EXPLANATION OF COVERAGE

It is important to read any Amendments and Riders to your Explanation of Coverage (EOC). Amendments and Riders may change or replace parts of the EOC.

We explain your benefits for prescription drugs, chiropractic care (if covered by your plan), and children’s preventive dental services (if covered by your plan) at the end of 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 1.877.MA.ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan meets Minimum Creditable Coverage standards that are in effect January 1, 2016 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, 2016. 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.
INTERPRETER AND TRANSLATION SERVICES

This is important information. You can call HNE Member Services to have this information read to you. We can answer your questions in English or Spanish. For other languages, HNE has language interpreter services available. Our hours are Monday through Friday from 8:00 AM to 6:00 PM. Translation services are FREE for our members.

(Spanish)
Esta es información importante. Puede llamar a Servicios de Atención al Miembro de HNE para solicitar la lectura de esta información. Podemos responder a sus preguntas en inglés o español. Para otros idiomas, HNE cuenta con servicios disponibles de intérpretes. Nuestro horario de atención es de lunes a viernes, de 8:00 a. m. a 6:00 p. m. Los servicios de traducción son GRATUITOS para nuestros miembros.

(Portuguese)
Esta informação é importante. Pode contactar os Serviços de Membros HNE para que esta informação lhe seja lida. Podemos responder às suas perguntas em inglês ou espanhol. Para outros idiomas, a HNE dispõe de serviços de interpretação linguística. O nosso horário é de segunda a sexta-feira, das 8h00 às 18h00. Os serviços de tradução são GRATUITOS para os nossos membros.

(Italian)
Informazioni importanti. Per richiedere la lettura di tali informazioni può contattare il servizio HNE Member Services. Possiamo rispondere alle Sue domande in inglese o spagnolo. Per le altre lingue, HNE dispone di un servizio di interpretariato. I nostri uffici sono aperti da lunedì a venerdì, dalle 8:00 alle 18:00. I servizi di traduzione sono GRATUITI per i nostri membri.

(Russian)
Это важная информация. Для получения информации Вы можете позвонить в Службу сервиса для членов HNE. Мы можем ответить на Ваши вопросы на английском или испанском языках. Для других языков HNE предоставляет услуги устного переводчика. Мы работаем с понедельника по пятницу с 8:00 до 18:00. Услуги перевода для наших членов БЕСПЛАТНЫ.

(Haitian Creole)
Sa se enfòmasyon ki enpòtan. Ou kapab rele Sèvis Manm HNE pou fè yo li enfòmasyon sa yo pou ou. Nou kapab reonn kesyon ou yo nan lang Anglè oswa Panyòl. Pou lòt lang yo, HNE gen sèvis enterpèt lang ki disponib. Orè nou se lendi jiska vandredi depi 8:00AM jiska 6:00PM. Sèvis tradiksyon an GRATIS pou manm nou yo.

(Greek)
Σημαντικές πληροφορίες. Μπορείτε να καλέσετε το τμήμα εξυπηρέτησης πελατών της HNE για να σάς διαβάσουν τις πληροφορίες. Μπορούμε να απαντήσουμε στις ερωτήσεις σας στα Αγγλικά ή τα Ισπανικά. Για άλλες γλώσσες, η HNE διαθέτει υπηρεσίες διερμηνείας. Οι ώρες λειτουργίας μας είναι από Δευτέρα έως Παρασκευή, 8:00 π.μ. έως 6:00 μ.μ. Οι μεταφραστικές υπηρεσίες είναι ΔΩΡΕΑΝ για τα μέλη μας.

(French)
Ce document contient des informations importantes. Vous pouvez appeler notre équipe d’HNE Member Services afin que ce document vous soit lu. Nous pouvons répondre à vos questions en anglais ou en espagnol. Pour les autres langues, HNE fait appel à des services d’interprétation. Nous sommes ouverts du lundi au vendredi, de 8 h à 18 h. Les prestations de traduction sont GRATUITES pour nos membres.
If you have further questions, please call HNE Member Services at 413.787.4004 or 800.310.2835
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- Amendment 01-2015-bas – General Benefit and/or Administrative Changes
- Amendment 02-2015 – General Benefit and/or Administrative Changes
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If you have further questions, please call HNE Member Services at 413.787.4004 or 800.310.2835
AMENDMENTS TO THIS EXPLANATION OF COVERAGE

AMENDMENT 03-2014-posppo

This is an Amendment to your Health New England, Inc. Explanation of Coverage (EOC). Please keep this Amendment with your EOC as it changes the terms of that EOC. Any language in the EOC that does not follow the terms of this Amendment no longer applies. This Amendment is effective upon group renewal on or after July 1, 2014, unless noted below.

The EOC is amended as follows:

<table>
<thead>
<tr>
<th>Benefit, Program, or Requirement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HNE Service Area</strong></td>
<td>The HNE Service Area has expanded to include all of Worcester County. The HNE Service Area consists of these Massachusetts counties: Berkshire, Franklin, Hampden, Hampshire, Worcester</td>
</tr>
<tr>
<td><strong>Services and Procedures that require Prior Approval</strong></td>
<td>HNE covers Photochemotherapy and Phototherapy only for the diagnoses specified in HNE’s Clinical Review Criteria for these services. You can find Clinical Review Criteria on hne.com, under Medical Policies. You can also request a paper copy from Member Services. HNE will allow up to an initial 36 visits without Prior Approval. For continued treatment you must have Prior Approval every three months. Prior Approval will only be given if your doctor has recorded that your condition has improved.</td>
</tr>
<tr>
<td><strong>Clarification: Screening Colonoscopy or Sigmoidoscopy</strong></td>
<td>HNE covers one screening colonoscopy or one screening sigmoidoscopy every five Calendar Years. This benefit is for only one procedure or the other (not one of each) every five Calendar Years.</td>
</tr>
<tr>
<td><strong>Applied Behavioral Analysis (ABA)</strong> (Note: Applies to PPO and POS plans only.)</td>
<td>HNE requires Prior Approval for all ABA services. If you obtain ABA services from an In-Plan PHCS provider or an Out of-Plan provider when you do not have Prior Approval, you will be responsible for all charges.</td>
</tr>
</tbody>
</table>
**AMENDMENT 01-2015-bas**

This is an Amendment to your Health New England, Inc. Explanation of Coverage (EOC). Please keep this Amendment with your EOC as it changes the terms of that EOC. Any language in the EOC that does not follow the terms of this Amendment no longer applies. This Amendment is effective January 1, 2015, unless noted below.

The EOC is amended as follows:

<table>
<thead>
<tr>
<th>Benefit, Program, or Requirement</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Exclusions and Limitations**   | **Section 4 – Exclusions and Limitations**  
Effective June 20, 2014, this item is **removed** from the list of *Exclusions*:  
- Gender reassignment operations and treatments |
| **Services and Procedures that require Prior Approval** | **Section 5 – Claims and Utilization Management Procedures**  
Effective June 20, 2014, this item is **added** to the list of *Services and Procedures that Require Prior Approval*:  
- Gender reassignment operations and treatments  
Effective September 10, 2014, this item is **added** to the list of *Services and Procedures that Require Prior Approval*:  
- Mobi-C Artificial Cervical Disc  
The Mobi-C Artificial Cervical Disc was not a covered benefit prior to September 10, 2014.  
Effective December 1, 2014, this item is **added** to the list of *Services and Procedures that Require Prior Approval*:  
- Preimplantation Genetic Diagnosis (PGD) |
<p>| <strong>Clarification: Corrective Intraocular Lenses</strong> | Corrective intraocular lenses are not covered by HNE. Toric lenses are an example of the type of lenses not covered by HNE. |</p>
<table>
<thead>
<tr>
<th>Benefit, Program, or Requirement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low-dose Computed Tomography Screening for Lung Cancer</td>
<td>Effective January 1, 2015 HNE covers screening for lung cancer with low-dose computed tomography. The screening is covered only for adults ages 55 to 80. Members must be in a high risk category for developing lung cancer. The screening must be approved by the vendor HNE uses to review high cost imaging services. These services can be best provided at a facility with a lung cancer program. HNE has determined which facilities have such a program. When the screening is done at one of these facilities, the Member will not be responsible for a Deductible or Copay. If the screening is done at any other facility, the services will be covered subject to any Deductible and Copay your plan may have. You can contact Member Services to find out what facilities HNE has specified for these services.</td>
</tr>
<tr>
<td>Time limits for HNE’s Response to Complaints and Appeals</td>
<td>Section 6 – Inquiries and Grievances The time limit within which HNE must respond to complaints and appeals is changed from “30 business days” to “30 calendar days.” This applies to: • Complaints • Benefit appeals (pre-service and post-service) • Clinical appeals (pre-service and post-service) • Time extensions you agree to. For example you may agree to a time extension related to a signed release for medical records. • New time limits when HNE offers to reconsider a decision. This change is effective March 14, 2014.</td>
</tr>
<tr>
<td>Clarification: Reimbursement for Covered Services Received from Out-of-Plan Providers</td>
<td>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 hne.com or call Member Services. HNE may require you to supply documents that show the services you received were Medically Necessary and/or Covered Services under your plan. If HNE determines that the services you received were not Covered Services or were not Medically Necessary, we may deny coverage. If HNE denies coverage, you will be responsible for the cost of the services. Please note: If you have an 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.</td>
</tr>
<tr>
<td>Benefit, Program, or Requirement</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| **Cost Estimator for Services & Out-of-Pocket Costs** | HNE now has a way for you to 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 maximum allowed amount or charge for a proposed admission, procedure or service.  
  - The estimated amount you will be responsible to pay for a proposed admission, procedure, or service. This includes any Deductible, Copay, Coinsurance, facility fee or other amount you pay. This will be based on the information HNE has at the time the request is made. The service must be a Medically Necessary covered benefit.  

If 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/TTD users call 800.439.2370.  
  - Email us at memberservices@hne.com.  
  - Go to hnedirect.com and log on as a Member. |
### AMENDMENT 02-2015

This is an Amendment to your Health New England, Inc. Explanation of Coverage (EOC). Please keep this Amendment with your EOC as it changes the terms of that EOC. Any language in the EOC that does not follow the terms of this Amendment no longer applies. This Amendment is effective on July 1, 2015, unless noted below.

The EOC is amended as follows.

<table>
<thead>
<tr>
<th>Benefit, Program, or Requirement</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Clarification:** Member Reimbursement for Services from Out-of-Plan Providers** | **Section 1 – Introduction**  
**Section 5 – Claims and Utilization Management Procedures**  
Claims for member reimbursement for services from Out-of-Plan providers must be received by HNE within one year from the date of the services. Member Cost Sharing* will apply to services from Out-of-Plan providers. |
| **Hospital Observation – Member Cost Sharing** | **Section 3 – Covered Benefits – Observation Room**  
Effective July 1, 2015, our explanation of the benefit for “Observation Room” is replaced with the text below.  
**Observation room**  
If you are in a hospital in observation status:  
- Health New England 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, if it applies. |
| **Substance Abuse Services** | **Section 3 – Covered Benefits – Behavioral Health (Mental Health and Substance Abuse Services)**  
Effective July 1, 2015, the following is added to the list of “What is Covered.”  
- Medically Assisted Therapies (MAT) for opioid addiction  
Member Cost Sharing* may apply.  
Effective October 1, 2015, the following is added to the list of “What is Covered.”  
- Clinical Stabilization Services (CSS) for treatment of substance abuse. (CSS is a 24 hour treatment program. It usually follows an inpatient detoxification. Prior Approval is not required when you use In-Plan providers.) |

* Member Cost Sharing is what you pay for Deductibles, Copays, or Coinsurance.

If you have further questions, please call HNE Member Services at 413.787.4004 or 800.310.2835
<table>
<thead>
<tr>
<th>Benefit, Program, or Requirement</th>
<th>Description</th>
</tr>
</thead>
</table>
| Health Diagnostic Laboratory, Inc. | **Section 4 – Exclusions and Limitations**  
The following is *added* to the list of services and items that Health New England does *not* cover.  
  - Services by Health Diagnostic Laboratory, Inc. |
| Cologuard® Screening Test | **Section 4 – Exclusions and Limitations**  
The following is *added* to the list of services and items that Health New England does *not* cover.  
  - Cologuard® genetic test for colorectal cancer screening |
| Surgical Management of Morbid Obesity | **Section 4 – Exclusions and Limitations**  
Health New England will allow repeat procedures for the surgical treatment of morbid obesity. The repeat procedures must meet clinical review criteria. You may access and view this criteria on hne.com. Click on Member, then click on Medical Information, and then click on Medical Policies. To get a paper copy of the criteria, you can call Member Services at 800.310.2835. There is no charge to you for a paper copy.  
The following is *deleted* from the list of “Limitations and Partial Exclusions.”  
  - HNE covers only one surgical procedure per lifetime for the surgical management of morbid obesity. “Lifetime” means the life of the covered Member. |
Clarification: Infertility Benefit

Section 3 – Covered Benefits – Infertility Treatment

The text below replaces the text for “Infertility Treatment.”

**Infertility Treatment (Requires Prior Approval)**

Health New England covers all infertility procedures that are not experimental. This includes, but is not limited to the items below:

- 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
- Frozen Embryo Transfer where the recipient is the medically infertile HNE Member
- 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))

There are limits to the benefits. There are also some exclusions. Health New England must approve some services in advance. Health New England covers infertility services for Massachusetts and Connecticut residents only. This is defined in the terms of Health New England’s Infertility Protocol. You can ask Health New England Member Services to send you a copy of the Protocol. Health New England covers infertility services for a Connecticut resident only until her 40th birthday, as Connecticut law requires.

**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

Clarification: Surrogacy

Section 4 – Exclusions and Limitations

The following is added to the list of services and items that Health New England does not cover.

- Any costs associated with any form of surrogacy, including gestational carriers
<table>
<thead>
<tr>
<th>Benefit, Program, or Requirement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender Reassignment Surgery</strong></td>
<td>Health New England has changed the clinical review criteria used for benefit decisions related to gender reassignment surgery. This change is effective January 1, 2015. This surgery requires Prior Approval. You may access and view this criteria on hne.com. Click on Member, then click on Medical Information, and then click on Medical Policies. To get a paper copy of the criteria, you can call Member Services at 800.310.2835. There is no charge to you for a paper copy.</td>
</tr>
<tr>
<td><strong>Changes to Health New England’s Clinical Review Criteria</strong></td>
<td>Health New England has changed the clinical review criteria used for benefit decisions related to the procedures listed below. These procedures require Prior Approval. You may access and view this criteria on hne.com. Click on Member, then click on Medical Information, and then click on Medical Policies. To get a paper copy of the criteria, you can call Member Services at 800.310.2835. There is no charge to you for a paper copy.</td>
</tr>
<tr>
<td>• Reduction Mammoplasty</td>
<td></td>
</tr>
<tr>
<td>• Abdominal Panniculectomy</td>
<td></td>
</tr>
<tr>
<td>• INFUSE Bone Graft – External</td>
<td></td>
</tr>
<tr>
<td>• Endothelial Keratoplasty – External</td>
<td></td>
</tr>
<tr>
<td>• Cochlear Implants</td>
<td></td>
</tr>
<tr>
<td><strong>Massachusetts Office of Patient Protection – Address Change</strong></td>
<td>Effective 12/31/2014, the mailing address for the Office of Patient Protection is:</td>
</tr>
<tr>
<td>Health Policy Commission</td>
<td></td>
</tr>
<tr>
<td>Office of Patient Protection</td>
<td></td>
</tr>
<tr>
<td>50 Milk Street, 8th Floor</td>
<td></td>
</tr>
<tr>
<td>Boston, MA 02109</td>
<td></td>
</tr>
<tr>
<td>The phone number and email address have not changed.</td>
<td></td>
</tr>
<tr>
<td><strong>Additional Preventive Services</strong></td>
<td>The items below will be covered as preventive services. Members will have no Cost Sharing for Deductibles, Copays, or Coinsurance when they use Health New England In-Plan providers.</td>
</tr>
<tr>
<td>• Behavioral Health counseling to promote a healthy diet and physical activity</td>
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<tr>
<td>This is for prevention of cardiovascular disease in adults who have known risk factors. Coverage for these services will be effective August 1, 2015.</td>
<td></td>
</tr>
<tr>
<td>• Low dose aspirin for women at risk for pre-eclampsia</td>
<td></td>
</tr>
<tr>
<td>Coverage for low dose aspirin will be effective September 1, 2015.</td>
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</table>
This is an Amendment to your Health New England, Inc. Explanation of Coverage (EOC). Please keep this Amendment with your EOC as it changes the terms of that EOC. Any language in the EOC that does not follow the terms of this Amendment no longer applies. This Amendment is effective on January 1, 2016, unless noted below.

The EOC is amended as follows.

<table>
<thead>
<tr>
<th>Benefit, Program, or Requirement</th>
<th>Description</th>
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<tr>
<td><strong>Phone and online video consultations through Teladoc™</strong></td>
<td>Health New England has added a benefit for 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. Member cost is the same as you would pay for a visit to your primary care provider (PCP). Teladoc is not intended to replace your PCP. Teladoc may follow up with your PCP after your consultation. To request a Teladoc consultation, call 800 Teladoc (800.835.2362) or visit Teladoc.com. Please note: Telehealth services are only available through Teladoc.</td>
</tr>
</tbody>
</table>
| **Services related to screening colonoscopies and sigmoidoscopies** | You will no longer be responsible for Copays, Coinsurance or Deductibles for the following when they are related to In-Plan screening colonoscopies and sigmoidoscopies:  
  - Preparation prescriptions  
  - Pathology services  
**Effective: Immediately** |
| **Sleep Studies and related Positive Airway Pressure devices** | You must have Prior Approval for sleep studies. This applies both to home sleep studies and to sleep studies done in a facility. You must also have Prior Approval for Positive Airway Pressure devices and supplies that may be prescribed as a result of a sleep study. These devices include, for example:  
  - CPAP (Continuous Positive Airway Pressure device)  
  - BiPAP (Bi-level Positive Airway Pressure device)  
  - Pressure Support Ventilator  
**Effective Date: February 1, 2016** |
<table>
<thead>
<tr>
<th>Benefit, Program, or Requirement</th>
<th>Description</th>
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<tbody>
<tr>
<td>Nuclear Cardiac Imaging</td>
<td>You must get Prior Approval for Nuclear Cardiac Imaging done in all outpatient settings. This includes outpatient facilities and doctors’ offices. You do not need Prior Approval for these services when they are provided in an emergency room or during an inpatient stay.</td>
</tr>
</tbody>
</table>
| Infertility Treatment           | Correction to Amendment 02-2015  
  The following is removed from the list of covered infertility procedures:  
  - Frozen Embryo Transfer where the recipient is the medically infertile HNE Member. |
| Infertility Treatment for Connecticut Residents | Section 3 – Covered Benefits – Infertility Treatment  
  Connecticut state law has changed with regard to how infertility services are covered. Services for Connecticut residents will not be restricted to Members under the age of 40. HNE’s infertility protocol will include this change. |
| Substance Abuse Services – Clarification | Clinical Stabilization Services (CSS) and Acute Treatment Services (ATS)  
  Health New England covers CSS and ATS for the treatment of substance abuse. Prior Approval is not required when you use an In-Plan facility licensed by the Massachusetts Department of Public Health. Your provider must contact Health New England within 48 hours of the admission. After the first 14 days of your stay, we may review whether your care continues to be Medically Necessary and appropriate. This 14 days is a combined total for CSS and ATS.  
  **PPO and POS members only**  
  If you use an Out-of-Plan facility, you must have Prior Approval.  
  **Services by a Licensed Alcohol and Drug Counselor I (LADC-I)**  
  HNE covers services by licensed alcohol and drug counselors who have a Massachusetts LACD-I level license. |
| Services Not Covered – Clarification | Section 4 – Exclusions and Limitations  
  The following is added to the list of exclusions:  
  - Laser hair removal |
<table>
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<tr>
<th>Benefit, Program, or Requirement</th>
<th>Description</th>
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| Prior Approval for High Cost Infusion Drugs | **Section 5 – Claims and Utilization Management Procedures**  
The following is added to the list of “Services and Procedures that require Prior Approval”:

- Infusion therapy is when a drug is delivered through a needle or catheter into a vein. Some drugs can be delivered by a subcutaneous infusion. (That is, delivered through a needle that is placed into the fatty tissue just below the skin’s first layer.) Some high cost infusion drugs require Prior Approval. These drugs are not a part of your prescription drug benefit. They are part of your Medical Benefit. To find out if a certain infusion drug requires Prior Approval, your provider can check the Pharmacy “Drug Lookup” on hne.com. |

**Effective Date: January 4, 2016**

| HMO Members – Residency Requirement Clarification | **Section 7 – Eligibility**  
For HMO plans, the following replaces the text under “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. |

| If you or a family member is covered by more than one insurance | When anyone has coverage with Health New England 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. We will determine which insurance is the primary payer (pays first) based on rules used throughout the industry, or as the law requires. **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. |
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 contracts with 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 hne.com

HNE updates the Plan Provider Directory each year. We may update it during the year, too. Providers are free to join or leave the network at any time. Some In-Plan Providers may have left or joined the HNE network since the last Directory was printed. Please call us or go to hne.com for the most up-to-date list of In-Plan Providers. The HNE website is updated weekly. HNE cannot guarantee that any provider or group of providers will continue to be In-Plan Providers.
HNE has a specific service area. It includes in Massachusetts:

- Hampden County
- Hampshire County
- Franklin County
- Berkshire County
- Parts of Worcester County

How the Plan Works

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.

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

Each month your employer pays HNE 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.

This HNE PPO Plan Offers Two Levels of Coverage:

1. In-Plan level of coverage

   - With HNE providers in the HNE Service Area
     Providers who contract directly with HNE are considered In-Plan. These providers are listed in the HNE Provider Directory. When you see an HNE provider, you pay the HNE In-Plan Copay or Coinsurance.

   - With (Private Healthcare Systems) PHCS providers outside the four counties of Western Massachusetts: Hampden, Hampshire, Franklin and Berkshire
     Providers who contract with PHCS are considered In-Plan. These providers are listed in the PHCS Provider Directory. When you see a PHCS provider, you pay the HNE In-Plan Copay or Coinsurance for most services. Certain services require that you notify HNE or a Reduction of Benefit applies.
2. **Out-of-Plan level of coverage**
   - *With providers not contracted with HNE or PHCS.*
     When you see a provider not contracted with HNE or PHCS the Plan pays at the Out-of-Plan level of benefits and you pay the Deductible and Coinsurance.
   - *With PHCS providers in the four counties of Western Massachusetts and the provider is not contracted with HNE: Hampden, Hampshire, Franklin and Berkshire*
     When you see a PHCS provider in Hampden, Hampshire, Franklin, or Berkshire County, and the provider is not contracted with HNE, the Plan pays at the Out-of-Plan level of benefits and you pay the Deductible and Coinsurance. Certain services require that you notify HNE or a Reduction of Benefit applies.

Some services require Prior Approval at the In-Plan and Out-of-Plan level of coverage.

### Summary Chart

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<thead>
<tr>
<th></th>
<th>In-Plan</th>
<th>Out-Of-Plan</th>
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<tbody>
<tr>
<td>HNE Providers</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>PHCS – Out of Four Counties</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>All Other Providers</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>PHCS – Within Four Counties</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

#### In-Plan Level of Benefits (Care from In-Plan Providers)
When you use Plan Providers, you will not have to submit claim forms. Covered Services from Plan Providers are paid at the In-Plan level and are covered in full, except for any Deductibles, Copays and Reductions of Benefit listed in this EOC. See "Your Payment Responsibilities" below.

#### Finding an HNE Provider
To find out what hospitals, doctors and providers participate with HNE:
- Check your HNE Provider Directory
- Call HNE Member Services at the number at the bottom of this page
- Check hne.com

Printed Provider Directories are updated annually. We may update it during the year, too. Our web site is updated weekly. Plan Providers are free to join and leave our network at any time. HNE cannot guarantee that the providers listed in our Directory are In-Plan Providers. Call Member Services if you are not sure. HNE In-Plan Providers are independent contractors. HNE does not control how they perform their work or provide services.

#### Finding a PHCS Provider
To find out what hospitals, doctors and providers participate with PHCS:
- Check your Provider Directory
- Call PHCS at 800.922.4362
- Visit the PHCS website at phcs.com.

Please note that a physician may be located at a PHCS hospital but not participate with PHCS. You should verify that the physician you will be seeing participates with PHCS.
Out-of-Plan Level of Benefits (Care from Out-of-Plan Providers)

Under the Plan, you may also use providers who do not participate with HNE. We call these providers “Out-of-Plan Providers.” When you use Out-of-Plan Providers, your level of coverage is lower.

Section 2 of this EOC contains more detailed information on how to get Covered Services from:

- In-Plan Providers (the In-Plan level of benefits)
- Out-of-Plan Providers (the Out-of-Plan level of benefits).

The Summary of Benefit Chart in Appendix A outlines your payment responsibilities.

Your Payment Responsibilities

Deductible for Medical Services

For some In-Plan services and most Out-of-Plan services you must pay a Deductible before the Plan begins to pay. The Chart of Benefits in Appendix A shows whether or not the Deductible applies. This Deductible may be based on a Calendar Year or a Policy Year. Calendar Year and Policy Year are defined in the “Definitions” section of this EOC.

Services from In-Plan Providers

A Deductible applies to some services from In-Plan Providers. For most services from In-Plan Providers, you pay a Copay or Coinsurance. A Copay is a set dollar amount. Coinsurance is a percentage. For those services requiring Prior Approval, your payment responsibility will be lower if you obtain that Prior Approval. See Section 5 of this EOC for a list of those services. In certain cases, if you do not obtain Prior Approval when required, you must pay a Copay or Coinsurance and you may have a Reduction of Benefit.

Copays, Coinsurance, and Reductions of Benefits are listed in the Summary of Benefit Chart in Appendix A. 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.

Emergency Care

If you are admitted to an In-Plan Hospital on an inpatient basis directly from the emergency room, you will not have to pay the emergency room Copay. You will, however, have to pay any applicable Deductible and hospital admission Copay. If your visit does not result in an admission, you must pay the Copay for that ER visit. HNE will not pay for Non-Emergency care received in an emergency room.

This plan has an Out-of-Pocket Maximum for services from In-Plan Providers. The amount of this 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)

Services from Out-of-Plan Providers

A Deductible applies to most services from Out-of-Plan Providers. After you meet your Deductible, HNE will pay a percentage of its Allowed Amount, and you pay the Copay or Coinsurance shown in the Summary of Benefit Chart in Appendix A. If the Out-of-Plan Provider’s charge is more than HNE’s Allowed Amount, the provider may bill you for the difference (the “Remaining Balance”). You are financially responsible for this Remaining Balance. This is in addition to the Deductible, Coinsurance, and any applicable Copay. This plan has an Out-of-Pocket Maximum for medical services from Out-of-Plan Providers. The amount of this Out-of-Pocket Maximum is shown in the

If you have further questions, please call HNE Member Services at 413.787.4004 or 800.310.2835
Summary of Benefit Chart in Appendix A of this EOC. This amount is the most you will pay in a Policy Year for the combined cost of your Medical Deductible and Coinsurance for Covered Services from Out-of-Plan Providers.

For those services requiring Prior Approval, your payment responsibility will be lower if you obtain that Prior Approval. See Section 5 of this EOC for a list of those services. In certain cases, if you do not obtain Prior Approval when required, you must pay your Deductible, Coinsurance or Copay and you may have a Reduction of Benefit. Some services are not covered without Prior Approval.

**Emergency Care**
If you are admitted to an Out-of-Plan Hospital on an inpatient basis directly from the emergency room, you will not have to pay the emergency room Copay. HNE will pay 100 percent of the billed charges for Covered Services that you receive, less any applicable Deductible and inpatient admission Copay. If your visit does not result in an admission, you must pay the Copay for that ER visit. If you receive care from an Out-of-Plan Hospital for a problem that is not an Emergency, HNE will pay 80 percent of its Allowed Amount, after you meet the Deductible.

**In-Plan/Out-of-Plan Providers Combined**
You may receive care from both an In-Plan Provider and an Out-of-Plan Provider for the same medical condition. The Plan will pay for the services that you received based on each provider’s status. For example, you may be admitted to an In-Plan Hospital by an Out-of-Plan Doctor. The Plan will pay the In-Plan Hospital at the In-Plan level. The Plan will pay the Out-of-Plan Doctor at the Out-of-Plan level.

**Claims Payment Information**
For In-Plan Providers, you do not have to submit claims to HNE. In-Plan Providers do this for you. If you receive services from an Out-of-Plan Provider, show your HNE ID Card. Most 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 so, you may ask HNE to repay you. If you pay the bill, send HNE a copy of the bill, and proof that you paid it. 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.

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.”

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.

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
When you want to receive the In-Plan level of coverage, you may visit any In-Plan Provider. Just call the Provider to schedule an appointment. Certain services and procedures require Prior Approval by HNE. See Section 5 of this EOC for more information and a list of these services. You must notify HNE of admissions to PHCS hospitals and skilled nursing facilities. As soon as you know about a planned admission, call HNE Member Services. For emergency admissions, call us as soon as possible. The services you receive must be Medically Necessary.

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. The end of this section also describes how to get Mental Health or Substance Abuse Services.

To get the In-Plan level of coverage, 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 hne.com, or call Member Services.

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

Under this Plan, you can receive all of your care from Out-of-Plan Providers. However, your level of coverage will be lower. To get care from an Out-of-Plan Provider, just schedule your appointment and show your HNE ID Card.

For services within the HNE Service Area, you receive the highest level of coverage with HNE providers. For services outside of the HNE Service Area, you receive a higher level of coverage with PHCS providers than with Out-of-Plan Providers.

Certain services and procedures require Prior Approval by HNE. This is required even when you use Out-of-Plan Providers. Please see the “Claims and Utilization Management Procedures” section of this EOC for a list of these procedures. If you do not obtain Prior Approval, your level of coverage will be lower. You must notify HNE of admissions to Out-of-Plan hospitals and skilled nursing facilities. As soon as you know about a planned admission, call HNE Member Services. For emergency admissions, call us as soon as possible.

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

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. To get emergency care, seek medical care at once. Go to the nearest emergency room (ER) or dial “911.” To receive the In-Plan level of coverage, follow-up care must be provided by In-Plan Providers.

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.)

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.”

What if I am out of the HNE Service Area when an Emergency occurs?

If you receive the In-Plan level of benefits, follow-up care must be provided by In-Plan Providers.
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 if you wish to receive the In-Plan level of benefits, 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 hne.com, or call HNE Member Services.

How to Get Mental Health or Substance Abuse Services

Outpatient Services
To get outpatient treatment for mental health or substance abuse services:

- Call the provider of your choice directly. Your doctor, family member, or your 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 a psychiatrist or clinical nurse specialist.

To look up In-Plan behavioral health providers, please check your Provider Directory, visit hne.com, or call HNE Member Services at 413.787.4004 or 800.310.2835 (TTY: 800.439.2370). 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: 800.439.2370). Our staff can help you choose a provider based on the nature of your concerns, your location, and appointment availability.

Inpatient Services
Inpatient admissions do not require Prior Approval from HNE. The admitting facility must contact 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: 800.439.2370). To receive a higher level of coverage, all inpatient mental health and substance abuse services must be approved by HNE, regardless of whether you are using In-Plan or Out-of-Plan Providers.

Emergency Care
If you need mental health or substance abuse 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 mental health and substance abuse services, please see Section 3 of this EOC.
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
- 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. To receive a higher level of coverage for certain services, you must obtain HNE’s approval. To receive the In-Plan level of coverage, you must receive your care from In-Plan Providers, following HNE policies and rules.

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
You must notify HNE of admissions to Out-of-Plan hospitals and skilled nursing facilities. You must also notify HNE of admissions to PHCS facilities. As soon as you know about a planned admission, call HNE Member Services. For emergency admissions, call us as soon as possible.

Hospital Care
HNE covers hospital care. There is no limit on the number of days covered.

Acute Inpatient Rehabilitation
HNE covers this service in a licensed rehab facility. There is no limit on the number of days covered. 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
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.)

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.

**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 of federal guidelines. Information about MHQP’s guidelines is at mhqp.org, under the tab for guidelines. HNE provides Subscribers with the updated guidelines we use on an annual basis.

What is Covered
- MHQP immunizations
- Some Non-Routine immunizations, such as for:
  - Exposure to rabies
  - Exposure to hepatitis
- Many travel immunizations

Routine Eye Exams
HNE covers one Routine eye exam each Calendar Year.

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 mammographic exams, or mammograms, as follows:
- One baseline mammogram for women 35 – 40
- Once per year for women 40 and older
- At other times when Medically Necessary

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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 fecal occult blood tests for colorectal cancer screening.

Screening Colonoscopy or Sigmoidoscopy
HNE covers one screening colonoscopy or sigmoidoscopy every five Calendar Years.

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.

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.

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.

Physician Office Visits
HNE covers care you receive from physicians, including specialists. See Section 5 of this EOC for a list of services that require Prior Approval.
Obstetric/Gynecology
All female Members may receive the services listed below from an 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 a podiatrist. This includes treatment of podiatric diseases and conditions.

Second Opinions
HNE covers second opinions. You may visit any Provider. Your level of coverage will be higher if you see an In-Plan Provider.

Hearing Tests
HNE covers hearing tests.

Diabetic Related Items
HNE covers the items and services below to diagnose or treat diabetes. 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, HbA1c tests, urinary protein/microalbumin, and lipid profiles.

Durable Medical Equipment (DME)
HNE covers the following DME for diabetics:

- Blood glucose monitors.
- Continuous glucose monitoring devices (Prior Approval is required)
- Voice synthesizers for blood glucose monitors for use by the legally blind. (You must receive Prior Approval. If approved, these items are not subject to Coinsurance.)
- Visual magnifying aids for use by the legally blind.
- Insulin pumps. (You must receive Prior Approval for 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 following items:
- 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**
See Section 2 of this EOC for information about how to obtain Emergency Care. Remember that if you wish to receive the In-Plan level of benefits, all follow-up care must be received from In-Plan Providers.

**What is Not Covered**
- Non-emergency care provided in an emergency room

**Observation Room**
If you are sent to an observation room from an ER:
- HNE will pay for the observation room charges
- 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.

There is a limit on the number of sleep studies HNE covers. The limit is two sleep studies per Calendar Year. HNE covers home sleep studies.
Genetic Testing  
*(Requires Prior Approval)*
HNE covers genetic testing that is not experimental or investigational. Examples of genetic testing are:

- Testing for the breast cancer gene (BRCA)
- The Colaris test for hereditary colorectal, ovarian, and endometrial cancer

Lab Services
HNE covers lab services. Not all labs are In-Plan. If your doctor uses an Out-of-Plan lab, the Out-of-Plan level of benefits will apply to the lab services.

*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)*
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 a doctor’s office

If your doctor is In-Plan, he or she will get Prior Approval for you. If you see an Out-of-Plan Provider, make sure they contact HNE before your exam. Please note that you will be responsible for all costs:

- If the request for Prior Approval for services from an In-Plan HNE Provider is denied.
- If you do not request Prior Approval for services from an Out-of-Plan Provider.

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 two months or 25 visits (whichever is greater). The limit applies to each condition and each treatment type. The coverage for PT and OT as part of a home health plan is unlimited. 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 or disabilities that fall under MGL 71B (referred to as Chapter 766) are not covered. Member must seek benefits available under Massachusetts state law and seek a Chapter 766 evaluation. See Section 4 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**
HNE covers medically necessary services for the diagnosis and treatment of Autism Spectrum Disorder (ASD) as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Health Disorders. This includes autistic disorder, Asperger’s disorder, and pervasive developmental disorders not otherwise specified.

HNE covers medically necessary services to diagnose ASD. This includes:
- Neuropsychological evaluations (Prior Approval 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.

There is no annual or lifetime dollar or unit of service limit on the coverage for services to diagnose and treat ASD. All services are subject to applicable Copays, Coinsurance, and Deductibles.

*What is Not Covered*
- Services related to ASD provided by school personnel under an individualized education program
Outpatient Surgical Services and Procedures

(Some procedures require Prior Approval)

HNE covers the following outpatient surgical services. These are part of the Outpatient 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 Outpatient Surgical Services and Procedures depends on your HNE plan as explained below. See the Summary of Benefit Chart in Appendix A of the EOC for your responsibility for Outpatient Surgical Services and Procedures.

If the Summary of Benefit chart shows a $0 Copay for Outpatient Surgical Services and Procedures

You will not pay a Copay for surgical services in an ambulatory care facility or the outpatient department of a hospital. You may pay an office visit Copay for surgical services in a doctor’s office. The Summary of Benefit Chart shows office visit Copays.

If the Summary of Benefit chart shows Coinsurance (a percentage) for Outpatient Surgical Services and Procedures

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 does not have Coinsurance (a percentage) or a $0 Copay for Outpatient Surgical Services and Procedures

Some surgical services and procedures can be done in an outpatient facility or in a physician’s office. The Copay or Coinsurance you pay is based on the type of service you receive. It is not based on where the service was done.

Some Outpatient 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 Copay for Outpatient Surgical Services and Procedures 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)

If these services are done in an In-Plan physician’s office, you will have to pay a Copay for the office visit. You do not have to pay an Outpatient Surgical Service and Procedures Copay.

These services require you to pay an Outpatient Surgical Services and Procedures Copay:

- 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 the Copay that 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 covers patient care items and services provided in a clinical trial for cancer or another life threatening disease, as long as:

- The trial you are in is a “Qualified Clinical Trial” as defined under Massachusetts law or federal law
- The service or item:
  - is consistent with the usual and customary standard of care
  - is consistent with the study protocol for the clinical trial
  - would be covered if the Member did not participate in the 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
- Voluntary termination of pregnancy when allowed by Massachusetts law

**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.

**Infertility Treatment**  
*(Requires Prior Approval)*

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

- Artificial Insemination (AI)
- In Vitro Fertilization and Embryo Placement (IVF-EP)
- 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))

There are limits to the benefits and there are some exclusions. HNE must approve some services in advance. HNE covers infertility services for Massachusetts and Connecticut residents only. This is defined in the terms of HNE’s Infertility Protocol. You can ask HNE Member Services to send you a copy of the Protocol. HNE covers infertility services for a Connecticut resident only until her 40th birthday, as Connecticut law requires.

For assisted reproductive technologies and intra-uterine insemination procedures, you or your treating doctor must obtain HNE’s Prior Approval for services to be covered. If Prior Approval is not requested, you will be responsible for all costs.

**What is Not Covered**
- Sperm or egg banking not connected with approved infertility treatment
Maternity 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. This includes consultation for breast feeding and parent education.
- 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.)

What is Not Covered

- 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.

What is Covered

- Surgery to treat non-dental conditions
- 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 impacted teeth
- Removal of wisdom teeth
- Root canals
Other Services

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 doctor 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

(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 Member’s doctor 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.
Durable Medical Equipment, Prosthetic Equipment, and Medical and Surgical Supplies

(Some items require prior Approval)

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

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

To be covered, DME must meet the following 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.

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. Some repairs and maintenance requires Prior Approval.

- 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. Prior Approval from HNE is required for these items.

- HNE covers certain high cost equipment in full. HNE provides coverage for the full cost with no Member Coinsurance required. For a list of these items, see below or contact HNE Member Services. Prior Approval from HNE is required for these items.

HNE covers items such as:

- 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
- Hospital beds
- Infusion pumps
- Limb prostheses (artificial arms and legs)
- Ostomy supplies
- Oxygen and related supplies (not subject to Coinsurance)
- Respiratory equipment and related supplies
- Wheelchairs

**You must have Prior Approval from HNE for:**
- Automatic CPAP (APAP) device
- Bi-Level Positive Airways Pressure device
- Certain diabetic equipment and supplies (see Diabetic-Related Items in this section of the EOC)
- Certain repairs and maintenance of DME
- Certain wheelchairs, including but not limited to power wheelchairs
- Customized items and supplies
- Facial prostheses (including artificial eyes)
- Orthotics
- Prosthetic limbs
- Specialized beds/mattresses for wound care
- Wound care supplies
- High cost equipment including:
  - Air fluidized beds
  - Bone growth stimulators
  - Cochlear implants
  - Continuous glucose monitoring devices
  - High frequency chest wall compression devices / oscillation vests
  - Intrapulmonary percussive ventilation systems
  - Speech generating devices
  - Wearable external defibrillators
  - Wound vacuum systems

**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, strollers, and scooters
- Exercise or sports equipment
- External urinary catheters
- 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.)
- Hot tubs, saunas, Jacuzzis®, swimming pools, or whirlpools
- Incontinence products
- Repair or replacement of equipment or devices as a result of loss, negligence, willful damage, or theft
- Safety equipment (e.g., car seats, safety belts, harnesses or vests)
- Saunders Lumbar Hometrac®
- 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 items or services need Prior Approval
- 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.

- **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)*

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:

- 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. You must send a request for reimbursement to HNE Member Services. The request 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.

**Human 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 following 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.
- Corneal transplant. Contact lenses following a corneal 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. A Member only needs to be tissue typed once during his or her lifetime. Tissue typing is similar to blood typing. Like blood type, tissue type does not change. Therefore, coverage is limited to one test per Member per lifetime. All other uses of HLA testing are covered when Medically Necessary. This service requires Prior Approval.

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
Behavioral Health (Mental Health and Substance Abuse Services)

How to Get Services

Outpatient Services
To obtain outpatient treatment for mental health or substance abuse, you may call the provider of your choice directly. Your doctor, family member, or your 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 a psychiatrist or clinical nurse specialist. There is not annual limit to the number of medication management visits you may obtain.

To look up In-Plan behavioral health providers, please check your Provider Directory, or visit hne.com, or call HNE Member Services at 413.787.4004 or 800.310.2835 (TTY: 800.439.2370). If you need help choosing a provider, you may call HNE’s Health Services Department at 413.787.4004, ext. 5028, or 800.842.4464, ext. 5028 (TTY: 800.439.2370). Our staff can help you choose a provider based on the nature of your concerns, your location, and appointment availability.

Inpatient Services
Inpatient admissions do not require Prior Approval from HNE. The admitting facility must contact the HNE Health Services Department within one business day to obtain authorization for continued stay. For information please call HNE’s Health Services Department at 413.787.4000, ext. 5028, or 800.842.4464 ext. 5028 (TTY: 800.439.2370). To receive a higher level of coverage, inpatient mental health and substance abuse services from Out-of-Plan Providers must be approved by HNE.

Emergency Care
If you need emergency care, follow the steps listed in Section 2 of this EOC. See the information under the heading “How to Obtain Care in an Emergency.”

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

Mental Health Services
HNE will only cover mental health services when they are Medically Necessary. Mental health services may be provided by:

- 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

Mental health services may be provided in the inpatient settings listed below. Services must be rendered by a licensed mental health professional acting within the scope of his license.

- A general hospital licensed to provide such services
- A facility under the direction and supervision of the Department of Mental Health
- A private mental hospital licensed by the Department of Mental Health
• A substance abuse facility licensed by the Department of Mental Health

Mental health services may be provided in the outpatient settings listed below. Services must be rendered by a licensed mental health professional acting within the scope of his license.

• A licensed hospital
• A mental health or substance abuse clinic licensed by the Department of Public Health
• A public community mental health center
• A professional office
• A Member’s home

In order to receive a higher level of coverage, inpatient mental health services from Out-of-Plan Providers must be approved by HNE.

Biologically based mental disorders
HNE covers the following biologically based mental disorders, as these disorders are described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). This manual is published by the American Psychiatric Association.

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

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

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

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

• They must interfere with, or truly limit, the function or social interactions of a person less than 19 years old.
• The interference or limit must be important, and must be documented.
• The disorders also must be described in the DSM.
• The person must be referred by the PCP, the pediatrician, or a licensed mental health provider.
Here are some examples. Problems or disorders would qualify for coverage if:

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

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

- The time the course of treatment (in the treatment plan) is over; 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 admissions for these conditions.

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

Psychopharmacological services and neuropsychological assessment services
HNE covers these services to the same extent as all other medical services.

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

In order to receive a higher level of coverage, inpatient mental health services from Out-of-Plan Providers must be approved by HNE.

What is Covered and What is Not Covered

What is Covered

- Inpatient services
- Outpatient services
- Intermediate services – Sometimes outpatient services alone are not enough to meet a Member’s needs. These services provide a range of non-inpatient services for more intensive and extensive treatment. Coverage for these services is based on Medical Necessity. Services include but are not limited to the services listed below.
  - Level III community-based detox
  - Acute Residential Treatment (ART)
  - Partial Hospital Program (PHP) and Intensive Outpatient Program (IOP)
  - Day treatment
  - 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 Unit (CSU)
  - Family Stabilization Team (FST)

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 residential treatment programs and halfway houses)
• Services required by a third party or court order

You must have Prior Approval from HNE for:
• Partial Hospital Program (PHP) and Intensive Outpatient Program (IOP)
• Acute Residential Treatment (ART)
• Neuropsychological testing
• Repetitive Transcranial Magnetic Stimulation (rTMS)
• Family Stabilization Team (FST)

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 Copays, Coinsurance and Deductibles, for mental health conditions must be the same as those for medical conditions. Also, mental health office visit Copays must not be greater 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 following information on the Insurance Complaint Form:

1. Your name and address;
2. The nature of your complaint;
3. Your signature authorizing the release of any information to help the DOI with its review of the complaint.

A parity complaint is not the same as an appeal under your Plan. You may still need to file an appeal with HNE. Filing an appeal with HNE may be necessary to protect your right to continued coverage of treatment while you wait for an appeal decision. See the appeal procedures outlined in Section 6 of this 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 reimbursement program for qualifying fitness costs and Weight Watchers® programs. We will reimburse you up to a total of $150 per family per Calendar Year for qualifying fitness memberships and fees and qualifying Weight Watchers® programs. Call HNE Member Services for details.

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. Any service that Workers’ compensation or other third party insurer is legally responsible to pay
2. Any services provided by the Veterans Administration for disabilities connected to military service. There also must be facilities which are reasonable available for these Members.
3. Services provided under MGL Chapter 71B in Massachusetts (referred to as “Chapter 766”). Services provided under Section 10-76-A-d of the General Statutes in Connecticut. These services include, for example:
   • 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 Section 10-76A-d evaluation if you believe your child may be disabled. This includes:
   • Physical disability
   • Mental retardation
   • Learning problems
   • Behavioral problems
4. 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
   - Acupuncture (except certain specific Covered Services, if any, listed elsewhere in this EOC or riders to this EOC)
   - Chiropractic services (except certain specific Covered Services, if any, listed elsewhere in this EOC or riders to this EOC)
   - Spiritualdevotions or culturally based healing traditions such as Chinese, Ayurvedic, and Christian Science

5. Care or treatments by family members

6. Educational or vocational 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
   - Job retraining
   - Vocational and driving evaluations
   - Therapy to restore function for a specific occupation

7. Extracorporeal Shock Wave Therapy (ESWT) for chronic plantar fasciitis

8. Eyeglasses, contact lenses, laser vision correction surgery and orthoptics. See “Limitations and Partial Exclusions” later in this section for some exceptions.

9. Gender reassignment operations and treatments

10. Hearing aids or exams to prescribe, fit, or change them for Members over the age of 21

11. Intradiscal Electrothermal Therapy (IDET)

12. Litholink services

13. 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.)

14. Medical expenses in any government hospital or facility. Services of a government doctor or other government health professional.

15. Postoperative Disposable Ambulatory Regional Anesthesia (PDARA) and Cold Therapy Devices

16. Pulmonary Rehabilitation Phase III exercise maintenance program

17. Charges to ship or copy Member medical records

18. Charges for failing to keep an appointment

19. 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 unbalance 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.

20. Arch supports, corrective shoes, and inserts (except those for diabetic foot care)

21. Sales tax on health care services, DME or other items

22. 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.

23. Services you receive after the date your coverage ends

If you have further questions, please call HNE Member Services at 413.787.4004 or 800.310.2835
24. Special duty or private duty nursing and attendant services
25. Specialty clothing for specific medical conditions
26. Travel, transportation, and lodging expenses in connection with treatment or medical consultation
27. 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.

- HNE covers only one surgical procedure per lifetime for the surgical management of morbid obesity. “Lifetime” means the life of the covered Member.

- 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.

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

If you have further questions, please call HNE Member Services at 413.787.4004 or 800.310.2835
- 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
- Breast reduction for male enlarged breasts
- 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
- 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.

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. 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 so, you may ask HNE to repay you. If you pay the bill, send HNE a copy of the bill, and proof that you paid it. 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.

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 are:

- Abdominal Panniculectomy (removal of fat from the abdomen)
- Applied Behavior Analysis (ABA)
- Autologous Chondrocyte Transplant
- Biofeedback for urinary incontinence
- Cardiac monitoring (long term, 30-day)
- Certain medical equipment (refer to Section 3 of this EOC)
- Chair van services and non-emergency ambulance trips
- Cleft lip and cleft palate treatment
- Clinical trials for cancer and other life threatening diseases
- Cochlear implants
- Corrective surgery of the palate, uvula, or related structures for obstructive sleep apnea
- Dermal injections for the treatment of facial lipodystrophy syndrome (LDS)
- Diagnostic Imaging:
  - Computed Tomography (CT or CAT scans)
  - Magnetic Resonance Angiogram (MRA)
  - Magnetic Resonance Imaging (MRI)
  - Nuclear Cardiac Imaging in a doctor’s office
  - Positron Emission Tomography (PET scans)

*Requests for Prior Approval of these diagnostic imaging procedures will be reviewed by MedSolutions. You or your doctor can contact MedSolutions at 888.693.3211. If you have any questions, please call Member Services at the number at the bottom of the page.*

- Endothelial Keratoplasty
- Eyelid surgery
- Female breast reduction surgery
- Gastric Stimulator including Enterra® Therapy system (Medically Necessary to treat diabetic, idiopathic, or neurogenic gastroparesis)
- Genetic testing (for example BRCA and Colaris tests)
- Hearing aids (covered for Members age 21 and under)
- Home Health Care – Skilled home care services, including for example:
  - Home infusion
  - Home perinatal monitoring
  - Home skilled nursing care
• Home physical, occupational and speech therapy
• Hospice services
• Hospital and anesthesia services for dental procedures for Members with a serious medical condition
• Human organ transplants and bone marrow transplants
• Implantable miniature ocular telescope
• Infertility treatment: Members must meet the requirements of HNE’s Infertility Protocol. You may call HNE Member Services for a copy of the Protocol.
• INFUSE® Bone Graft
• Injectable drugs (Some injectable drugs require Prior Approval. These are not a part of your prescription drug benefit. They are part of your medical benefit. HNE is responsible for these drugs’ Prior Approval. To find out if an injectable drug requires Prior Approval, check HNE’s Drug Formulary on hne.com or call HNE Member Services.)
• Laser treatment for psoriasis
• Mandibular Advancement Device for obstructive sleep apnea
• Mental health and substance abuse services listed below. For Prior Approval call HNE’s Health Services Department at 800.842.4464 ext. 5028.
  • Partial Hospital Program (PHP) and Intensive Outpatient Program (IOP)
  • Acute Residential Treatment (ART)
  • Neuropsychological testing
  • Repetitive Transcranial Magnetic Stimulation (rTMS)
  • Family Stabilization Team (FST)
• Nutritional support (see Section 3 of this EOC)
• Oncogene typing associated with treatment for breast cancer
• Orthognathic surgery (jaw surgery)
• Orthotics
• Outpatient Hyperbaric Oxygen therapy (HBO)
• Prosthetic limbs
• Proton Beam Therapy
• Radiofrequency ablation for chronic spinal pain
• Rhinoplasty (“nose jobs”)
• Sacral nerve stimulation for urinary incontinence
• Scleral lenses
• Speech therapy after the initial evaluation
• Spinal cord stimulation
• Spinal Muscular Atrophy (SMA) testing
• Stretta® treatment for gastroesophageal reflux disease (GERD)
• Surgical management of obesity
• Total Ankle Replacement (TAR)
• Total hip resurfacing
• Transmembrane Activator and CAML Interactor (TACI) gene testing
• Any other services listed in this EOC that indicate that Prior Approval is needed

Prior Approval Process
To get Prior Approval, your treating doctor must contact HNE. The doctor can either send us a Prior Approval Request Form or contact HNE by phone.
HNE’s Health Services Department sends Prior Approval Request Forms to your doctor. HNE will decide whether the service is:

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

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

If HNE denies coverage for the services HNE will:

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

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

If your doctor has asked for Prior Approval, you may call 800.310.2835 (TTY: 800.439.2370) 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 and include applicable clinical practice guidelines and review criteria
- Offer your doctor or treating practitioner a case discussion or reconsideration (see below)
- Provide you with clear, concise information about:
  - 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

If you have further questions, please call HNE Member Services at 413.787.4004 or 800.310.2835
• 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.

<table>
<thead>
<tr>
<th>Type of Grievance</th>
<th>Example</th>
<th>HNE will respond within</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaint</td>
<td>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.</td>
<td>30 calendar days</td>
</tr>
<tr>
<td>Benefit Appeal</td>
<td>Appeal of a service or request that is denied as “not a covered benefit” because it is excluded from coverage by your plan.</td>
<td></td>
</tr>
<tr>
<td>Pre-Service</td>
<td>Appeal of a benefit denial for a service you have not received yet.</td>
<td>30 calendar days</td>
</tr>
<tr>
<td>Post-Service</td>
<td>Appeal of a benefit denial for a service you have already received.</td>
<td>30 calendar days</td>
</tr>
<tr>
<td>Clinical Appeal</td>
<td>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</td>
<td></td>
</tr>
<tr>
<td>Pre-Service</td>
<td>Appeal of a clinical denial for a service you have not received yet.</td>
<td>30 calendar days</td>
</tr>
<tr>
<td>Post-Services</td>
<td>Appeal of a clinical denial for a service you have already received.</td>
<td>30 calendar days</td>
</tr>
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### Overview: Grievances and Decision Time Frames

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</tr>
</thead>
<tbody>
<tr>
<td>Expedited Appeal</td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>
| Urgent Care                       | 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                         | 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)| 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) |
| Expedited Appeal for a terminally ill Member | 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
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
- Refer to and include the specific plan provisions on which the decision was based
- Specify alternative treatment options covered by HNE, if any
- Notify you of the process for requesting an external review or, where applicable, an expedited external review

If you have further questions, please call HNE Member Services at 413.787.4004 or 800.310.2835
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 60 business days of receipt of the request for review, unless it determines that it needs additional time. The panel may extend the time by an additional 15 business days. 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 four business days. 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: mass.gov/hpc/opp/
Email: HPC-OPP@state.ma.us
Address:
Health Policy Commission
Office of Patient Protection
Two Boylston Street, 6th Floor
Boston, MA 02116
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 age 26.

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. 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.

Subscribers

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
- For Groups of 50 or more eligible employees: An eligible retiree, as defined by the policy of the Group and as approved by HNE
- 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

Dependents

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 (QMSCO) to provide health coverage (See more about QMSCO below.)
- A disabled Dependent, as described later in this section

If you have further questions, please call HNE Member Services at 413.787.4004 or 800.310.2835
Adopted Dependents

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

Qualified Medical Child Support Orders (QMCSO)

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 child is in school and a serious illness or injury causes them to leave school or stop going full time?

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’s Chief Medical Officer (CMO) will decide if a dependent is qualified as a Disabled Child Dependent. This is at the sole discretion of the CMO. 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**

**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

**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 your Group’s annual Open Enrollment Period. There are certain events after which you can enroll a new dependent under your plan. These are: marriage, birth, adoption, and your dependent moving into the HNE Service Area. 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?

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

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

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.

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.

If you have further questions, please call HNE Member Services at 413.787.4004 or 800.310.2835
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. Your employer must submit and Enrollment/Add/Termination Form to HNE. HNE may also require documents that prove that 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. 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.

How do I enroll?
To enroll in HNE you must meet eligibility requirements of Section 7 of this EOC. You 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

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. 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

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 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
What Rights Do I Have When HNE Ends My Coverage?

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

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)

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

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 plan 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**

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**

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, or visit mahealthconnector.org, or
- 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) Have access, during business hours, to Member Services Representatives who can answer your questions and help solve problems.
h) 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.
i) Make recommendations regarding HNE’s Member rights and responsibilities policies.

Member Responsibilities
As a Member of HNE, you have certain responsibilities. These are to:
j) 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.
k) Follow the treatment plans and instructions for care that you have agreed on with your provider.
l) 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.
m) Follow all HNE policies and procedures.
n) Treat providers and HNE staff with the respect and courtesy that you would expect for yourself.
o) Arrive on time for appointments or give proper notice if you must cancel or will be late.
p) 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.
q) Participate in decision-making on your health care.
r) Inform HNE of any other insurance coverage you may have. This helps us process claims and work with other payers.
s) Notify us of status changes (such as a new address) that could affect your eligibility for coverage.
t) 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.

u) 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 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.

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 have certain diagnostic imaging procedures from 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 is requiring this information to coordinate Medicare benefits and payments. To comply with the CMS requirements, you must provide Social Security numbers (SSNs) for yourself and your covered dependents upon request.

What happens if 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, such as a homeowner or auto insurance policy. If so, that “med pay” coverage will be primary to coverage under this EOC. If so, HNE will work with the other carrier. If the other carrier allows you to be repaid directly for medical expenses, you agree to allow the payment to be made to HNE.

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 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 is 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 fees.
SECTION 13 – OTHER PLAN ADMINISTRATION 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
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
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
Nothing in this EOC will create or is meant to create any relationship between the parties other than that of independent contracting parties. The Group and HNE 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

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.

Amendment, Termination of the Plan Amendment, or Termination

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 President of Group or the Plan’s bookkeeper, each of whom are individually authorized to amend or terminate the Plan and to sign insurance contracts with HNE or other carriers, including amendments to those contracts. In addition, termination of the HNE group insurance contract entered into between the Group and HNE will constitute termination of the Plan, unless the Group exercises its sole discretion to obtain a substitute contract of insurance.

Power and Authority of Insurance Company

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

If you have further questions, please call HNE Member Services at 413.787.4004 or 800.310.2835
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

**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.

Please note: HNE PPO Members may visit Out-of-Plan Providers. Therefore, HNE provides coverage for a new PPO Member who continues to see an Out-of-Plan Provider, subject to applicable Deductible and Coinsurance.

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 provider disenrolls.** HNE will notify you at least 30 days before the disenrollment. HNE will help you select a new provider 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 provider:
  - 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 pregnant Members is involuntarily disenrolled.** If this occurs and you are in your second or third trimester of pregnancy, HNE will permit you to continue treatment with your provider through the postpartum period. You will not be allowed to continue to see this provider if he or she is disenrolled for reasons related to quality or for fraud.

- **If a provider who is treating terminally ill Members is involuntarily disenrolled.** If this occurs and you are terminally ill, HNE will permit you to continue treatment with your provider until your death. You will not be allowed to continue to see this provider if he or she is disenrolled for reasons related to quality or for fraud.

Transitional Coverage for New Members

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

- The Member’s employer only offers the Member a choice of carriers in which the doctor is not a 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
This EOC, any amendments and riders, and the Employer Group Agreement between your Group and HNE.

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
- Acupuncture services (except certain specific Covered Services, if any, listed elsewhere in the EOC or riders to this EOC)
- 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.

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 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.

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).

Employer Group Agreement
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.

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

**Formulary**
A list of drugs offered to Members.

**Group**
The business or organization which has offered the Plan to its employees.

**Group Contract**
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.

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

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

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

**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.

**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 – In-Plan**
This amount is the most you pay for Cost Sharing on Essential Health Benefits from In-Plan Providers 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 this Maximum. The In-Plan 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

**Out-of-Pocket Maximum – Out-of-Plan**
This amount is the most you pay for the combined cost of the plan Medical Deductible and Coinsurance for Covered Services from Out-of-Plan Providers in a Policy Year. Not all payments made by Members are counted toward this Maximum. The Out-of-Plan 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 Remaining Balances (any part of an Out-of-Network Provider’s charge that exceeds HNE’s Maximum Allowable Fee.)
- Any Reduction of Benefit made when Prior Approval for services was required but not obtained.
- Payments made for specific benefits for which Coinsurance or Deductibles are excluded from the Out-of-Pocket Maximum.

**Policy 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 Policy Year could start on January 1st and end on December 31st of the same year, or a Policy year could start on July 1st and end on June 30th of the following year.

**Prior Approval**
The process by which HNE reviews and approves coverage for certain services before the services are performed.
Qualified Beneficiary
Persons who are covered under a Group health plan on the day before a COBRA Qualifying Event.

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

Reduction of Benefit
The amount (in addition to applicable Copays, Coinsurance, Deductibles and/or Remaining Balances) that Members pay when they receive certain services without requesting Prior Approval.

Remaining Balance
That portion of an Out-of-Plan Provider’s charge above HNE’s Allowed Amount. The Member is financially responsible for this amount.

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 in the Employer Group Agreement.
## APPENDIX A. A Summary of Your Payment Responsibilities

### Summary of Benefit Chart

**UMass AFSCME Unit B**  
**Custom PPO Essential**  
**PPO 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.

Please note: For Out-of-Plan services, you are also responsible for any Remaining Balances. A Remaining Balance is that portion of an Out-of-Plan Provider’s charge that is above HNE’s Allowed Amount.

Note about Prior Approval:  
Some services may require Prior Approval. These services are marked with † in the chart. In some cases, if you fail to ask for Prior Approval the service will not be covered at all. (See, for example, Infertility Treatment below.) In other cases, for example Acute Hospital Care at an Out-of-Plan facility, if you fail to ask for Prior Approval you may have a Reduction of Benefit up to the amount indicated below. Remember that exclusions or limitations of this plan still apply, even if you ask for Prior Approval. For example, services that are not Medically Necessary are not covered, even if you ask for Prior Approval.

<table>
<thead>
<tr>
<th></th>
<th>In-Plan Providers HNE and PHCS</th>
<th>Out-of-Plan Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible per Policy Year:</strong></td>
<td>You must pay this amount for Covered Services before HNE will begin to pay benefits. This is a combined amount for HNE, PHCS, and Out-of-Plan providers. As indicated in the chart below, some services are not subject to the Deductible.</td>
<td>$500 per individual / $1,000 per family</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>In-Plan Out-of-Pocket Maximum:</strong></td>
<td>The most you pay for cost sharing on Essential Health Benefits during a Policy Year before your plan begins to pay 100% of the Allowed Amount. This is a combined amount for HNE &amp; PHCS Providers.</td>
<td>$2,500 per individual / $5,000 per family</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-Plan Out-of-Pocket Maximum:</strong></td>
<td>This is the most you will pay in a Policy Year for the combined cost of your Medical Deductible and Coinsurance for Covered Services from Out-of-Plan Providers.</td>
<td>Not applicable / $3,500 per individual / $7,000 per family</td>
</tr>
<tr>
<td>Benefit</td>
<td>Your Cost In-Plan Providers HNE and PHCS Providers</td>
<td>Your Cost Out-of-Plan Providers</td>
</tr>
<tr>
<td>---------</td>
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</tr>
<tr>
<td><strong>Inpatient Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Hospital Care and Inpatient Rehabilitation † (elective admissions to Out-of-Plan facilities require Prior Approval)</td>
<td>$500 after Deductible; and for PHCS providers up to $500 Reduction of Benefit</td>
<td>20% Coinsurance after Deductible &amp; up to $500 Reduction of Benefit</td>
</tr>
<tr>
<td>Skilled Nursing Facility † (limited to 100 days per Calendar Year; admissions to Out-of-Plan facilities require Prior Approval)</td>
<td>$500 after Deductible; and for PHCS providers up to $500 Reduction of Benefit</td>
<td>20% Coinsurance after Deductible &amp; up to $500 Reduction of Benefit</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Routine Exams</td>
<td>$0</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Well Child Care</td>
<td>$0</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Child and Adult Routine Immunizations</td>
<td>$0</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Routine Prenatal &amp; Postpartum Care</td>
<td>$0</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Routine Eye Exams (limited to one per Calendar Year)</td>
<td>$0</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Annual Gynecological Exams (limited to one per Calendar Year)</td>
<td>$0</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Routine Mammograms (routine mammograms limited to one per Calendar Year)</td>
<td>$0</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years; office visits prior to the procedure are subject to applicable Deductible &amp; Copays)</td>
<td>$0</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Benefit</td>
<td>Your Cost In-Plan Providers HNE and PHCS Providers</td>
<td>Your Cost Out-of-Plan Providers</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Nutritional Counseling (limited to four visits per Calendar Year)</td>
<td>$0</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Preventive Screenings Listed under &quot;Outpatient Preventive Care&quot; in the Covered Benefits Section of the EOC</td>
<td>$0</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td><strong>Outpatient Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Office Visit (Deductible may apply to some In-Plan office services.)</td>
<td>$20 Copay per visit</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Second Opinions (Deductible may apply to some In-Plan office services.)</td>
<td>$20 Copay per visit</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Telephone and video consultations with internists, family practitioners, and pediatricians for non-emergency medical conditions through Teladoc™</td>
<td>$20 Copay per consultation</td>
<td>Not covered</td>
</tr>
<tr>
<td>Hearing Tests in Specialist Office or Outpatient Facility (other than routine screenings covered as part of your Annual Routine Exam)</td>
<td>$20 Copay per visit after Deductible</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td><strong>Diabetic-Related Items:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Services (Deductible may apply to some In-Plan office services.)</td>
<td>$20 Copay per visit</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Lab Services</td>
<td>$0</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment (some DME requires Prior Approval)</td>
<td>20% Coinsurance; and for PHCS providers up to $500 Reduction of Benefit</td>
<td>20% Coinsurance after Deductible &amp; up to $500 Reduction of Benefit</td>
</tr>
<tr>
<td>Individual Diabetic Education</td>
<td>$20 Copay per visit</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Group Diabetic Education</td>
<td>$20 Copay per session</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Emergency Room Care (Copay waived if admitted)</td>
<td>$150 Copay per visit</td>
<td>$150 Copay per visit</td>
</tr>
<tr>
<td>Diagnostic Testing</td>
<td>$0 after Deductible</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Benefit</td>
<td>In-Plan Providers HNE and PHCS Providers</td>
<td>Out-of-Plan Providers</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Sleep Study (maximum of two per Calendar Year; Prior Approval is required starting February 1, 2016) †</td>
<td>$150 Copay after Deductible (one Copay per year; no Copay for home sleep studies; and for PHCS providers up to $500 Reduction of Benefit)</td>
<td>20% Coinsurance after Deductible &amp; up to $500 Reduction of Benefit</td>
</tr>
<tr>
<td>Lab Services</td>
<td>$0</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms</td>
<td>$0 after Deductible</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging †</td>
<td>$150 Copay after Deductible (maximum three Copays per year); and for PHCS providers without Prior Approval, Member pays all costs</td>
<td>20% Coinsurance after Deductible; without Prior Approval, Member pays all costs</td>
</tr>
<tr>
<td>Outpatient Short-Term Rehabilitation Services (Limited to two months or 25 visits, whichever is greater, per condition per Calendar Year for physical or occupational therapy. This limit does not apply when services are provided to treat autism spectrum disorder.)</td>
<td>$20 Copay per visit per treatment type after Deductible</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Day Rehabilitation Program (limited to 15 full day or ½ day sessions per condition per lifetime)</td>
<td>$25 Copay after Deductible for 1 day or 1/2 day</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Early Intervention Services (covered for children from birth to age 3)</td>
<td>$0</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder †</td>
<td>$0 (for PHCS Providers, without Prior Approval Member pays all costs)</td>
<td>20% Coinsurance after Deductible (without Prior Approval Member pays all costs)</td>
</tr>
<tr>
<td>Outpatient Surgical Services and Procedures (some services require Prior Approval; office visit Copay may apply if done in an In-Plan doctor's office)</td>
<td>$250 after Deductible</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Allergy Testing and Treatment</td>
<td>$20 Copay per visit</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Allergy Injections</td>
<td>$0</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Benefit</td>
<td>Your Cost In-Plan Providers HNE and PHCS Providers</td>
<td>Your Cost Out-of-Plan Providers</td>
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<tr>
<td>-------------------------------</td>
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</tr>
<tr>
<td><strong>Infertility Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some Infertility services are</td>
<td>$20 Copay per visit; and for PHCS providers</td>
<td>20% Coinsurance after Deductible; without Prior Approval, Member pays all costs</td>
</tr>
<tr>
<td>covered only for Massachusetts residents and for Connecticut residents under the age of 40. Some services require Prior Approval.</td>
<td>without Prior Approval Member pays all costs</td>
<td></td>
</tr>
<tr>
<td>Office Visit (Deductible may apply to some In-Plan office services)</td>
<td>$20 Copay per visit; and for PHCS providers without Prior Approval Member pays all costs</td>
<td>20% Coinsurance after Deductible; without Prior Approval, Member pays all costs</td>
</tr>
<tr>
<td>Outpatient Surgery/Procedure</td>
<td>$250 after Deductible; and for PHCS providers without Prior Approval Member pays all costs</td>
<td>20% Coinsurance after Deductible; without Prior Approval, Member pays all costs</td>
</tr>
<tr>
<td>Lab Test</td>
<td>$0; and for PHCS providers without Prior Approval Member pays all costs</td>
<td>20% Coinsurance after Deductible; without Prior Approval, Member pays all costs</td>
</tr>
<tr>
<td>Inpatient Care †</td>
<td>$500 after Deductible; and for PHCS providers without Prior Approval Member pays all costs</td>
<td>20% Coinsurance after Deductible; without Prior Approval, Member pays all costs</td>
</tr>
<tr>
<td><strong>Maternity Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Routine Prenatal and Postpartum Visit</td>
<td>$20 Copay per visit</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>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)</td>
<td>$500 after Deductible</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td><strong>Dental Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Treatment of Non-Dental Conditions in a Doctor's Office (Deductible may apply to some In-Plan office services.)</td>
<td>$20 Copay after Deductible</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Emergency Dental Care in a Doctor's or Dentist's Office</td>
<td>$20 Copay per visit</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Emergency Dental Care in an Emergency Room</td>
<td>$150 Copay per visit</td>
<td>$150 Copay per visit</td>
</tr>
</tbody>
</table>

If you have further questions, please call HNE Member Services at 413.787.4004 or 800.310.2835
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Your Cost In-Plan Providers HNE and PHCS Providers</th>
<th>Your Cost Out-of-Plan Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Other Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care †</td>
<td>$0 after Deductible; and for PHCS providers up to $500 Reduction of Benefit</td>
<td>20% Coinsurance after Deductible &amp; up to $500 Reduction of Benefit</td>
</tr>
<tr>
<td>Hospice Services †</td>
<td>$0; and for PHCS providers up to $500 Reduction of Benefit</td>
<td>20% Coinsurance after Deductible &amp; up to $500 Reduction of Benefit</td>
</tr>
<tr>
<td>Durable Medical Equipment (some items require Prior Approval)</td>
<td>20% Coinsurance; and for PHCS providers up to $500 Reduction of Benefit</td>
<td>20% Coinsurance after Deductible &amp; up to $500 Reduction of Benefit</td>
</tr>
<tr>
<td>Prosthetic Limbs †</td>
<td>20% Coinsurance; and for PHCS providers without Prior Approval Member pays all costs</td>
<td>20% Coinsurance after Deductible; without Prior Approval Member pays all costs</td>
</tr>
<tr>
<td>Ambulance and Transportation Services (non-emergency transportation requires Prior Approval; if Prior Approval is not obtained for non-emergency transportation, Member pays all costs)</td>
<td>$100 Copay per day after Deductible</td>
<td>$100 Copay per day after Deductible</td>
</tr>
<tr>
<td>Kidney Dialysis</td>
<td>$0</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Nutritional Support † (not covered without Prior Approval)</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>$20 Copay per visit after Deductible</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Wigs (Scalp Hair Prostheses) for hair loss due to treatment of any form of cancer or leukemia. (HNE covers 1 prosthesis per Calendar Year)</td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td>Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation.)</td>
<td>$20 Copay per visit after Deductible; and for PHCS providers up to $500 Reduction of Benefit</td>
<td>20% Coinsurance after Deductible &amp; up to $500 Reduction of Benefit</td>
</tr>
<tr>
<td>Benefit</td>
<td>Your Cost</td>
<td>Your Cost</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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</tr>
<tr>
<td></td>
<td>In-Plan Providers</td>
<td>Out-of-Plan Providers</td>
</tr>
<tr>
<td></td>
<td>HNE and PHCS Providers</td>
<td></td>
</tr>
<tr>
<td>Hearing Aids† (Covered with Prior Approval for Members age 21 and under. 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.)</td>
<td>$0 up to $2,000 per device per ear (you are responsible for all costs beyond maximum); and for PHCS providers without Prior Approval Member pays all costs</td>
<td>20% Coinsurance after Deductible; up to $2,000 per device per ear (you are responsible for all costs beyond maximum). Without Prior Approval Member pays all costs.</td>
</tr>
<tr>
<td>Human Organ Transplants and Bone Marrow Transplants † (Without Prior Approval, payments you make to Out-of-Plan Providers for Deductible and Coinsurance do not count toward your Deductible or Maximum Coinsurance amounts.)</td>
<td>$500 after Deductible; and for PHCS providers up to $500 Reduction of Benefit</td>
<td>20% Coinsurance after Deductible &amp; up to $500 Reduction of Benefit</td>
</tr>
<tr>
<td><strong>Behavioral Health</strong> (Includes Mental Health and Substance Abuse)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Services †</td>
<td>$20 Copay per visit</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Inpatient Services †</td>
<td>$500 after Deductible; and for PHCS providers up to $500 Reduction of Benefit</td>
<td>20% Coinsurance after Deductible &amp; up to $500 Reduction of Benefit</td>
</tr>
</tbody>
</table>
APPENDIX B. Disclosures Required by Law

Notice of COBRA Rights

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 your 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 Spouse, 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.

If you have further questions, please call HNE Member Services at 413.787.4004 or 800.310.2835
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 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.

If you have further questions, please call HNE Member Services at 413.787.4004 or 800.310.2835
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
    Susan Hensley – 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

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 the Employee Benefits Security Administration (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, can be completed in a matter of months. Others are ongoing, and will be followed by HNE throughout the year.

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

If you would like any information regarding the HNE Quality Management Program Description or Work Plan, please contact the Director of Quality Operations at 413.233.3435. HNE will provide this information on request.

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

HNE has a written program for how health care services and delivery are reviewed. The program is made up of activities in the areas of utilization, case, and disease management. Its purpose is to help Members to receive the appropriate care. HNE may conduct reviews before or during the delivery of services. HNE uses nationally recognized guidelines and resources for these reviews. HNE also uses criteria 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:

- HNE uses Hayes, Inc. to research new and emerging medical technologies. Hayes also researches new uses of existing technologies. The research is structured and evidence-based. Analyses of market, regulatory, legal, ethical, and actuarial issues are part of the study. Hayes then makes coverage recommendations to HNE.

- To evaluate drugs, HNE uses a pharmacy benefits manager. For information about HNE’s pharmacy benefits manager, contact HNE Member Services. The pharmacy benefits manager uses a committee of physicians and pharmacists to review new FDA-approved drugs that have been available in the United States for at least six months. Some of the criteria used to evaluate drugs are:
  - Safety
  - The potential effects of treatment under optimal circumstances
  - The actual effects of treatment under real life conditions
  - Potential health outcomes and resulting total cost of drugs and medical care, and potential savings available
• Any restrictions needed to assure safe, effective, or proper use of the drug, patient outcome, or cost effectiveness

• The recommendations by Hayes and HNE’s pharmacy benefits manager are then screened by an internal HNE committee. If more medical input is needed, an In-Plan physician will be consulted. He or she will provide a written opinion to HNE.

• The findings are then reported to another HNE committee, which includes In-Plan physicians, for discussion at its next meeting. This allows for local practicing physician input.

• Recommendations will then go to the HNE Medical Policy Committee for final decision. The committee makes a decision based on its review of the recommendations and other HNE specific data, such as:
  • Prevalence of disease(s) associated with proposed technologies
  • Benefits to HNE Members
  • Cost
  • Use of current technologies and projected use of new technology

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

Notice of Termination for Nonpayment of Premiums

HNE will not deny a Member’s claim for covered health care services on the grounds that, prior to the date covered health care services were received, the employer’s plan 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.

Premium Rates and Payment Arrangements (Prepaid Fees)

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.

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 massmedboard.org.

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.

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.

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

“Protected health information” or “PHI” is information about you, including demographic information, that:
- Can reasonably be used to identify you; and
- That relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

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

How does 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. For example: name, address, social security number, date of birth, marital status, dependent information and, employment information.
- Providers (such as doctors and hospitals) who are treating you or who are involved in your treatment and/or their staff when they submit claims or request authorization on your behalf for certain services or procedures.
- Attorneys who are representing our Members in automobile accidents or other cases.
- Insurers and other health plans.

How does HNE protect my personal health information?
HNE has many physical, electronic, and procedural safeguards in place to protect your information. Information is protected whether it is in oral, written or electronic form. HNE policies and procedures require all HNE employees to protect the confidentiality of your PHI. An employee may only access your PHI when they have an appropriate reason to do so. Each employee must sign a statement that he or she has read and understands HNE’s privacy policy. On an annual basis, HNE will send a notice to employees to remind them of this policy. Any employee who violates HNE’s privacy policies is subject to discipline, up to and including dismissal.

How does HNE use and disclose my protected health information?
HNE uses and discloses your PHI for many different reasons. We can use or disclose your PHI for some reasons without your written agreement. For other reasons, we need you to agree in writing that we can use or disclose your PHI.

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

C-1

HNEMASTER-14 PPO - UMass AFSCME Unit B (8V)

If you have further questions, please call HNE Member Services at 413.787.4004 or 800.310.2835
Treatment: We may disclose your protected health information to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers) who request it in connection with your treatment. We may also disclose your protected health information to health care providers (including their employees or business associates) in connection with preventive health, early detection and disease and case management programs.

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

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

HNE does not and will not use PHI that is genetic information about you for underwriting purposes.

Other Permitted or Required Uses and Disclosures of Protected Health Information

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

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

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

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

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

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

Law Enforcement: We may disclose your protected health information under limited circumstances to law enforcement officials. For example, disclosures may be made in response to a warrant or subpoena or for the purpose of identifying or locating a suspect, witness or missing persons or to provide information concerning victims of crimes.
**Coroners, Funeral Directors and Organ Donation:** We may disclose your protected health information in certain instances to coroners, funeral directors and organizations that help find organs, eyes, and tissue to be donated or transplanted.

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

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

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

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

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

**Will HNE give my PHI to my family or friends?**

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

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

**Will 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
If you have further questions, please call HNE Member Services at 413.787.4004 or 800.310.2835

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, and their business associates, 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 PHI, we must obtain your written authorization. Among other things, a written authorization request will specify the purpose of the requested disclosure, the persons or class of persons to whom the information may be given, and an expiration date for the authorization. If you do provide a written authorization, you generally have the right to revoke it.

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

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

**What are my rights with respect to my PHI?**

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

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

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

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

**Right to Amend Your Protected Health Information:** You have the right to ask us to amend any protected health information about you that is contained in a “designated record set” (see above). All requests for amendment must be in writing and on 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 an Accounting of Certain Disclosures:** You have the right to have us provide you an accounting of times when we have disclosed your protected health information for any purpose other than the following:

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

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

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

**Who should I contact if I have a question about this notice or a complaint about how HNE is using my personal health information?**

**Complaints and Communications with Us**

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

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

You can also call us at 413.787.4004 or 800.310.2835. You will not be retaliated against for filing a complaint with us.

**Complaints to the Federal Government**

If you believe your privacy rights have been violated, you also have the right to file a complaint with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint with the federal government.
**Effective Date of Notice**
This Notice takes effect on July 1, 2013. We must follow the privacy practices described in this Notice while it is in effect. This Notice will remain in effect until we change it. This Notice replaces any other information you have previously received from us with respect to privacy of your medical information.

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