reflux disease (GERD)
39. Suit therapy or the home use of a suit therapy device to treat any condition including, but not limit to, cerebral palsy or other neuromuscular conditions
40. Travel, transportation, and lodging expenses in connection with treatment or medical consultation
41. Ultraviolet lights and cabinets
42. Weight control programs

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 EOC.)

- 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 Calendar Year. Glasses must be purchased within six months of the cataract surgery.

- Reconstructive or restorative 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.

- Skin substitute (bioengineered, tissue-engineered, or artificial skin) – Health New England has a medical policy to clarify what is covered and for what indications. You can view our medical policies on healthnewengland.org. At the top of the page click "Members," scroll down and click "Learn More" under "Member Resources." Then click "Behavioral Health/Medical Policies." Or, you can call Member Services to have a copy mailed to you, free of charge.

Federal Women's Health and Cancer Rights 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
- Prosthesis
- Any physical complications resulting from the mastectomy, including lymphedemas

Cosmetic Services

HNE covers services which maintain or restore essential body functions.

HNE does not cover:

- Cosmetic surgery and procedures. These are services that:
    - Improve appearance only
    - Do not restore bodily function
    - Are not Medically Necessary
- Surgeries to change or improve appearance or self-image
- Drugs, services and appliances to change or improve appearance or self-image
- Cosmetic care for psychological or emotional reasons
- Follow up treatment for cosmetic services

Here are some examples of services that are cosmetic. HNE does not cover:

- Botox injections for cosmetic purposes
- Breast implants not performed during reconstruction after breast cancer
- Chemical exfoliation for acne

- Chemical peel
- Chin implant (not covered except for correction of problems secondary to disease, injury or severe birth defect)
- Collagen implant (e.g., Zyderm)
- Correction of abdominal separation
- Ear surgery
- Earlobe repair to close a stretched or torn ear pierce hole
- Face lifts
- Fat transfer or fat grafts
- Laser hair removal
- Liposuction
- Reduction of labia minora
- Removal of acne scars
- Removal of excess hair
- Removal of excessive skin
- Removal of spider angiomata
- Removal or repair of scars
- Salabrasion
- Scar revision
- Treatment for non-symptomatic varicose veins

This list above does not contain all of the services HNE does not cover. This is only a partial list. HNE does not cover any cosmetic procedure. HNE does not cover any procedure that is not Medically Necessary.

SECTION 5 – CLAIMS AND UTILIZATION MANAGEMENT PROCEDURES

WHAT'S IN THIS SECTION?

In this section, we explain how HNE makes decisions about Covered Services. This is part of "utilization management."

HNE must approve some services before you get them. This is called "Prior Approval." We list services that require Prior Approval in this section. We also explain how to get Prior Approval.

HNE reviews some services during the time you receive them. This is called "concurrent review." We conduct concurrent review for services like inpatient stays, home health care, and other ongoing courses of treatment.

HNE reviews services already received by a Member. This is called "retrospective review."

A decision not to cover a service is called an "Adverse Determination." We will tell you in writing when we make an Adverse Determination. We also will notify the doctor who requested the service. You or your doctor may appeal our decision.

About Claims for Coverage from Out-of-Plan Providers

For In-Plan Providers, you do not have to submit claims to HNE. In-Plan Providers do this for you. Sometimes you may need to submit claims to HNE. An example may be if you receive Covered Services from an Out-of-Plan Provider in an emergency or with Prior Approval from HNE. Present your HNE ID Card. Most Out-of-Plan Providers will bill HNE directly. If possible, ask the Out-of-Plan Provider to send a standard medical claim form to HNE.

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

- Pay the Out-of-Plan Provider, ***or***
- If we do not pay the claim, tell the Out-of-Plan Provider the reason for non-payment, ***or***
- Ask the provider in writing for any additional information we need to pay the claim.

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

If the Out-of-Plan Provider will not bill HNE, you must make a claim to HNE. Send HNE a bill or claim which lists each service, the amount charged, the date and the diagnosis. In some cases, you may have to pay the Out-of-Plan Provider's bill before HNE can pay it. 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 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. You must pay any Copays that apply. HNE will pay you for the cost of Covered Services, less any applicable Deductible and Copays or Coinsurance.

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. Health New England uses clinical criteria to decide if some services or procedures are Medically Necessary. You may call HNE's Health Services Department if you want a copy of the criteria HNE uses to make such decisions.

Please note: With this HMO plan, 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.

If you receive Emergency services in a foreign country, you must have your bill translated into English. The amount you are billed must also be converted to U.S. dollar values. These dollar values must be the dollar value on the date you received the services.

Utilization Management Program

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

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

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

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

Services and Procedures that Require Prior Approval

Some treatments and services require Prior Approval. These services and treatments are covered only if HNE approves them in advance. If any cosmetic procedure is performed at the same time as the approved services, HNE may deny the non-approved treatment. HNE covers Medically Necessary treatment due to complications from the non-covered services. The services or treatments that require Prior Approval can be found at https://healthnewengland.org/Providers/Resources.

Prior Approval Process

To get 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 service 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 should make sure that HNE receives a Prior Approval Request Form at least seven days before your procedure. HNE will make a decision within two working days after we get all needed information. Prior Approval is needed to move from a hospital to another inpatient care location. HNE will decide within one business day of getting all facts. 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 (TTY: 711) to know its status or outcome. You may call HNE's Health Services Department if you want a copy of the clinical criteria HNE uses to make its decision.

Section 3 of this EOC tells you if a particular durable medical equipment (DME) 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 EOC. Whether or not you obtain Prior Approval, items that are not covered under this EOC may be denied.

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

Concurrent Review Procedures

HNE may pre-approve certain procedures and services. This includes things like some inpatient hospital stays and ongoing courses of treatment. Once your stay or ongoing treatment begins, HNE may continue to review whether your care is Medically Necessary and appropriate. This is called "concurrent review." In these cases, if HNE decides to end or reduce coverage, you will be notified. We will give this written notice before the coverage ends or is reduced.

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

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

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

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

Retrospective Review Procedures

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

Written Notification of an Adverse Determination

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

HNE will:

- Identify the specific information on which the Adverse Determination was based
- Discuss your presenting symptoms or condition, diagnosis, and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant medical review criteria
- Specify alternative treatment options covered by HNE, if any
- Reference or include applicable clinical practice guidelines and review criteria
- Offer your doctor or treating practitioner a case discussion or reconsideration (see below)
- Provide you with clear, concise information about:
    - HNE's grievance process
    - How to get external review (This review is your right under state law (105 CMR 128.400))

Case Discussion and Reconsideration

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

If you are still dissatisfied, you may request a clinical appeal or an expedited appeal. Your doctor or treating practitioner may also request a clinical appeal or an expedited appeal for you. The case discussion and reconsideration process do *not* need to take place before you begin the HNE grievance process or an expedited appeal. More information is available in Section 6 of this EOC.

SECTION 6 – INQUIRIES AND GRIEVANCES

WHAT'S IN THIS SECTION?

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

At the end of this section, we describe the process for filing an external appeal. You file an external appeal with the Massachusetts Office of Patient Protection.

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

HNE is responsible for reviewing all benefit claims under the Plan. HNE will decide your claim according to its claims procedures. These are described in Section 5 of this EOC.

Appealing Denied Claims

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

Important Appeal Deadlines

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

Inquiry Process

You can ask HNE to reconsider:

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

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

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

Internal Grievance Process

A "grievance" can be any of the following:

- A complaint about any aspect or action of HNE that affects you
- An issue about quality of care

- A complaint about how HNE is run
- A benefit appeal
- An appeal of an Adverse Determination
- Clinical appeals

A grievance can be oral or written.

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

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

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

Overview: Grievances and Decision Time Frames

This chart is for quick reference only. See the rest of the EOC section for more detail.

Type of Grievance	Example	HNE will respond within
Complaint	**Example:** 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.	30 calendar days
Benefit Appeal	**Example:** Appeal of a service or request that is denied as "not a covered benefit" because it is excluded from coverage by your plan.	
Pre-Service	**Example:** Appeal of a benefit denial for a service you have not received yet.	30 calendar days
Post-Service	**Example:** Appeal of a benefit denial for a service you have already received.	30 calendar days
Clinical Appeal	**Example:** Appeal of a decision to deny, reduce, change or end coverage of a health service for failure to meet the requirement for coverage, if the decision was based upon a review of information provided and based on: • Medical necessity • Appropriateness of health care setting and level of care, or • Effectiveness	
Pre-Service	**Example:** Appeal of a clinical denial for a service you have not received yet.	30 calendar days
Post-Services	**Example:** Appeal of a clinical denial for a service you have already received.	30 calendar days

Overview: Grievances and Decision Time Frames This chart is for quick reference only. See the rest of the EOC section for more detail.		
Type of Grievance	**Example**	**HNE will respond within**
Expedited Appeal	Appeal of a clinical denial for a service that your doctor feels is urgent, or for continued coverage while you are still in the hospital.	
Urgent Care	**Example:** Any request for medical care or treatment that requires an expedited review because delaying care in order to follow the timeframe for non-urgent care: • Could seriously jeopardize your life or health or ability to regain maximum function; or • In the opinion of your provider, would subject you to severe pain that cannot be adequately managed without the requested care.	72 hours
Inpatient	**Example:** Appeal of a clinical denial for continued coverage of a hospital stay while you are still in the hospital.	Before you are discharged
Immediate (requires certification)	**Example:** Services or durable medical equipment that your doctor certifies is Medically Necessary and, if not immediately provided, could result in serious harm to you.	Upon certification, reversal within 48 hours (or sooner), pending resolution of the appeal
Expedited Appeal for a terminally ill Member	**Example:** Complaints, Benefit Appeals, and Clinical Appeals are decided according to this time limit for a terminally ill Member unless the request for review qualifies as an Expedited Appeal as listed above.	5 business days

Submitting Your Grievance

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

Grievances may be submitted:

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

Please include the following information:

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

You may contact us by:

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

Fax: **(**413) 233-2685
(For complaints and appeals only. If you are faxing about a billing issue, please fax to Member Services at (413) 233-2655)

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

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

You or your authorized representative may submit the grievance. If you submit a grievance by mail, HNE will send a written receipt to you within five business days. If you submit your grievance orally, for example, on the telephone, HNE will put your grievance in writing. HNE will then send a written copy of your oral grievance to you within 48 hours. If your grievance is about a clinical denial, 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 subordinate to anyone who was involved.

Requests for Medical Records

In most cases, HNE either already has the medical records relevant to your grievance or HNE can obtain the records without obtaining a signed medical record release from you. In some cases, however, such as when we need records from Out-of-Plan Providers, HNE may ask you to send us 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 calendar days after you return the release to issue a decision. You may choose not to sign the release, or HNE may not receive a signed release within the required time limit (refer to the Overview chart above). If so, 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 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. In no event will this time period be greater than 30 calendar days from the agreement to reconsider. The time period for requesting external review will begin to run on the date of the resolution of the reconsidered grievance.

Complaints and Benefit Appeals

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

Appeals of Clinical Denials

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

If you do not agree with HNE's decision, in many cases, you have a right to an external review. See "External Appeals Process" later in this section.

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

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

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

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

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 service or DME should not await the outcome of the normal grievance process.

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

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 on 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 you are a Member with a terminal illness and you appeal a decision of an immediate or urgently needed service, HNE will make a decision on your grievance and notify you and your provider within the time frames listed above for expedited appeals.

If HNE continues to deny coverage or treatment, you have the right to request a conference. HNE will schedule a conference within 10 days of receipt of your request. If your doctor, after consulting with an HNE Medical Director, decides that the effectiveness of the proposed service or treatment would be materially reduced if it is not provided at the earliest possible date, HNE will schedule the 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 or 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 HNE has denied your clinical appeal and you do not agree with HNE's decision, you can ask for an external appeal. To do so, you need to file a written request with the Massachusetts Health Policy Commission, Office of Patient Protection (OPP). HNE will provide you with the necessary filing forms when it notifies you of its final decision. You can also obtain the necessary forms by calling OPP or checking its website. The fee for filing an appeal is $25. This fee may be waived by OPP if it determines that the payment of the fee would result in an extreme financial hardship to the Member. Information on contacting OPP is at the end of this section. You must submit the request within four months after you receive HNE's final decision on your appeal. A request for external review can be submitted by you or your authorized representative, and the request must include:

1. The signature of you or your authorized representative consenting to the release of medical information.
2. A copy of the written final Adverse Determination from HNE.

The OPP will screen appeal requests. The OPP decides:

- Whether the request complies with OPP's requirements for external review requests (such as the $25 filing fee)
- Whether the request involves a service or benefit that has been explicitly excluded from coverage
- Whether the request is the result of a final Adverse Determination

Requests that pass the screening are sent to an independent review panel chosen by OPP. If the service or treatment you are requesting is a covered benefit, the appeal panel will decide if it is Medically Necessary. The panel will notify you and HNE of its decision within 45 days of receipt of the request for review, unless it determines that it needs additional time.. The decision of the review panel is final and binding.

Expedited External Review Process

You, or your authorized representative, can ask the panel to decide more quickly by requesting an expedited review. The request for an expedited external review must contain a certification, in writing, from your physician, that a delay in providing the health care services would pose a serious and immediate threat to your health. The OPP will screen the request within 48 hours of receipt. The OPP screening determines whether the request complies with the OPP's requirements for expedited external review requests. If the panel agrees to handle the request as an expedited external review, it will decide the request within 72 hours. The decision of the review panel is final and binding.

If the subject of the external review involves the termination of ongoing services, you may ask the external review panel to continue coverage for the terminated service while the review is pending. Any such request must be made before the end of the second business day following receipt of the final Adverse Determination. The review panel may allow your request if it determines that substantial harm to your health may result without such continuation or for such other good cause as the review panel will determine. Any continuation of coverage will be at HNE's expense regardless of the final external review decision.

Massachusetts Office of Patient Protection

Massachusetts has set up an Office of Patient Protection (OPP) within the Health Policy Commission. This office will accept consumer complaints and will manage the external review process described above. You can get the following information from the OPP:

- A list of sources of independently published information assessing Member satisfaction and evaluating the quality of health care services offered by HNE
- The percentage of doctors who voluntarily and involuntarily ended their participation with HNE during the previous Calendar Year for which such data has been compiled. The OPP can also tell you the three most common reasons for voluntary and involuntary disenrollment.
- The percentage of premium revenue HNE spends for health care services for the most recent year for which data is available
- A report detailing, for the previous Calendar Year:
  (i) The total number of filed grievances
  (ii) Grievances that were approved internally
  (iii) Grievances that were denied internally
  (iv) Grievances that were withdrawn before resolution
  (v) External appeals pursued after exhausting the internal grievance process and the resolution of all such appeals

How to contact the Office of Patient Protection:

Toll-free telephone: (800)\ .436-7757

Fax: (617) 624-5046

Website: https://masshpc.gov/opp /

Email: HPC-OPP@mass.gov

Address:

Health Policy Commission
Office of Patient Protection
50 Milk Street, 8th Floor
Boston, MA 02109

SECTION 7 – ELIGIBILITY

WHAT'S IN THIS SECTION?

In this section, we describe the requirements that you must meet to be a Member of HNE. This is called "eligibility." There are eligibility requirements for Subscribers. There are also eligibility requirements for Dependents. Dependents are anyone else covered under your plan.

Dependent coverage normally ends at the end of the month in which the dependent turns age 26.

HNE may require proof of eligibility from time to time. If you are eligible for coverage, HNE will not exclude you from coverage on the basis of age, occupation, actual or expected health condition, claims experience, duration of coverage, or medical condition.

Federal and state law forbid the use of genetic information as a reason to deny health insurance or to decide how much you pay for your health insurance. HNE does not use genetic tests or family history to determine:

- Your eligibility for health insurance
- Your health insurance premiums or terms of coverage

If you are insured through a Group Contract

If the eligibility rules in your Employer's Group Agreement differ from those in this EOC, the terms of your Employer's Group Agreement govern.

Residency Requirement

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

Subscribers

If you are insured through a Group Contract

To be eligible as a Subscriber, you must meet the Group's own eligibility rules and be in one of the following categories:

- A bona fide employee of the Group:
- Who works on a full-time basis
- With a normal work week of 30 or more hours (In response to the COVID-19 pandemic, your Group may have allowed you to remain eligible for coverage even if your normal work week was reduced to under thirty (30) hours.)
- An owner or partner of the Group, as approved by HNE
- A Qualified Beneficiary as defined by applicable laws and regulations on continuation of health coverage

If you are insured with an Individual (Non-Group) Contract

To be eligible as a Subscriber:

- You must be a resident of the Commonwealth of Massachusetts
- You must live within the HNE Service Area.
- You must not be enrolled for coverage under Part A or Part B of Title XVIII of the federal Social Security Act, or a state plan under Title XIX or such act or any successor program.

Dependents

If you are insured through a Group Contract

To enroll as a Dependent, you must meet the Group's own eligibility rules and be in one of the following categories:

- The legal (married) Spouse of the Subscriber
- The divorced Spouse of the Subscriber, as described later in this section
- A child of the Subscriber or the Subscriber's Spouse who is under 26 years old
- An adopted child of the Subscriber or the Subscriber's Spouse who is under 26 years old, and as described later in this section
- A child for whom the Subscriber has been named legal guardian as follows:
- The child must be under 26 years old.
- The Subscriber must enroll the child as a Dependent within 30 days after being named legal guardian by the court.
- Children under legal guardianship will normally be covered from the date the Subscriber was named legal guardian by the court.
- A child of an eligible Dependent who is under 26 years old, until the parent is no longer a Dependent
- A child of the Subscriber who is under 26 years and for whom the Subscriber is required by a Qualified Medical Child Support Order (QMCSO) to provide health coverage (See more about QMSCO below.)
- A disabled Dependent, as described later in this section

If you are insured with an Individual (Non-Group) Contract

To enroll as a Dependent, you must be in one of the following categories:

- The legal (married) Spouse of the Subscriber
- A child of the Subscriber or the Subscriber's Spouse who is under 26 years old
- An adopted child of the Subscriber or the Subscriber's Spouse who is under 26 years old, and as described later in this section
- A child for whom the Subscriber has been named legal guardian as follows:
- The child must be under 26 years old.
- The Subscriber must enroll the child as a Dependent within 60 days after being named legal guardian by the court.
- Children under legal guardianship will normally be covered from the date the Subscriber was named legal guardian by the court.
- A child of an eligible Dependent who is under 26 years old, until the parent is no longer a Dependent
- A disabled Dependent, as described later in this section

A dependent child of the subscriber or of the subscriber's spouse can be covered until the end of the month in which the child turns age 26.

Adopted Dependents

When can I enroll a child whom I have adopted or am trying to adopt?

If you are insured through a Group Contract

HNE will cover a child who has been living in the Subscriber's home and for whom the Subscriber has received foster care payments from the date the Subscriber files a petition to adopt. The Subscriber must enroll the child within 30 days of the date of filing the petition. In all other cases, HNE will cover the child from the date that the child has been placed for adoption in the Subscriber's home by a licensed placement agency. The Subscriber must enroll the child as a Dependent within 30 days of the date of placement.

If you are insured with an Individual (Non-Group) Contract

HNE will cover a child who has been living in the Subscriber's home and for whom the Subscriber has received foster care payments from the date the Subscriber files a petition to adopt. The Subscriber must enroll the child within 60 days of the date of filing the petition. In all other cases, HNE will cover the child from the date that the child has been placed for adoption in the Subscriber's home by a licensed placement agency. The Subscriber must enroll the child as a Dependent within 60 days of the date of placement.

Qualified Medical Child Support Orders (QMCSO) – *Applies only to Group Contracts*

What is a QMCSO?

A QMCSO 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 recipient's 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 Plan sponsor and the order qualifies, the Plan will comply with all state medical child support laws on eligibility and enrollment, even if the Plan has more restrictive rules.

Student Dependents

What happens if my son or daughter goes to a school that is out of the HNE Service Area? Will HNE still cover him or her?

If your child goes to a school outside the HNE Service Area, HNE covers him or her for care that is received outside the HNE Service Area in an Emergency. HNE will also cover certain other services with Prior Approval. See "Out-of-Area Student Coverage" in Section 2.

What happens if my child is in school and a serious illness or injury causes them to leave school or stop going full time? – *Michelle's Law applies only to Group Contracts*

Michelle's Law

"Michelle's Law" applies to dependent college students. It protects them from losing coverage if a serious illness or injury causes them to leave school or stop going full time.

It requires all group health plans to continue coverage if:

1. The child qualifies as a Dependent under the plan, and
2. The Child is enrolled in the plan as a full-time student (college or like place of higher learning). Enrollment must take place before the first day that the medically necessary leave is needed.

In addition, the child's leave of absence must:

- Start while the child is suffering from serious illness or injury
- Be medically necessary, as certified by the child's treating physician
- Cause the child to lose student status under the terms of the plan

Coverage will continue until the earlier of:

- One year after the leave of absence due to medical necessity
- The date coverage would otherwise end under the terms of the plan

Disabled Child Dependents

What happens if my child is disabled when he or she turns 26?

HNE will continue coverage for a Dependent if:

- The Dependent is totally disabled by a physical or mental condition
- The disability prevents the Dependent from earning his or her own support, and
- The disability is long-term or will go on indefinitely

HNE will continue the Dependent's coverage until the disability ends. At reasonable intervals, HNE may require proof of disability and dependency. We may require that a doctor of HNE's choice examine the Member. The disabled child must have been covered by HNE prior to reaching age 26 or must have had continuous group health coverage from the onset of the disability prior to joining HNE.

Divorced Spouses – *Applies only to Group Contracts*

What happens if I divorce? Is my former Spouse still eligible for coverage?

If you are divorced and have not remarried, your former Spouse is eligible to continue as a Dependent on your policy as follows:

- Unless your divorce judgment specifically states otherwise
- Unless he or lives outside of the HNE Service Area
- Until the time specified in your divorce judgment
- Until you or your former Spouse remarry

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

What happens if I remarry? Is my former Spouse still eligible for coverage?

If you remarry and your divorce judgment requires that you continue health care coverage for your ex-spouse, he or she may continue coverage under your employer's group plan. However, he or she must purchase an individual policy and will have to pay a separate premium for that policy.

SECTION 8 – HOW TO ENROLL AND HOW COVERAGE BEGINS

WHAT'S IN THIS SECTION?

This section explains how to sign up for HNE. This is called "enrollment." Once you enroll, HNE determines when your coverage begins. This is called your "Effective Date."

You may enroll during the Open Enrollment Period and in specific circumstances outside the Open Enrollment Period. There are certain events after which you can enroll a new Dependent under your plan. These events are explained below. You must send us your request to enroll the Dependent within 30 days of the event.

HNE will not provide any coverage before the set Effective Date.

There are special rules for late enrollments.

Subscriber Enrollment

When can a Subscriber enroll?

If you are enrolling through a Group Contract

A Subscriber can enroll in the Plan at any of the following times:

- During your Group's annual Open Enrollment Period
- Within 30 days of your date of hire (or 30 days after meeting your employer's waiting period)
- Within 30 days of becoming eligible under your employer's policy (For example, you switched from part-time to full time and therefore became eligible for coverage under the Plan.)
- Within 30 days after moving your residence into the HNE Service Area

If you are enrolling in an Individual (Non-Group) Contract, contact the Massachusetts Health Connector at (877) 623-6765 (TTY:711**)**, or visit mahealthconnector.org.

Are there any times when I can enroll outside the above time periods?

If you are enrolling through a Group Contract

Yes. The Health Insurance Portability and Accountability Act (HIPAA) provides some exceptions to these rules. If you did not enroll in the Plan when first eligible, you may enroll yourself and your eligible Dependents at a later date under these conditions:

- You did not enroll in HNE because you, your Spouse, or an eligible Dependent 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, your Spouse, or an eligible Dependent had other insurance coverage when you otherwise became eligible to enroll in HNE. Subsequently you lost your eligibility for coverage, or employer contributions toward such coverage were terminated, as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment.
- If you marry
- If you acquire a new Dependent through birth, adoption, or placement for adoption

If you meet any of the above conditions, you must make a written request for enrollment within 30 days of the date of the event. Your coverage with HNE will be effective as of the date of the event.

If you are enrolling with an Individual (Non-Group) Contract

Yes. Some people may meet special conditions to enroll in a plan outside of the Open Enrollment Period. You must meet one of the following special conditions.

- You had health insurance coverage that ended within the last 60 days.
- You, your Spouse, or an eligible Dependent had COBRA continuation coverage under another plan, and that coverage has since been "exhausted."
- You, your Spouse, or an eligible Dependent had other insurance coverage. Subsequently you lost your eligibility for coverage, or employer contributions toward such coverage were terminated, as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment.
- You marry.
- You acquire a new Dependent through birth, adoption or placement for adoption.

For information on special conditions for enrolling outside an Open Enrollment Period, contact:

- The Health Connector at (877) 623-6765 (TTY:711), or visit mahealthconnector.org

Special Enrollment Rights – *Applies only to Group Contracts*

Special Enrollment Rights

Sometimes, you may enroll outside of the open enrollment period. This is explained below. The Group's Special Enrollment Notice also contains important information about the special enrollment rights that you may have. (A copy of this may have been previously given to you.) Contact the Group if you need another copy.

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, or
- 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 within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

Dependent Enrollment

What happens if I am already enrolled but then acquire a new Dependent or marry?

If you acquire a new Dependent or marry, you may add your new Dependent to the Plan. The Effective Date of coverage for new Dependents will be the date of any one of the following events:

- Marriage
- Birth
- Adoption or placement for adoption
- Legal guardianship
- The Subscriber becoming legally responsible for the Dependent's health coverage.

If you are enrolled through a Group Contract

Your employer must submit an Enrollment/Add/Termination Form to HNE. HNE may also require documents that prove the new Dependent is eligible. You must submit this information to HNE within 30 days of the Effective Date. If you do not notify HNE within 30 days of the Effective Date, you may add new Dependents only at your Group's next Open Enrollment period.

If you are enrolled with an Individual (Non-Group) Contract

If you enrolled through the Health Connector, you must contact the Health Connector to enroll a Dependent. HNE may require documents that prove the new Dependent is eligible. This information must be submitted to HNE within 60 days of the Effective Date. If you do not notify HNE within 60 days of the Effective Date, you may add new Dependents only at the next Open Enrollment period. For more information call the Health Connector at (877) 623-6765 (TTY:711).

If I am already enrolled and my Dependent moves into HNE's Service Area, does my Dependent become eligible for coverage?

A dependent who moves into the HNE Service Area and meets the other Dependent eligibility requirements is eligible to enroll.

If you are enrolled through a Group Contract

To enroll the Dependent, the Subscriber must submit an enrollment form to the employer Group. HNE must receive the completed enrollment form within 30 days of the date the Dependent moved into the HNE Service Area. Once enrolled, the coverage begins as of the date the dependent moved into the HNE Service Area.

If you are enrolled with an Individual (Non-Group) Contract

If you enrolled through the Health Connector, you must contact the Health Connector to enroll a Dependent. HNE must receive the necessary information to enroll the Dependent within 60 days of the date the Dependent moved into the Service Area. Once enrolled, the coverage begins as of the date the Dependent moved into the HNE Service Area. For more information call the Health Connector at (877) 623-6765 (TTY:711).

How do I enroll?

To enroll in HNE you must meet eligibility requirements of Section 7 of this EOC.

If you are enrolling through a Group Contract

Your Group must also submit the following to HNE within 30 days of the requested Effective Date of coverage:

- A completed and signed Enrollment/Add/Termination Form
- Any other forms or information the HNE may request

If you are enrolling with an Individual (Non-Group) Contract

Contact the Massachusetts Health Connector at (877) 623-6765 (TTY:711), or visit mahealthconnector.org.

For newborn and adopted dependents: If we receive a claim for an un-enrolled dependent and the claim identifies you as the parent or legal guardian, we will contact you. If you intend to enroll the newborn on your HNE plan, we will assist you with the enrollment process.

Transition of Care Begun Before You Joined HNE

What happens if I am new to HNE and 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 information in Section 14 of this EOC.

SECTION 9 – TERMINATION

WHAT'S IN THIS SECTION?

In this section, we describe how and when your coverage may end. You may end your coverage at any time. HNE may end your coverage for certain specified reasons.

If you are insured through a Group Contract
Your employer may end your coverage. If you lose coverage, you may have the right to continue coverage. For more information, see Section 10 of this EOC.

How This Agreement May End

Termination of Participation

If you are insured through a Group Contract

Your eligibility for Plan benefits ends as of the date specified by your employer. Coverage will also end:

- If your hours drop below the number of hours required for eligibility
- If you submit false claims
- For certain other reasons described below.

Coverage for your Spouse and dependents stops when your coverage stops and for other reasons specified in the EOC (e.g., divorce, dependent's attaining age limit, and other reasons). Benefits also will end for employees, Spouses, and dependents upon termination of the Plan.

HNE may cancel your coverage or refuse to renew your coverage only as follows:

- If you or your employer fails to make required payments. These include, but are not limited to, premiums, Copays, Deductibles and Coinsurance. If the Group fails to pay the agreed premium when it is due, HNE will consider the Group in default and may end the coverage of Members enrolled through the Group. If this happens, all of the Group's Members will lose coverage as of the date specified by HNE. HNE will notify Members of this within 60 days of the date the group coverage ends. If HNE ends coverage retroactively, HNE will notify affected subscribers of their right to elect to continue coverage for up to 60 days. The continued coverage will be with the same benefits and premium that the employer Group paid. If the Subscriber does not choose to continue coverage, the Member will have to pay for any services provided after the coverage ends.

- 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.

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

- If you relocate outside the HNE Service Area. If you move out of the HNE Service Area, or are away from the HNE Services Area for more than 90 consecutive days, HNE may end your membership.

- If you have coverage through a Group, coverage can end if your Group's coverage is not renewed or is cancelled by the Group through which you are covered.

- If HNE cancels your Plan Option or does not renew your contract as of a date approved by the Commissioner of Insurance. This termination may be put in effect with no prior notice to you.

- As allowed by state or federal law

If you are insured with an Individual (Non-Group) Contract

HNE may cancel your coverage or refuse to renew your coverage only as follows:

- If you fail to make payments required under the contract. These include, but are not limited to, premiums, Copays, Deductibles and Coinsurance.
- 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.
- If you commit an act of physical or verbal abuse that poses a threat to providers, other HNE Members, or HNE's employees or agents. This rule does not apply to acts related to your physical or mental condition. The effective date of termination may, at HNE's option, be any day after the date of the abuse.
- If you relocate outside the HNE Service Area. If you move out of the HNE Service Area, or are away from the HNE Services Area for more than 90 consecutive days, HNE may end your membership.
- If HNE cancels your Plan Option or does not renew your contract as of a date approved by the Commissioner of Insurance. This termination may be put in effect with no prior notice to you.
    - As allowed by state or federal law

Coverage for your Spouse and dependents stops when your coverage stops and for other reasons specified in the EOC (e.g., divorce, dependent's attaining age limit, and other reasons).

What Rights Do I Have When HNE Ends My Coverage?

HNE will provide for continuation of benefits to the full extent required by law.

If you are insured through a Group Contract

See Section 10 of this EOC for more information. If you had group coverage, HNE will cooperate with the Group about offering continued coverage as required by law.

SECTION 10 – CONTINUATION OF COVERAGE OPTIONS

WHAT'S IN THIS SECTION?

SECTION 10 OF THE EOC APPLIES ONLY TO GROUP CONTRACTS

In this section, we describe different ways you can continue your coverage if it ends. We describe the Federal COBRA law. COBRA describes your rights to continue coverage if you lose group health insurance. We also describe the Massachusetts State Law called Mini-COBRA. Mini-COBRA also describes your rights to continue coverage if you lose group coverage.

We describe the rights of employees on military leave to continue group coverage.

We describe how to sign up for non-group coverage through the Massachusetts Health Connector.

Continuation Coverage Under Federal Law (COBRA) – *Applies only to Group Contracts*

COBRA is an abbreviation for a U.S. law named the "Consolidated Omnibus Reconciliation Act."

You may have the right, under COBRA law to continue coverage, if you lose your group health insurance. COBRA law limits the time period for the coverage. You are responsible for the premium payments during that time. Under COBRA law, you may have the right to continue coverage for up to 36 months. If your employer has 20 employees or more, your employer should give you details about your rights under this law. If you lose coverage for any of these reasons, most of the time you can continue coverage:

- The Subscriber leaves employment or is laid off, or if the employer reduces the Subscriber's hours (except if employment is ended for gross misconduct).
- A Spouse gets divorced from the Subscriber.
- The Subscriber turns 65 and is entitled to Medicare.
- A child Dependent loses eligibility for coverage under the plan. (Loss of eligibility when the child turns age 26.)
- The Subscriber dies.

Federal law determines the amount Members pay to be covered. It also determines the length of time that coverage is continued. Appendix B in this EOC has more detailed information about your rights under COBRA. See Appendix B.

Continuation Coverage Under Massachusetts State Law – *Applies only to Group Contracts*

In Massachusetts there is a law which provides Members the right to continue health coverage if they lose their eligibility for any of the following reasons:

1. Divorce. See Section 7 of this EOC for rules about covering Divorced Spouses. The divorced Spouse can also continue to be covered under the COBRA law and under the state Mini-COBRA law. (See paragraph 3 below.) A divorced Spouse can also convert to individual (non-group) coverage.

2. Plant closings. Coverage can continue if the Subscriber loses employment because of a plant closing or partial plant closing. You can continue your membership for 90 days after your employment ends or until you become eligible for other group health coverage, whichever comes first.

3. Massachusetts "Mini-COBRA." This Massachusetts law (G.L. c. 176J, §9) applies to employers with 2-19 covered employees. This law is a state version of the COBRA law. It applies to employees of covered employers and their families. Under this law, these employees can continue group coverage and will pay group rates for certain time periods. This applies to cases where coverage under the Plan would otherwise end. The law applies to certain "Qualifying Events":
    a. Death of the eligible employee
    b. Termination or reduction of hours of employment, other than for gross misconduct
    c. Employee becomes eligible for Medicare
    d. A divorce or legal separation
    e. A child's loss of Dependent status under the Plan
    f. You are found to be disabled under the Social Security Act

You must notify HNE within 60 days of the date of the Qualifying Event or the date on which coverage would end under the Plan because of the Event, whichever is later.

Employees on Military Leave – *Applies only to Group Contracts*

Employees going into the military service, or who are returning from military service, may choose to continue Plan coverage. These rights are based on the Uniformed Services Employment and Reemployment Rights Act (USERRA). These rules are as follows:

1. These rights apply only to Employees and their Dependents covered under the Plan before leaving for the military service.

2. The maximum period of coverage of a person under such an election shall be the lesser of:
    a. The 24 month period beginning on the date on which the person's absence begins; or
    b. The day after the date on which the person was required to apply for or return to a position or employment and fails to do so

3. A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan. However, a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

4. An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

Conversion to Non-Group Coverage – *Applies only to Group Contracts*

HNE Members who lose HNE eligibility for group coverage may be eligible for coverage with an Individual (Non-Group) contract through the Massachusetts Health Connector or Health Services Administrators. Call HNE for more information. You can also contact:

- The Health Connector at (877) 623-6765 (TTY:711), or visit https://www.mahealthconnector.org/
- Health Services Administrators at (877) 777-4414, or visit hsainsurance.com

SECTION 11 – MEMBER RIGHTS AND RESPONSIBILITIES

WHAT'S IN THIS SECTION?

We describe your rights as an HNE Member. We also describe your responsibilities as an HNE Member.

Member Rights

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

a) Receive information on HNE, its services, 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 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 doctor 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 Member Services at (413) 787-4004 or (800) 842-4464.

e) Contact us with a grievance or complaint about HNE or a plan provider. See the "Inquiries and Grievances" section of this EOC 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 In-Plan PCP, except those who have notified HNE that they are not accepting new patients.

i) Have access, during business hours, to Member Services Representatives who can answer your questions and help solve 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.

Member 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 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 any questions, you should call Member Services at (413) 787-4004 or (800) 842-4464.

o) Follow all HNE policies and procedures.

p) Treat providers and HNE staff with the respect and courtesy that you would 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 payers.

u) Notify us of status changes (such as a new address) that could affect your eligibility for coverage.

v) Help HNE and plan providers get prior medical records as needed. 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 an In-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

WHAT'S IN THIS SECTION?

In this section, we describe what HNE does when another insurer or someone else should be paying for Covered Services. You or any of your dependents may have another type of insurance in addition to HNE. HNE will work with the other insurance company to decide who should pay for the claim. This is called "coordination of benefits." We also do this if you or one of your dependents has Medicare coverage.

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

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

At times, HNE provides coverage for benefits and services under this EOC 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 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 as benefits that HNE paid. HNE will be fully released from liability under this EOC to the extent of such payments.

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

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

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

Coordination of Benefits

What happens if I have other group health insurance?

When anyone has coverage with HNE and with 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 on 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. A copy of these rules is available upon request. ***Please show all your health insurance cards to doctors, hospitals, pharmacies, and other health care providers at the time of your visit.*** This will help with correct billing and payment for the services you receive.

We will always provide you with the benefits described in this EOC. However, HNE will only provide coverage under HNE policies and rules. For example, if you see an Out-Of-Plan Provider without HNE's approval, HNE will not cover the services you receive, even if your other plan covers them.

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 requires 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 I or one of my Dependents is enrolled in Medicare?

You must tell us if you or a family member is enrolled in Medicare Part A or B. Medicare rules determine whether HNE or Medicare pays first for care. HNE follows these Medicare "order of payment" rules.

What happens if I have benefits under a "medical payment" benefit?

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

What happens if I am injured at work? Will HNE pay for the services that I receive?

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

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 may pay 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 liable person to recover the benefits HNE provided. This is known as "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 for any benefits provided to you under this EOC. This amount may differ from the provider's fee-for-service charges. 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 its 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. HNE then has the right to ask that you pay HNE for the benefits and services you received.

If you are paid by a third party, HNE will ask you to pay for the provider's charges for the benefits and services you received. HNE's right to reimbursement will apply 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 seeking this recovery. If you have a lawyer, you must ask him or her to cooperate as well. If you fail to cooperate or provide requested

assistance, you may be liable for any expenses incurred by HNE in enforcing its rights under this EOC. These expenses include reasonable attorney's fees.

SECTION 13 – OTHER PLAN ADMINSTRATION PROVISIONS

WHAT'S IN THIS SECTION?

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

Type of Plan – *Applies only to Group Contracts*

The Plan is a group health plan (a type of welfare benefit plan that is subject to the Provisions of ERISA). Your rights under ERISA law are explained in Appendix B.

Amendments

This EOC is effective as of the date on the bottom of this page. If HNE changes any benefits after this date, HNE will notify Group representatives or Subscribers at least 60 days before the effective date of the change. In addition, we will send notice of the amendment to each affected Subscriber. If you would like to know if HNE has made any changes to this EOC, please call HNE Member Services. HNE will send each Subscriber a new EOC at least once every five years.

HNE may amend this EOC at any time if the changes:

1. Are not in violation of any law, and
2. Comply with applicable rules and regulations of the Massachusetts Commissioner of Insurance

In addition, we will amend this EOC if required by law, regulation, or rule. These changes will apply to all Agreements of this type, not just to this EOC. These changes will be effective whether or not an individual Member in fact receives notice of the amendment.

No Contract of Employment – *Applies only to Group Contracts*

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the Group to the effect that you will be employed for any specific period of time.

Contracting Parties – *Applies only to Group Contracts*

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

Members and Other Third Parties

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

Health New England Providers

The relationship between HNE and its In-Plan Providers is a direct or indirect independent contractor relationship. Neither HNE nor any Provider has control of the way the other party performs its work or renders its services. No act or omission of any party (including its employees, agents, or servants) means that such party is an employee, agent, servant, representative or joint venturer with any 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 who is signed up with a provider or group of providers. This payment is made regardless of whether the Member is actually treated. This method of payment is known as "capitation." 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 or her pool until the end of the year. If the pool meets set goals or targets, HNE will pay some or the entire amount that has been put aside, or the full amount plus a bonus. HNE does not base payments or bonuses on denials or coverage of services.

Member and Providers

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

Agreement Binding on Members

When you enroll, or receive benefits or coverage under the Plan, you agree to all terms and conditions of this EOC. Subscribers will be responsible for the compliance of their Dependents with this EOC. 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 EOC. HNE may enforce the provision at a future date. Similarly, no waiver occurs if HNE fails to enforce any remedy that arises from a default under the terms of this EOC.

Severability

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

Entire Agreement

If you are insured through a Group Contract

This EOC, any written appendices, amendments, or modifications, and the Employer Group Agreement, make up the entire Agreement between the parties. Any prior agreements, promises, negotiations, or representations that relate to the subject matter of this Agreement are of no force or effect.

If you are insured with an Individual (Non-Group) Contract

This EOC and any written appendices, amendments, or modifications, make up the entire Agreement between the parties. Any prior agreements, promises, negotiations, or representations that relate to the subject matter of this Agreement are of no force or effect.

Amendment or Termination of the Plan – *Applies only to Group Contracts*

The Group, as Plan Sponsor, has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument signed by the authorized representative of the Group who has been authorized to amend or terminate the Plan and/or execute contracts on the Group's behalf. In addition, termination of the employer group agreement entered into between the Group and HNE will constitute termination of the Plan, unless the Group exercises its sole discretion to obtain other health care coverage.

Power and Authority of HNE – *Applies only to Group Contracts*

This plan is fully insured. Benefits are provided under a group insurance contract entered into between the Group and HNE. Claims for benefits are sent to HNE. HNE, not the Group, is responsible for paying claims. HNE is the Named Fiduciary for benefit claims and is responsible for:

- Determining eligibility for and the amount of any benefits payable under the Plan; and
- Providing the claims procedures to be followed and the claims forms to be used by eligible individuals pursuant to the Plan

Claims for benefits are sent to HNE as the named Fiduciary for benefit claims at this address:

Health New England, Inc.
One Monarch Place – Suite 1500
Springfield, MA 01144-1500
Telephone: (800) 842-4464

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

Governing Law

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

Notice

Any notice under this EOC 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 – Suite 1500
Springfield, MA 01144-1500

To a Subscriber/Member: To the latest address on file with HNE

If you are insured through a Group Contract
To the Group: To the address written on the Employer Agreement, or to the address on any written Notice of change of address by the Employer Group

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 arrange, or for delay in arranging, services or supplies in the event of any of the following:

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

SECTION 14 – CONTINUED TREATMENT (TRANSITIONAL CARE)

WHAT'S IN THIS SECTION?

In this section, we describe when we would cover services from an Out-of-Plan Provider who has been treating you. This is called "continued treatment" or "transitional care." We may cover these services if you are an HNE Member and the In-Plan Provider treating you leaves HNE. We may cover these services if you are a new HNE Member and you were receiving treatment from an Out-of-Plan Provider before you enrolled.

This coverage is limited to a certain time period, described below.

The Out-of-Plan Provider must agree to certain requirements for HNE to cover continued treatment.

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 leaves HNE's network. This happens:

- **If your Primary Care Provider (PCP) leaves HNE.** HNE will notify you at least 30 days before your PCP leaves HNE. 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 leaves HNE, whichever is shorter

  You will not be allowed to continue to see your PCP if your PCP leaves HNE 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, HNE will assign a PCP for you. We 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. Log in 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 provider up-to-date information on PCPs in your area who are accepting new patients. They can also answer any other questions you may have.

- **If your specialist leaves HNE.** 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
    - Up to 90 days after the specialist leaves HNE, 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 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

  You will not be allowed to continue to see these providers if disenrolled for reasons relating to quality or for fraud.

- **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.

- **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.

Continuation of coverage applies to medical providers and to behavioral health and substance abuse disorder providers.

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 30 days from the Effective Date of coverage if:

- The Member only has a choice of carriers (*through a Group Contract or an Individual (Non-Group) Contract*) in which the doctor is not participating Provider, and
- The doctor is providing the Member with an ongoing course of treatment or is the Member's PCP.

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

Requirement 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 before the provider left HNE
- Not to require the Member to pay any cost sharing over:
    - The amount that could have been required if the provider participated with HNE, or
    - The amount the Member would owe if the provider had not left HNE
- To adhere to HNE's quality assurance standards
- To provide HNE with needed medical information about the care provided
- To adhere to HNE's policies and procedures. This includes procedures for:
    - Obtaining Prior Approval
    - Providing services according to a treatment plan, if any, approved by HNE

Nothing in this section means that HNE must cover benefits that would not have been covered if the provider involved had stayed an In-Plan Provider.

SECTION 15 – DEFINITIONS

Adverse Determination

- A rescission is a retroactive cancellation of coverage. The Plan will not rescind coverage unless there is fraud or an intentional misrepresentation of material fact. Rescission does not include termination for non-payment of premiums.
- A decision, based on 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
    - A determination that a requested or recommended health care service or treatment is experimental or investigational

Affordable Care Act (ACA)

Federal law that reforms the health care system in the United States.

Agreement

If you are insured through a Group Contract

This EOC, any amendments and riders, and the Employer Group Agreement between your Group and HNE.

If you are insured with an Individual (Non-Group) Contract

This EOC, any amendments and riders, and any written modifications.

Allowed Amount

Maximum amount on which payment is based for Covered Services.

Alternative Medicine

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, 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 EOC or riders to this EOC)
- Herbal medicine
- Homeopathy
- Naturopathy
- Hypnosis
- Spiritual devotions of culturally based healing traditions such as Chinese, Ayurvedic, and Christian Science
- Holistic medicine

Alternative Medicine is also called “complementary medicine.”

Autism Definitions

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

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

Autism Spectrum Disorders: any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.

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

Diagnosis of Autism Spectrum Disorders: medically necessary assessments, evaluations including neuropsychological evaluations, genetic testing or other tests to diagnose whether an individual has one of the autism spectrum disorders.

Treatment of Autism Spectrum Disorders: includes the following care prescribed, provided or ordered for an individual diagnosed with one of the autism spectrum disorders by a licensed physician or a licensed psychologist who determines the care to be medically necessary: habilitative or rehabilitative care; pharmacy care; psychiatric care; psychological care; and therapeutic care.

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

Center of Excellence (COE)
A designation that validates the quality, outcomes, performance, and volume of a facility which does transplants.

Coinsurance
Your share of the cost of a Covered Service, calculated as a percent (for example 20%) of the Allowed Amount for the service.

Copay
The amount you must 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.

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

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

This includes personal care that does not require the continuing attention of trained medical or paramedical personnel. To decide whether care is 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 by paying out-of-pocket for certain Covered Services before HNE pays benefits. 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. Payments for services through the use of coupon programs do not count towards your Deductible.

Dependent
Any person:

- Who meets the Dependent requirements of Section 7 of this EOC
- Who is enrolled in HNE as a Dependent
- For whom HNE has received the premium specified in the Employer Group Agreement

Effective Date
The date on which coverage begins under this EOC.

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

Emergency Service Programs
All programs subject to contract between the Massachusetts Behavioral Health Partnership and nonprofit organizations for the provision of community-based emergency psychiatric services, including, but not limited to, behavioral health crisis assessment, intervention and stabilization services 24 hours per day, 7 days per week, through: (i) mobile crisis intervention services for youth; (ii) mobile crisis intervention services for adults; (iii) emergency service provider community-based locations; and (iv) adult community crisis stabilization services

Employer Group Agreement – *Applies only to Group Contracts*
An agreement between your Group and HNE that details premium rates, Effective Dates, and other terms.

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

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental 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

All benefits that were mandated by the state of Massachusetts prior to January 1, 2012 are also included in EHB. The ACA provides that there can be no annual dollar limits on EHBs.

If you have questions, please call Health New England Member Services at (413) 787-4004 or (800) 310-2835 (TTY: 711), Monday – Friday, 8 a.m. – 6 p.m. or visit healthnewengland.org.

Experimental
Services considered to be unsafe, experimental, or investigational. Applies to any:

- Medical procedure
- Equipment
- Treatment or course of treatment
- Implant
- Drugs or medicines

This is determined by sources including:

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

Extended Network
Providers outside of the HNE Service Area that are covered at an In-Plan level (visit healthnewengland.org/provider-search to find an Extended Network Provider)

Formulary
A list of drugs offered to Members.

Group – *Applies only to Group Contracts*
The business or organization which has offered the Plan to its employees.

Group Contract – *Applies only to Group Contracts*
An agreement between HNE and an employer Group or union that provides health care coverage. HNE agrees to provide this coverage according to the Explanation of Coverage and any amendments and riders. For this coverage, the Group agrees to pay premiums to HNE on behalf of its enrolled employees.

Health Care Services
Services for the diagnosis, prevention, treatment, cure or relief of a physical, behavioral, substance use disorder or mental health condition, illness, injury or disease.

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

Hospital Services
Services that are provided by acute general care hospitals.

Identification Card (ID Card)
The card that HNE issues to Members when they enroll.

In-Plan Doctor
A licensed doctor or oral surgeon who has agreed to provide Covered Services to HNE Members.

In-Plan Hospital
A licensed acute care general hospital that provides Hospital Services. In-Plan Hospitals have agreed to provide Covered Services to HNE Members.

In-Plan Provider
Any hospital, doctor, health care facility, agency, organization, pharmacy, or person that is properly licensed to furnish health care services. In-Plan Providers have agreed to provide Covered Services to HNE Members.

Licensed Mental Health Professional
A licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed certified social worker, a licensed mental health counselor, a licensed supervised mental health counselor, a licensed psychiatric nurse mental health clinical specialist, a licensed psychiatric mental health nurse practitioner, a licensed physician assistant who practices in the area of psychiatry, a licensed alcohol and drug counselor I, as defined in section 1 of chapter 111J, or a licensed marriage and family therapist within the lawful scope of practice for such therapist

Medically Necessary
Health New England defines certain services which are reasonably calculated by a provider to prevent, diagnose, evaluate, and treat conditions (illness, injury, disease) as Medically Necessary or as a Medical Necessity. The service must meet all the following in order to be Medically Necessary.

- Service is clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease
- Service is based on the following
    - Credible scientific evidence published in peer reviewed medical literature recognized by the relevant medical community
    - Specialty Society recommendations
    - Views of physician experts practicing in relevant clinical area
    - Per scientific evidence, service, or intervention is not in widespread use
- Service is not more costly than an alternative service or sequence of services, which is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease
- Service is not primarily for the convenience of the patient, physician, or other health care provider
- Service is substantiated by submitted clinical records

Health New England uses clinical criteria to decide if some services or procedures are Medically Necessary. You may call HNE's Health Services Department if you want a copy of the criteria HNE uses to make such decisions.

Member
Any person enrolled in HNE who has a right to services under this EOC.

Mental Health Acute Treatment
24-hour medically supervised mental health services provided in an inpatient facility, licensed by the department of mental health, that provides psychiatric evaluation, management, treatment and discharge planning in a structured treatment milieu

Non-Formulary
Any brand name drug not listed in the Formulary.

Non-Routine
Health care for the treatment of illness or injury. Care that is not for the prevention of or screening for health problems.

If you have questions, please call Health New England Member Services at (413) 787-4004 or (800) 310-2835 (TTY: 711), Monday – Friday, 8 a.m. – 6 p.m. or visit healthnewengland.org.

Nurse Practitioner
A registered nurse who holds authorization in advanced nursing practice as a nurse practice under M.G.L. c. 112, §80B.

Open Enrollment Period
The period each year when eligible persons may enroll in HNE or change options.

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 on Essential Health Benefits 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
- Payments made for benefits which are not Essential Health Benefits
- Any payment for drugs obtained through the use of a manufacturer drug coupon program

Plan Year
The twelve month period used in the application of the plan Deductible (if any) and the plan Out-of-Pocket Maximum. For example, a Plan Year could start on January 1st and end on December 31st of the same year, or a Plan year could start on July 1st and end on June 30th of the following year.

Primary Care Provider (PCP)
The In-Plan doctor, participating nurse practitioner, or participating physician assistant you choose to provide or arrange for all of your care. We describe how to choose and when to seek services in Section 2 of this EOC.

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

Psychiatric Collaborative Care Model
The evidence-based, integrated behavioral health service delivery method in which a primary care team consisting of a primary care provider and a care manager provides structured care management to a patient, and that works in collaboration with a psychiatric consultant that provides regular consultations to the primary care team to review the clinical status and care of patients and to make recommendations

Qualified Beneficiary – *Applies only to Group Contracts*
Persons who are covered under a Group health plan on the day before a COBRA Qualifying Event.

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

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

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

Subscriber
An enrolled person who meets the eligibility requirements and for whom HNE has received the premium specified by HNE.

If you have questions, please call Health New England Member Services at (413) 787-4004 or (800) 310-2835 (TTY: 711), Monday – Friday, 8 a.m. – 6 p.m. or visit healthnewengland.org.

APPENDIX A. A Summary of Your Payment Responsibilities

Summary of Benefit Chart

HMO Thrive Gold 2000 Connector
HMO Benefit Chart

This chart provides a summary of key services offered by your plan. Consult your Member Agreement for a full description of your plan's benefits and provisions.

Visit healthnewengland.org/provider-search to find an In-Plan Provider.

Note about Prior Approval:
Some services may require Prior Approval. These services are marked with † in the chart. If you do not obtain Prior Approval, benefits may be denied.

	In-Plan
Deductible per Plan Year: You must pay this amount for Covered Services before Health New England will begin to pay benefits. As indicated in the chart below, some services are not subject to the Deductible.	$2,000 per individual / $4,000 per family
Out-of-Pocket Maximum: The most you pay for cost sharing on Essential Health Benefits during a Plan Year before your plan begins to pay 100% of the Allowed Amount. This Out-of-Pocket Maximum does not include your cost sharing for pediatric dental services.	$9,800 per individual / $19,600 per family

Benefit	Your Cost
Inpatient Care	
Acute Hospital Care	$1,000 Copay per admission after Deductible
Skilled Nursing Facility † (limited to 100 days per Calendar Year)	$1,000 Copay per admission after Deductible
Inpatient Rehabilitation † (limited to 60 days per Calendar Year)	$1,000 Copay per admission after Deductible
Preventive Care	
Adult Routine Exams	$0
Well Child Care	$0
Child and Adult Routine Immunizations	$0
Routine Prenatal & Postpartum Care	$0
Routine Eye Exams (limited to one per Calendar Year) Please note: for children under age 19, routine eye exams must be done by an EyeMed Provider.	$0
Annual Gynecological Exams (limited to one per Calendar Year)	$0

If you have questions, please call Health New England Member Services at (413) 787-4004 or (800) 310-2835 (TTY: 711), Monday – Friday, 8 a.m. – 6 p.m. or visit healthnewengland.org.

Benefit	Your Cost
Routine Mammograms (routine mammograms limited to one per Calendar Year)	$0
Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years)	$0
Nutritional Counseling (maximum of 4 visits per Calendar Year)	$0
Preventive Screenings Listed under "Outpatient Preventive Care" in the *Covered Benefits* Section of the EOC	$0
Outpatient Care	
PCP Office Visit (Non-Routine) (Deductible may apply to some office services)	$10 Copay per visit
Specialist Office Visits (Deductible may apply to some office services)	$30 Copay per visit
Second Opinions (Deductible may apply to some office services)	$30 Copay per visit
Teladoc Urgent Medical: Telephone and video consultations with internists, family practitioners, and pediatricians for non-emergency medical conditions through Teladoc®. Teladoc is a network of providers contracted to provide virtual Urgent Care services. Teladoc is not intended to replace your PCP.	$0
Hearing Tests in Specialist Office or Outpatient Facility (other than routine screenings covered as part of your Annual Routine Exam)	$30 Copay per visit after Deductible
Diabetic-Related Items:	
Outpatient Services (Deductible may apply to some office services)	$30 Copay per visit
Lab Services	$30 Copay
Durable Medical Equipment †	20% Coinsurance
Individual Diabetic Education	$30 Copay per visit
Group Diabetic Education	$10 Copay per session
Emergency Room Care (Copay waived if admitted)	$500 Copay per visit after Deductible
Diagnostic Testing	$0 after Deductible
Sleep Study †	$500 Copay after Deductible (one Copay per year; no Copay for home sleep studies)
Lab Services	$30 Copay
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms	$50 Copay after Deductible
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging †	$500 Copay after Deductible
Radiation Therapy and Chemotherapy	$0 after Deductible

Benefit	Your Cost
Outpatient Short-Term Rehabilitation Services (Limited to 60 visits per Calendar Year for physical or occupational therapy. The limit does not apply when services are provided to treat autism spectrum disorder, or when provided as part of the home health care benefit.)	$30 Copay per visit per treatment type after Deductible
Day Rehabilitation Program (limited to 15 full day or ½ day sessions per condition per lifetime)	$25 Copay after Deductible for 1 day or 1/2 day
Early Intervention Services (Covered for children from birth to age 3.)	$0
Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorders †	$0
Surgical Services and Procedures in an Outpatient Facility (Some services require Prior Approval. This Copay is based on the type of service. To find out if the Copay applies to a specific procedure, please contact Health New England Member Services.)	$1,000 Copay after Deductible
Allergy Testing and Treatment	$30 Copay per visit
Allergy Injections	$0
Infertility Services	
Some services require Prior Approval.	
Office Visit (Deductible may apply to some office services)	$30 Copay per visit
Outpatient Surgery/ Procedure	$1,000 Copay after Deductible
Lab Test	$30 Copay
Inpatient Care †	$1,000 Copay per admission after Deductible
Maternity Care	
Non-Routine Prenatal and Postpartum Visit	$30 Copay per visit
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.)	$1,000 Copay per admission after Deductible
Dental Services	
Surgical Treatment of Non-Dental Conditions in a Doctor's Office	$30 Copay after Deductible
Emergency Dental Care in a Doctor's or Dentist's Office	$30 Copay per visit
Emergency Dental Care in an Emergency Room	$500 Copay per visit after Deductible
Other Services	
Home Health Care †	$0 after Deductible
Hospice Services †	$0
Durable Medical Equipment †	20% Coinsurance
Prosthetic Limbs †	20% Coinsurance
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval)	$100 Copay per day after Deductible
Kidney Dialysis	$0

If you have questions, please call Health New England Member Services at (413) 787-4004 or (800) 310-2835 (TTY: 711), Monday – Friday, 8 a.m. – 6 p.m. or visit healthnewengland.org.

Benefit	Your Cost
Nutritional Support †	$0
Cardiac Rehabilitation	$30 Copay per visit after Deductible
Wigs (Scalp Hair Prostheses) for hair loss due to treatment of any form of cancer or leukemia † (Health New England covers 1 prosthesis per Calendar Year.)	20% Coinsurance
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation)	$30 Copay per visit after Deductible
Hearing Aids† (Covered with Prior Approval for Members age 21 and under. Health New England covers the cost of one hearing aid per hearing impaired ear, every 36 months, up to a maximum of $2,000 for each hearing aid)	$0 up to $2,000 per device per ear (you are responsible for all costs beyond maximum)
Human Organ Transplants and Bone Marrow Transplants †	$1,000 Copay per admission after Deductible
Wellness Services	
Massage Therapy (Limited to two visits per Calendar Year per family.)	$0 up to 2 visits per family
Acupuncture (Limited to 12 visits per Calendar Year.)	$20 Copay per visit
Behavioral Health (includes Mental Health and Substance Use Disorder)	
Outpatient Services (Some services require Prior Approval.)	$10 Copay per visit
Teladoc Behavioral Health: Telephone and video consultations for non-emergency behavioral health issues and substance use disorder issues through Teladoc®.	$10 Copay per consultation
Inpatient Services †	$1,000 Copay per admission after Deductible
Chiropractic Services	
Visits to an In-Plan chiropractor (for medically necessary chiropractic services)	$20 Copay per visit
Prescription Drugs	
At an In-Plan Pharmacy (up to a 30 day supply)	
Generic Drugs	$10 Copay
Formulary Drugs	$50 Copay
Non-Formulary Drugs	$150 Copay
Formulary Specialty Drugs	$200 Copay
Non-Formulary Specialty Drugs	$250 Copay
Through Mail Order: (up to a 90 day supply of maintenance medication)	
Generic Drugs	$20 Copay
Formulary Drugs	$100 Copay
Non-Formulary Drugs	$450 Copay

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APPENDIX B. Disclosures Required by Law

Notice of COBRA Rights – *Applies only to Group Contracts*COBRA is the Federal Consolidated Omnibus Budget Reconciliation Act. Under the Federal COBRA law or the Massachusetts Mini-COBRA law, if you or your Dependents lose Group health insurance coverage, you may have the right to continue coverage for up to 36 months at your own expense.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

Your employer must offer this coverage to you in certain cases where coverage under the Plan would otherwise end. These cases are known as "Qualifying Events." Coverage is at Group rates, plus up to a 2 percent administrative charge. If you lose coverage your employer should give you detailed information on your rights under COBRA or Mini-COBRA. The information below provides a brief summary of your rights under COBRA/Mini-COBRA.

Qualified Beneficiaries and Qualifying Events under COBRA/Mini-COBRA

An employer must provide COBRA/Mini-COBRA benefits to Qualified Beneficiaries upon the occurrence of a Qualifying Event. In general, Qualified Beneficiaries are people who are covered under a Group health benefit plan on the date before the Qualifying Event.

If you are an ***employee*** covered by the Plan, you have a right to choose continuation coverage if you lost your Group health coverage for either of the following reasons:

- You lose your job (for reasons other than gross misconduct on your part).
- Your work hours are reduced.

The length of continuation coverage in either of these circumstances is 18 months.

If you are the ***Spouse*** of an employee covered by the Plan, you have the right to choose continuation coverage for yourself if you lose Group health coverage under the Plan for any of the following reasons. Coverage can continue for up to the time shown in brackets.

- The death of your Spouse [36 months]
- Your Spouse loses his or her job (for reasons other than gross misconduct) or he or she is told to work fewer hours [18 months]
- Divorce or legal separation from your Spouse [36 months]
- Your Spouse becomes entitled to Medicare [36 months]

Dependent children of an employee covered under the Plan have the right to choose continuation coverage if Group health coverage under the Plan is lost for any of the five following reasons. Coverage can continue for up to the time shown in brackets.

- The death of the employee-parent [36 months]
- The employee-parent loses his or her job (for reasons other than gross misconduct) or he or she is told to work fewer hours [18 months]
- Parents' divorce or legal separation [36 months]
- The employee-parent becomes entitled to Medicare [36 months]
- The Dependent ceases to be a "Dependent child" under the terms of the Plan [36 months]

Also, there might be a right to continuation coverage for certain eligible retirees and their Spouses, surviving Spouses, and Dependent children connected with bankruptcy. This applies if your employer begins a Title 11 bankruptcy proceeding. If this takes place, you should contact your employer regarding your rights.

The definition of "Qualified Beneficiary" for COBRA/Mini-COBRA purposes also includes a child born to, or placed for adoption with, a covered employee during the period of the employee's continuation coverage. To be covered, the newborn or adopted child must be enrolled in continuation coverage following the Plan's rules. The child is then treated like all other COBRA/Mini-COBRA Qualified Beneficiaries. The maximum coverage period for such a child is measured from the same date as for the other Qualified Beneficiaries with respect to the same Qualifying Event. Coverage is ***not*** measured from the date of the child's birth or placement for adoption.

Notification Requirements

Responsibilities of the Employer

The COBRA/Mini-COBRA law requires employers to issue the following notices:

- Notice of rights at the time coverage begins: An employer must notify each employee and his or her Spouse of their rights under COBRA/Mini-COBRA at the time coverage begins.

- Notice to Plan Administrator of Qualifying Event: The employer has the responsibility to notify the Plan Administrator of the employee's death, termination of employment, reduction of hours of employment, Medicare entitlement, or if the Plan provides retiree health coverage, the commencement in a proceeding in bankruptcy with respect to the employer.

- Notice of rights at the time a Qualifying Event occurs: Once a Plan Administrator becomes aware of a Qualifying Event of any kind, the Plan Administrator must notify the Qualified Beneficiary of his or her rights under COBRA/Mini-COBRA within 14 days of the date the Plan Administrator becomes aware of a Qualifying Event.

What Qualified Beneficiaries Must Do

If you are a Qualified Beneficiary, there are things you must do under the law. You must notify your employer:

- Within 60 days of a divorce or separation.

- If a Dependent child is no longer considered a Dependent under the terms of the plan: Within 60 days after this Qualifying Event.

- If you have been found to be disabled under Titles II or XVI of the Social Security Act as of the date of your job loss or reduction of hours: You must tell your employer within 60 days of such finding, and within the initial 18 month continuation coverage period. You must also notify your employer within 30 days of the date of a final determination that you are no longer disabled.

- If a second Qualifying Event occurs during your continuation coverage period: See "Multiple Qualifying Events" below for more information.

You must notify your employer within 60 days of the date of the Qualifying Event. Your employer will provide you with a notice and election form.

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

Election Period

Once the Plan Administrator receives notice that a Qualifying Event has occurred, continuation coverage under COBRA/Mini-COBRA will be offered to each Qualified Beneficiary. Each Qualified Beneficiary will have an independent right to elect COBRA/Mini-COBRA continuation coverage. Covered employees may elect COBRA/Mini-COBRA continuation coverage on behalf of a Spouse, and parents may elect COBRA/Mini-COBRA continuation coverage on behalf of their children.

The election period is the period of time in which a Qualified Beneficiary may elect to continue his or her coverage under COBRA/Mini-COBRA by making a written request for the coverage. Under the law, Qualified Beneficiaries have 60 days to notify the employer that they want continuation coverage. The 60 day period starts to run from the later of: (1) the date you ordinarily would have lost coverage because of one of the events described above; or (2) the date of the notice of your right to elect continuation coverage. If you do not choose continuation coverage, your Group health insurance coverage under the Plan will end.

Payment of Premiums

To continue coverage, you must pay up to 102% of the "applicable premium" for your coverage. The applicable premium is the premium that would apply to similarly situated Members of the Plan who have not had a Qualifying Event. Please note that for individuals covered by the Plan, the employee generally only pays part of the premium. The employer pays the rest. If you lose coverage because of a Qualifying Event, you pay the entire premium for your continuation coverage. You must make your first payment no later than 45 days after you elect to continue coverage. (This is the date the Election Notice is post-marked, if mailed.) After the first payment, premium payments are due monthly, at the election of the payer, within a 30-day grace period. Your employer is not required to pay your premium for you until your employer receives payment from you. Therefore, you should make every effort to pay your premium in a timely manner to ensure that your coverage is not cancelled for non-payment of premiums.

Duration of Coverage

If you choose continuation coverage, you are entitled to get coverage that is identical to the coverage given by the Plan to similarly situated employees (or their Dependents). If Group health coverage is lost because of a lost job or reduced hours of work, the law requires that Qualified Beneficiaries have the chance to get continuation coverage for 18 months. However, if the Qualifying Event is a lost job or reduced hours of work, and the employee became entitled to Medicare less than 18 months before the Qualifying Event, Qualified Beneficiaries other than the employee have the chance to get continuation coverage for 36 months after the date of Medicare entitlement. (For example, if the covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for Dependents can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months)). In the case of all other Qualifying Events, Qualified Beneficiaries get the chance to have continuation coverage for 36 months.

Special rule for Qualified Beneficiaries who are determined to be disabled. An 18-month period of continuation coverage may be extended for up to 11 months (for up to a total of 29 months of continuation coverage) if you have been found to be disabled under Titles II or XVI of the Social Security Act as of the date of your job loss or reduction in hours. The 11-month extension also applies if a Qualified Beneficiary becomes disabled at any time within the first 60 days of the 18-month continuation coverage period, provided that the Plan Administrator is notified of the disability in a timely manner, as described above. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The 11-month extension applies to all disabled and non-disabled Qualified Beneficiaries entitled to COBRA/Mini-COBRA coverage as a result of the same Qualifying Event, subject to the above notice requirements. During the additional 11 months, the cost of coverage may be as high as 150% of the applicable premium.

Multiple Qualifying Events. Additional Qualifying Events can occur while continuation coverage is in effect. If any of the following Qualifying Events occur during the 18-month period after termination or reduction in work hours, then coverage is extended to 36 months: (1) death of the former employee; (2) divorce or legal separation of the former employee from Spouse; (3) former employee becomes entitled to Medicare; (4) Dependent child ceases to be Dependent under the terms of the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. In no event will coverage extend beyond 36 months after the initial Qualifying Event. You should notify the Plan Administrator immediately if a second Qualifying Event occurs during your continuation coverage period.

When COBRA/Mini-COBRA Coverage Ends

COBRA/Mini-COBRA coverage ends in any of the following circumstances:

- The maximum period for coverage expires (e.g., 18 months, 29 months, or 36 months).
- The employer no longer provides group health coverage.
- The premium for your continuation coverage is not paid on time. (It must be paid no later than the end of the grace period, which is 30 days after the payment was due. In addition, your first payment can be made as late as 45 days after the date you choose to continue coverage.)
- The individual becomes covered under another group health plan (as an employee or otherwise) that does not contain any limitation applicable to the individual.
- The individual becomes entitled to Medicare.
- Coverage has been extended for up to 29 months due to disability and there has been a final ruling that the person is no longer disabled. (You must notify the Plan Administrator within 30 days of any such final determination.)
- The Plan terminates continuation coverage for any reason the Plan would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud).

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under the law is provided subject to your eligibility for coverage under the Plan. Once your continuation coverage ends for any reason, it cannot be reinstated.

This notice is a summary of the law and therefore is general in nature. The law itself and the rules of your employee benefit plan have more details and they govern. Additional information regarding COBRA continuation coverage and other rights under your employee benefit plan is available from the Plan Administrator. Please contact your employer if: you have any questions about the law; you have recently divorced or separated; you or your Spouse has changed address; or a Dependent child has lost Dependent status under the Plan.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, you may visit the website for the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at dol.gov/ebsa, or contact EBSA at:

Boston Regional Office
JFK Federal Building
15 New Sudbury Street, Room 575
Boston, MA 02203
Director
Telephone: (617) 565-9600
Fax: (617) 565-9666

For more information about health insurance options available to you through a Health Insurance Marketplace, visit www.healthcare.gov.

Employees' Rights Under ERISA Law – *Applies only to Group Contracts*

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements,

and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Coverage

Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. (Please note that "Spouse" and "Dependent," for purposes of group health plan coverage, are defined by federal law, not state law.) You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Right

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents related to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA.

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 and can be completed in a matter of months. Others are ongoing and will be followed by HNE throughout the year.

HNE's Board of Directors has made the Quality Management Committee responsible for oversight of the overall quality program. The HNE Quality Management Committee meets throughout the 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 a copy of the current Quality Management Program Description, the annual work plan and/or the most recent Quality Program Evaluation, please contact Shelly Smith, Quality Management Lead, at (413) 233-3538 or send an email to quality @hne.com.

Summary Description of Process for Developing Clinical Guidelines and Utilization Review Criteria

HNE has a written program for how health care services and delivery are reviewed. The program is made up of activities in the areas of utilization, case management, 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. 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:

For new and emerging medical technologies

- 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.

- The recommendations by Hayes are then screened by an internal HNE committee. If more medical input is needed, we will get the advice of an independent medical reviewer and/or a physician in the community.

- The findings are reported to HNE's Medical/Pharmacy Policy Committee (MPPC) 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 MPPC.

For drugs that are considered Experimental, investigational, or not generally accepted in the medical community

- HNE's Medical/Pharmacy Policy Committee (MPPC) reviews these drugs. Experimental or investigational drugs may not be reviewed by MPPC if they fail to meet one or more of the following medical necessity criteria:
    - Have final approval from the appropriate governmental regulatory body
    - Have the creditable scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community which permits reasonable conclusions concerning the effect on health outcomes
    - Be proven materially to improve the net health outcome
    - Be as beneficial as any established alternative
    - Show improvement outside the investigational settings

- These recommendations are then screened by and presented at MPPC. If more medical input is needed, HNE will get the advice of an independent medical reviewer and/or a physician(s) in the community. Final recommendations are then presented to the Clinical Care Assessment Committee and HNE Board of Directors.

An FDA approved drug used outside the FDA approved drug label for dosage, route and other information would be considered as Off-Label Use. The FDA does not regulate the usage of the medicine. Therefore, the prescriber makes decisions based on her or his best judgment. CMS has approved clinical decision support tools for use to determine medically accepted indication of off-label use of pharmaceuticals. These are:

- Authoritative compendia
    - American Hospital Formulary Service-Drug Information (AHFS-DI)
    - NCCN Drugs and Biologics Compendium
    - Thomson Micromedex DrugDex
    - Clinical Pharmacology

- Acceptable peer-reviewed medical literature
    - Review of peer reviewed medical literature listed excludes in-house publications of entities whose business relates to the manufacture, sale, or distribution of pharmaceutical products and abstracts (including meeting abstracts). The following list includes, but is not limited to, acceptable peer-reviewed publications:
    - Annals of Internal Medicine
    - Journal of the American Medical Association
    - Journal of Clinical Oncology
    - Lancet
    - Drugs
    - New England Journal of Medicine
    - Journal of the National Comprehensive Cancer Network (NCCN)

The review of the off-label request and information submitted by the provider is reviewed by a clinical pharmacist(s). Additional input may be sought through review with medical directors, advice of an independent

medical reviewer, and/or a physician(s) in the community. A request for an off-label use pharmaceutical may not be approved if one or more of the following is true:

- The use is identified as not supported by one or more of the CMS approved authoritative compendia
- A review by HNE of peer-reviewed medical literature identifies a particular use of a drug is not safe and effective
- The FDA removes a previously covered indication

Notice of Termination for Nonpayment of Premiums

If you are insured through a Group Contract

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 has been terminated for nonpayment of premiums, unless the carrier has sent written notice of the termination to the Member prior to the date the covered health care services were received.

If you are insured with an Individual (Non-Group) Contract

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 Subscriber's plan has been terminated for nonpayment of premiums, unless the carrier has sent written notice of the termination to the Subscriber prior to the date the covered health care services were received.

Premium Rates and Payment Arrangements (Prepaid Fees)

If you are insured through a Group Contract

With HNE, your employer pays a prepaid monthly fee on your behalf for HNE benefits. The fee is known as a "premium." It is due on or before the first day of the billing period to which it applies. The premium rates are shown in the Employer Group Agreement. The Group must send HNE the premium due for each Subscriber. In most cases, Subscribers pay a portion of the premium to their employer. The employer pays the rest. The rates charged may change from year to year, or at other times, per the terms of the Employer Group Agreement.

If you are insured with an Individual (Non-Group) Contract

With HNE, you pay a prepaid monthly fee for HNE benefits. The fee is known as a "premium." It is due on or before the first day of the billing period to which it applies. HNE must receive the premium due. The rates charged may change from year to year, or at other times.

Pediatric Specialty Care

HNE covers pediatric specialty care by persons with recognized expertise in specialty pediatrics for Members who require such services. This also includes services for mental health care.

Physician Profiling Information

This information is available from the Massachusetts Board of Registration in Medicine for physicians who are licensed to practice in Massachusetts. You can request a printout on a doctor by calling (781) 876-8230 or, in Massachusetts only, (800) 377-0550. You can also find information about a Massachusetts licensed physician by visiting http://www.mass.gov/check-a-physician-profile.

HNE's Involuntary and Voluntary Disenrollment Rates

HNE's involuntary disenrollment rate is 0%. HNE's voluntary disenrollment rate is 0%.

APPENDIX C. Notice of Privacy Practices

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

NOTICE OF PRIVACY PRACTICES

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 such as Race, Ethnicity, Language, Disability (RELD), Sexual Orientation and/or Gender Identity, 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. This includes protecting all of your information whether it is oral, written or in electronic format. 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 September, 2025. 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 use or share your health Information?

HNE and its affiliated entities participate in an organized health care arrangement (OHCA) and Accountable Care Organizations (ACOs), such as the Pioneer Valley Accountable Care ACO and the BeHealthy Partnership ACO. HNE providers and other participants in these OHCAs and ACOs, will share your medical information among themselves, for treatment, payment, and operations related to the OHCA or ACO.

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. For more information see: https://www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html**.**

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
- Disclosing information to providers for their payment purposes

Health Care Operations: When we collect Race, Ethnicity, Language, Sexual Orientation, and Gender Identity data, it will not be used for underwriting purposes or denial of coverage or benefits 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, setting of care or other health-related benefits and services

- Reinsurance activities
- 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 Exchanges 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 a 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:

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.

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.

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.

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.

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.

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.

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.

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.

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.

Research: We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

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.

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

Other Uses and Disclosures (Require Written Authorization): For all other uses or disclosures not described above, HNE will always obtain your written authorization prior to conducting these activities.

Disclosure of "Highly Confidential" PHI: Certain kinds of PHI are deemed as "highly confidential" due to the sensitivity of the information. For example:

- Alcohol and drug abuse prevention, treatment and referral
- Genetic testing information
- HIV/AIDS or other sexually transmitted diseases testing, diagnosis or treatment
- Psychotherapy notes

Additional protection might be added for these kinds of PHI as required by state and federal law. HNE will only disclose "highly confidential" PHI only when we have obtained prior written authorization from you unless otherwise required by law.

Reproductive Health Care Information: We are prohibited from using or disclosing your reproductive health care information for any of the following purposes:

- Health oversight activities, law enforcement, judicial or administrative proceedings, disclosures to coroners and medical examiner (regarding decedents).

Furthermore, we will not use or disclose PHI for the following purposes:

- To conduct a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating lawful reproductive health care;

- To impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating lawful reproductive health care;

- To identify any person for any purpose described in (1) or (2).

If we receive a request for your reproductive health care information, the requestor will be required to sign an attestation in certain scenarios to confirm they will not use your information for a non-permitted purpose. For example, we will require the requestor to sign an attestation if the request is related to health oversight activities or law enforcement purposes. The Attestation Regarding Use or Disclosure of Reproductive Health Care PHI can be found on Health New England's website at https://healthnewengland.org/forms.

Substance Use Disorder Records Privacy (42 CFR Part 2): We provide additional protection for Substance Use Disorder (SUD) records in accordance with 42 CFR Part 2. These records are specially protected and require your written consent for most uses and disclosures. Once consent is given, your SUD records may be redisclosed in accordance with HIPAA, unless otherwise restricted.

You have the right to revoke your consent at any time. Revocation must be submitted in writing and will not affect any disclosures made prior to the revocation.

Additionally, de-identified SUD data may be disclosed to public health authorities without your consent, following HIPAA de-identification standards.

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 so.
- That person has submitted proof of legal authority to act on your behalf.
- That person is involved in your health care or payment for your health care and needs your PHI for these purposes. If you are present 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 Provider, 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 (also found on Health New England's website at https://healthnewengland.org/forms). 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 an 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 a List (accounting) of Certain Disclosures: You have the right to request an account of the times we have shared your health information. This accounting requirement applies for six years from the date of the disclosure, beginning with disclosures occurring after April 12, 2003. HNE will provide an accounting for all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). If you request this accounting more than once in a 12-month period, we may charge you a reasonable fee.

Right to a Notice in the even or a Breach: <u>In the event of a data breach, you have the right to receive notice regarding the incident</u>.

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 (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 by calling (877) 696-6775 or visit https://www.hhs.gov/ocr/complaints/index.html.

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

This Notice of Privacy Practices is available on Health New England's website at https://healthnewengland.org/notice-of-privacy-practices.

Last revised: 9/2025

APPENDIX D. Pediatric Vision Services

Health New England covers vision services for Members under age 19. EyeMed Vision Care administers this benefit. You will get the most from your coverage if you use EyeMed In-Network providers. To find an EyeMed In-Network provider:

- Call toll free (844) 203-2074 or
- Visit eyemed.com and select the EyeMed ACCESS Network in the Provider Search

Important note: Routine vision exams for children under age 19 will covered with $0 copay only if you use an EyeMed In-Network provider. Routine vision exams by Health New England providers who are not EyeMed providers will not be covered for children under age 19.

What is Covered and What is Not Covered

What is Covered

The chart below and on the next page shows covered services and your cost.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Services Fully Covered In-Network		
Exam with Dilation as necessary	$0 copay	$28
Frames Any available frame at provider location	100% coverage for provider designated frames	$40
Standard Plastic Lenses		
Single Vision	$0 copay	$21
Bi focal	$0 copay	$33
Trifocal	$0 copay	$53
Lenticular	$0 copay	$53
Standard Progressive Lens	$0 copay	$70
Lens Options		
UV Treatment	$0 copay	$9
Tint (Solid & Gradient)	$0 copay	$9
Standard Plastic Scratch Coating	$0 copay	$9
Standard Polycarbonate	$0 copay	$23
Photochromic / Transitions Plastic	$0 copay	$51
Contact Lenses *(Contact lens allowance includes material only)*	100% coverage for provider designated contact lenses	
Extended Wear Disposables	Up to a 6-month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses	$84
Daily Wear Disposables	Up to a 3-month supply of daily disposable, single vision spherical contact lenses	$84
Conventional	1 pair from selection of provider designated contact lenses	$84
Medically Necessary	Paid in full	$210

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Additional Discounts and Benefits		
Exam Options: Standard Contact Lens Fit & Follow-up Premium Contact Lens fit & Follow-up	 Member pays up to $55 10% Off Retail Price	 N/A N/A
Standard Plastic Lenses Premium Progressive Lens	$0 Copay, 80% of charge less $120 Allowance	$196
Lens Options Standard Anti-Reflective Coating Polarized Other Add-Ons	 $45 20% off Retail Price 20% off Retail Price	 N/A N/A N/A
Laser Vision Correction Lasik or PRK from U.S. Laser Network *(For LASIK providers call (877) 552-7376)*	15% off Retail Price or 5% off promotional price	N/A
Additional Pairs Benefit	Members also receive a 40% discount off complete pair eyeglass purchases, & a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency Limits	Examination: Once every 12 months Lenses or Contact Lenses: Once every 12 months Frame: Once every 12 months	

What is Not Covered

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses
- Medical and/or surgical treatment of the eye, eyes or supporting structures
- Any eye or vision examination, or any corrective eyewear required by a policyholder as a condition of employment; safety eyewear
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof
- Plano (non-prescription) lenses
- Non-prescription sunglasses
- Two pair of glasses in lieu of bifocals
- Services rendered after the date an insured person ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days from the date of such order
- Services or materials provided by any other group benefit plan providing vision care
- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available.

One Monarch Place • Suite 1500
Springfield, MA 01144-1500
healthnewengland.org

Prescription Drug Coverage

This is a rider to your Health New England, Inc. Explanation of Coverage (EOC). Please keep this rider with your EOC. It is a part of your EOC and explains your coverage for prescription drugs.

FF HMO
$10/$50/$150/$200/$250
$20/$100/$450
BRXAB

Your Prescription Drug Cost Sharing

Your Prescription Benefit is based on the Health New England Formulary. Please call Member Services or visit healthnewengland.org for a copy of the Health New England Formulary.

Out-of-Pocket Maximum

Copays or coinsurance you pay for prescription drugs are applied to the yearly Out-of-Pocket Maximum for your plan.

From a Pharmacy

Your cost for up to a 30-day supply of prescription drugs received from an In-Plan pharmacy is as follows:

	In-Plan
Generic	$10 Copay
Brand Name (Formulary)	$50 Copay
Brand Name (Non-Formulary)	$150 Copay
Specialty (Formulary)	$200 Copay
Specialty (Non-Formulary)	$250 Copay

Mail Order Prescriptions

Your cost for a 90-day supply of maintenance medications through Health New England's participating mail order supplier is as follows:

	In-Plan
Generic	$20 Copay
Brand Name (Formulary)	$100 Copay
Brand Name (Non-Formulary)	$450 Copay

To understand your prescription drug benefit, please read this booklet carefully. If you have questions, call Health New England Member Services at (413) 787-4004 or (800) 310-2835, Monday - Friday, 8 a.m.-6 p.m. Or visit healthnewengland.org.

Your Prescription Drug Benefit – Health New England Formulary

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Types of Covered Drugs

Health New England covers most types of prescription pharmacy drugs. A pharmacy drug is defined as a medication, device, or other product processed through the pharmacy benefit. Health New England also covers a small number of non-prescription drugs and medical supplies. Covered drugs must be medically necessary.

Health New England's listing of covered drugs is called a formulary. The formulary contains both generic and brand drugs. Drugs may have different levels of copays. Health New England does not waive or reduce copays for any drug. In certain Health New England benefit plans, members must pay the full cost of the drug.

New to market and existing drugs with new U.S. Food and Drug Administration (FDA) approved diagnoses are not added to the formulary right away. After a drug is approved by the FDA, there is a minimum 6-month period called the Clinical Review Period (CRP). This applies to all new drugs, including those filled at a retail pharmacy, from a specialty pharmacy, in a doctor's office, or at an infusion suite.

Health New England does not cover drugs during the CRP. If your doctor believes that it is medically necessary to prescribe this drug, they may request an exception. If Health New England approves the drug during this period, your copay will be 50% of the cost of the drug. Health New England may decide not to cover the drug once the CRP ends. If Health New England does decide to cover the drug, a copay tier will be assigned.

Health New England reviews new drugs and creates new clinical policies regarding coverage. Health New England decisions are reviewed and approved by a committee of local practicing doctors, medical directors, and pharmacists.

Copay Tiers

Health New England has five levels of copays (tiers) for drugs.

Drugs are grouped into generic, brand/formulary, brand/non-formulary, formulary/specialty and non-formulary/specialty tiers. ***To find the most up-to-date information about what tier your drug falls under, you may call Health New England Member Services or visit our online searchable formulary at healthnewengland.org.***

You may fill your drug at an In-Plan retail pharmacy or mail order pharmacy. Your copay is dependent on which pharmacy is used. If a copay is more than the retail price of a drug, you will pay the retail (lower) price. Copays are due when the drug is picked up at the retail pharmacy or ordered through mail order.

Health New England has a national network of In-Plan retail pharmacies. Please visit healthnewengland.org or contact Member Services to locate a pharmacy.

Generic/Tier 1: Includes mostly generic drugs, which are approved by the FDA. These drugs contain the same active ingredients as brand name drugs, are just as safe and effective, and usually cost less. ***Note: In***

Massachusetts, pharmacists are required to fill generic drugs unless your doctor orders the brand name by including "no substitution" on the prescription.

Brand Formulary/Tier 2: Includes mostly brand/formulary drugs. These drugs are marketed under a trademarked brand name, by one company, and do not have less expensive generic equivalents. Brand/Formulary drugs are selected based on a review of the relative safety, effectiveness and cost of the many FDA approved drugs on the market. Your copay for Brand/Formulary products is higher than generic drugs, but lower than Brand/Non-Formulary drugs.

Brand Non-Formulary/Tier 3: Includes mostly brand name drugs that are not a Brand/Formulary drug. These products are still covered, but at the highest copay level. Health New England covers brand name drugs that have FDA approved generic equivalents only if medical necessity has been shown. Your doctor may request prior authorization for a brand name drug by filling out a drug request form and faxing it to Health New England for review with documentation of medical necessity. Medical necessity includes, but is not limited to, inadequate response to or allergic reaction to the generic(s) and failure of alternatives in the drug class.

Formulary Specialty/Tier 4: Formulary Specialty Drugs (Tier 4) are selected based on a review of the relative safety, effectiveness and cost of the many FDA-approved drugs on the market.

Non-Formulary Specialty/Tier 5: Any drug that Health New England has not selected as a Formulary Specialty Drug is a Non-Formulary Specialty Drug (Tier 5). This category includes brand drugs that have formulary generic and brand alternatives. These drugs are still covered, but at the highest copay level.

Certain drugs are covered with $0 copay (deductible may apply). For the most up-to-date list of drugs available at $0 copay, please call Member Services at (413) 787-4004 or (800) 310-2835.

Changes to Health New England's Formulary

Health New England's formulary is available via the website: healthnewengland.org. A copy may also be requested by contacting Member Services. Health New England makes changes to the formulary and will send these changes to you (or to your employer if you are in a group plan) at least 60 days in advance. If a generic equivalent becomes available for any brand name drug on the formulary, the brand name drug will automatically not be covered unless medical necessity is shown. Each year, Health New England sends a reminder to our doctors about where they can find the Health New England formulary and will include formulary changes during the year in newsletters for members and doctors.

Injectable Drugs

There are two types of injectable drugs: self-injectable and those that must be given by a health care doctor. Self-injectable drugs are only covered if you have a pharmacy benefit with Health New England. Copays and/or deductibles may apply for both types of injectable drugs.

Prior authorization may be required for all injectable drugs. To verify drug coverage, please visit Health New England's drug look up tool on healthnewengland.org or by calling Health New England Member Services.

What is Covered

Some drugs require prior approval or have quantity limits. For coverage details, please refer to the drug lookup tool at healthnewengland.org.

- Certain tobacco cessation drugs are covered with no copay or deductible
- Compounded drugs under $100 that do not contain excluded ingredients
- Diabetes related drugs and supplies
- GLP-1 drugs that are FDA-Approved to treat diabetes
- Birth control drugs and devices that have been approved by the FDA
- Hormone Replacement Therapy (HRT) prescription drugs
- Long term antibiotic therapy for the treatment of Lyme disease

- Note: Cancer and HIV/AIDS are sometimes treated with drugs used "off label." This means that the drug usage and/or dosing has not been approved by the FDA. For these off label uses, Health New England requires approval in advance. These off label uses must meet set standards. The drugs and treatment methods must be recognized in one of these ways:
  - Through standard references
  - Through other medical literature or
  - By the Massachusetts Commissioner of Insurance
- Needles and syringes
- Opioid antagonists (drugs that block the effects of an opioid drug)
  - Generic: No charge for certain opioid antagonists
  - Brand/Formulary and Brand/Non-Formulary: No charge for certain opioid antagonists
- The following drugs are covered with no cost sharing (no copay, no deductible) when filled at an in-plan pharmacy. These items require a written prescription from a doctor:
  - Prescription Drugs:
    - Generic prescription fluoride supplements for children without fluoride in their water source
  - Over-the-counter Drugs:
    - For women who become pregnant, generic prenatal vitamin supplements that include folic acid
    - Generic aspirin drugs for certain medical diagnoses and age ranges
  - For additional details or questions, please contact Health New England Member Services.

Prescription Benefits for Chronic Conditions

Health New England will cover 1 generic drug and 1 brand name drug (where available) to treat the following chronic conditions:

- Diabetes
- Asthma
- Coronary artery disease (CAD)
- Heart failure

What is Not Covered

- Vitamins not covered under the preventive list
- Experimental drugs
- Non FDA-approved drugs
- Non-prescription drugs, unless otherwise provided under the plan
- Drugs for cosmetic purposes
- Infertility drugs for donors
- Marijuana or other related drugs for medicinal use
- Drugs for Assisted Redrugive Technology (ART) and Intrauterine Insemination (IUI) cycles/attempts without prior approval
- Medical foods or supplements
- Diagnostic Agents
- Bulk Chemicals
- Drugs that are not medically necessary and/or appropriate
- Drugs considered to be plan exclusions by Health New England
- Compounded drugs that include certain ingredients not covered by Health New England
- GLP-1 drugs to non-diabetics to treat weight loss and associated comorbidities
- For more details or questions, please contact Health New England Member Services.

Prescription Drug Limitations

Prior Authorization Program

Prior authorization for certain prescription drugs is required. Health New England's pharmacy benefit manager (PBM) performs prior authorization review using Health New England approved criteria.

Health New England Step Therapy Program Guidelines

Step therapy is an approach to drug management and is part of the Health New England prior authorization program. Health New England requires you to first try certain drugs to treat your medical condition before we will cover a different drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

The use of samples of the requested drug does not fulfill the requirement to bypass the trial of the first-line drug. If your doctor believes it is medically necessary for you to use a step therapy drug before trying a first line drug, they can request a prior authorization. Health New England's formulary contains all drugs requiring step therapy and the required trials to meet Health New England Step Therapy Program Guidelines.

Health New England will inform you (or your employer if you are in a group plan) in writing about drugs added to the step therapy program via an amendment to your EOC.

Health New England's Quantity Limit Program Guidelines

Health New England's Quantity Limit Program electronically checks prescriptions before they are filled to ensure the quantity and dosing is consistent with the FDA recommendations, encourages appropriate drug use, ensures patient safety, and avoids misuse, waste, and abuse.

Health New England sets quantity limits on most drugs to follow the FDA approved daily dosing guide, generally accepted pharmaceutical guidelines, and efficient dosing regimens. If your doctor believes it is medically necessary for you to use a quantity over Health New England's allowed limit, they will need to contact Health New England for a prior authorization.

Health New England will inform you (or your employer if you are in a group plan) in writing about drugs added to the quantity limit program via an amendment to your EOC. Health New England Member Services can provide you with an updated list of drugs with quantity limits. Please call Member Services or visit our online drug lookup tool at healthnewengland.org.

Health New England's Clinical Review Period Guidelines

Health New England does not cover drugs during the Clinical Review Period. If your doctor feels that it is medically necessary to prescribe this drug, they may request an exception. At the end of the clinical review period, Health New England may decide not to cover the drug. If this happens, Health New England will not cover the drug after the clinical review period.

Health New England's Medical Necessity Guidelines

Covered drugs must be medically necessary. If your doctor believes it is medically necessary for you to use a drug that is not covered, they can request a prior authorization. Please call Member Services or visit our online drug lookup tool at healthnewengland.org.

Health New England's Program for the Safe Use of Opioid Drugs

Health New England monitors the use of prescription opioid drugs. This program includes short-acting, long-acting, and opioid-based cough medications.

Short-acting opioids (i.e oxycodone immediate release) have both days' supply and dosing limits. Prior authorization is needed over these limits. Long-acting opioids (i.e. fentanyl) and opioid-based cough drugs (i.e. guaifenesin with codeine) require prior authorization on first fill.

Online Access to Pharmacy Information through OptumRx

OptumRx, Health New England's pharmacy benefits manager (PBM), has an easy-to-use online portal for members. Visit the OptumRx portal via MyHNE secure member portal at healthnewengland.org. This portal gives information about your pharmacy benefits and access to features such as claim details, mail order, refill reminders, drug pricing, and pharmacy locations.

Obtaining Prescriptions

Access 90 Program

This program allows members to receive up to a 90-day supply of maintenance drugs at participating retail pharmacies. Members pay three times their 30-day copay for any retail 90 prescriptions. Find out if your drug qualifies by visiting our drug look-up tool on healthnewengland.org or by calling Health New England Member Services.

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 cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Health New England cumpre as leis de direitos civis federais aplicáveis e não exerce discriminação com base na raça, cor, nacionalidade, idade, deficiência ou sexo.

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). 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). 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).

One Monarch Place • Suite 1500
Springfield, MA 01144-1500
healthnewengland.org

Health New England

Chiropractic Services Benefit	
HMO	**Office Visit Copay: $20**
This benefit is administered by OptumHealth Care Solutions, Health New England's chiropractic services manager.	
What your plan covers	• We cover 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, you will not be held financially liable for the services. • We will cover your visits with an In-Plan chiropractor. A $20 Copay applies for each visit. Copays you pay for chiropractic services are applied to your Plan's Out-of-Pocket Maximum.
Exclusions	• Maintenance care (Care given to reduce the incidence or prevalence of illness, impairment, or risk factors, or to promote optimum function) • Orthotics • Services that are not medically necessary • Services with an Out-of-Plan chiropractor • Exclusions or limitations included in the Explanation of Coverage.
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

Health New England

Pediatric Dental Services for Children under Age 19

Your coverage with Health New England includes dental services for Members under age 19. Altus Dental Insurance Company administers these services.

If someone covered under your Health New England policy is under the age of 19, Altus Dental will send an ID Card and a *Certificate of Coverage* (*Certificate*). All services are subject to the terms described in that *Certificate*. To be covered, services must be dentally necessary and appropriate as per Altus Dental review guidelines.

The charts on the following pages are a brief summary of the benefits Altus Dental provides. For a full description of pediatric dental benefits, see the *Certificate of Coverage* from Altus Dental.

Important Note: Check your Health New England Explanation of Coverage to see if your Cost Sharing for pediatric dental services goes toward your Health New England plan Out-of-Pocket Maximum.

How to Contact Altus Dental

By telephone:	Toll free Customer Service at **(877) 223-0588** Customer Service representatives are available Monday – Thursday from 8 a.m. to 7 p.m., and Friday from 8 a.m. to 5 p.m.
By mail:	Altus Dental Insurance Company, Inc. P.O. Box 1557 Providence, RI 02901-1557
Website:	altusdental.com

Deductible and Maximums

Plan Year Deductible (applies to certain services only)	$50 per individual $150 per family	This is the dollar amount you must pay first before the plan will make any payment for certain covered services.
Plan Year Maximum	None	There is no maximum for what the plan will pay for all covered services received in a plan year.
In Network Out-of-Pocket Maximum	$350 per individual $700 per family	This is the most each covered person will pay for all covered services received from a participating dentists in a plan year.
Out of Network Out-of-Pocket Maximum	None	There is no maximum for what each covered person will pay for all covered services received from a non-participating dentist in a plan year.

Summary of Covered Dental Procedures

Below is a description of covered services under your plan. The chart shows what you pay **after the plan year deductible is met**. Your *Certificate* will provide you with more information about your dental plan. Refer to the "Services Not Covered by the Plan" section of your Certificate for further limitations in coverage.

ℙ Indicates Pre-Treatment Estimate recommended for this service

𝔻 Indicates deductible applies to this procedure

Procedure	You Pay		Frequency/Limitations†
	In-Network	Out-of-Network✱	
Diagnostic			
Oral exam	0%	20%	Twice per policy year
Comprehensive Exam	0%	20%	Twice per lifetime per dentist location
Bitewing x-rays	0%	20%	Two sets per policy year
Complete x-ray series and panoramic film.	0%	20%	Once every 36 months
Single tooth x-rays	0%	20%	As required

† Time limits on services (e.g. 6, 12, 24, 36, or 60 months) are computed to the exact day. Services are then covered the following day. For example, when a service is covered once every 12 months, if the service was done on July 1, it will not be covered again until the following year on July 2 or after.

✱ Out-of-Network care: For services received out-of-network, your costs may be greater than shown because non-participating dentists are paid at a reduced level. Please refer to your Certificate of Coverage for further details.

Procedure	You Pay		Frequency/Limitations†
	In-Network	Out-of-Network*	
Preventive			
Cleaning	0%	20%	Twice per policy year
Fluoride treatment	0%	20%	Once every 3 months
Sealants	0%	20%	Once every 36 months on unrestored molars
Space maintainers.	0%	20%	
Minor Restorative			
Amalgam (silver) fillings	25% 𝔻	45% 𝔻	Once per 12 months per tooth surface
Composite (white) fillings	25% 𝔻	45% 𝔻	Once per 12 months per tooth surface
Stainless steel crowns	25% 𝔻	45% 𝔻	
Rebasing or relining of partial or complete dentures	25% 𝔻	45% 𝔻	Once every 24 months
Recementing crowns and onlays.	25% 𝔻	45% 𝔻	
Major Restorative			
ℙ Crowns (over natural teeth when teeth cannot be restored with regular fillings). Stainless steel crowns are covered at a different coinsurance amount.	50% 𝔻	70% 𝔻	Replacement limited to once every 60 months
Endodontics			
Root canal therapy on permanent teeth.	25% 𝔻	45% 𝔻	One procedure per tooth per lifetime
Vital pulpotomy.	25% 𝔻	45% 𝔻	One procedure per tooth per lifetime
Apicoectomy	25% 𝔻	45% 𝔻	One procedure per tooth per lifetime
Periodontics			
ℙ Root planning and scaling	25% 𝔻	45% 𝔻	Once per quadrant every 36 months
Prosthodontics			
ℙ Partial and complete dentures	50% 𝔻	70% 𝔻	Replacement limited to once every 60 months

† Time limits on services (e.g. 6, 12, 24, 36, or 60 months) are computed to the exact day. Services are then covered the following day. For example, when a service is covered once every 12 months, if the service was done on July 1, it will not be covered again until the following year on July 2 or after.

* Out-of-Network care: For services received out-of-network, your costs may be greater than shown because non-participating dentists are paid at a reduced level. Please refer to your Certificate of Coverage for further details.

Procedure	You Pay		Frequency/Limitations†
	In-Network	Out-of-Network*	
Extractions and Oral Surgery			
Simple extractions not requiring surgery	25% 𝔻	45% 𝔻	One procedure per tooth per lifetime
Surgical extractions & other routine oral surgery when not covered by a patient's medical plan.	25% 𝔻	45% 𝔻	One procedure per tooth per lifetime
Orthodontics			
ℙ Medically necessary braces & related services Requires prior authorization. No payment will be made if not obtained.	50%	70%	Covered only when medically necessary; patient must have severe and handicapping malocclusion as defined by HLD index score of 28 and/or one or more auto qualifiers. One procedure per lifetime.
Other Services			
Palliative treatment (minor procedures necessary to relieve acute pain)	25% 𝔻	45% 𝔻	
General anesthesia or intravenous (I.V.) sedation	25% 𝔻	45% 𝔻	

† Time limits on services (e.g. 6, 12, 24, 36, or 60 months) are computed to the exact day. Services are then covered the following day. For example, when a service is covered once every 12 months, if the service was done on July 1, it will not be covered again until the following year on July 2 or after.

* Out-of-Network care: For services received out-of-network, your costs may be greater than shown because non-participating dentists are paid at a reduced level. Please refer to your Certificate of Coverage for further details.