FULLY FUNDED PLANS ONLY

October 28, 2013

RE: Semi-Annual Notice of Changes

Dear Employers and Brokers:

As part of our commitment to provide affordable access to high quality health care, we continually review the benefits and services offered to our members. As a result, from time to time, we update the coverage we provide and change the way that coverage is administered. We then notify our subscribers and their employers, our brokers, and our contracted providers of these changes.

We have attached a copy of an amendment to the HNE Explanation of Coverage. We will notify HNE subscribers of this amendment with the next edition of our member newsletter, *Living Well*. If you have any questions, please call us at 413.233.3535.

Sincerely,

Wendy Tirrell

Wendy Tirrell
Sales Manager

AMENDMENT 02-2014-slg

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 January 1, 2014, unless noted below.

The EOC is amended as follows:

Benefit, Program, or Requirement	Description
Out-of-Pocket Maximum – What is included	**Effective on plan renewal on or after January 1, 2014** The plan Out-of-Pocket Maximum includes your cost sharing for all Essential Health Benefits (EHB). See the "Definitions" section of the EOC for a list of what is included in EHB.
Definitions	**Effective on plan renewal on or after January 1, 2014** The following are added to the "Definitions" section of the EOC. **Affordable Care Act (ACA)** Federal law that reforms the healthcare system in the United States. **Allowed Amount** Maximum amount on which payment is based for covered health care services. **Cost Sharing** The amount a Member pays for covered services. This can include Deductibles, Copays, and Coinsurance. **Out-of Pocket Maximum** This amount is the most you pay for cost sharing on Essential Health Benefits during a policy period. A policy period is usually a year. Once you reach this amount your plan pays 100% of the allowed amount. Not all payments made by Members are counted toward the Out-of-Pocket Maximum. The Out-of-Pocket Maximum does not include, for example: • Any part of the premium paid for the policy. • Any payment you make for non-covered services. • Payments made for benefits which are not Essential Health Benefits.

Benefit, Program, or Requirement	Description
Definitions (continued)	**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.
Genetic testing – BRCA and Colaris	The genetic tests listed below will no longer have Member Cost Sharing: • BRCA test for the breast cancer gene • Colaris test for hereditary colorectal, ovarian, and endometrial cancer HNE requires Prior Approval for these tests.
Clinical Trials	**Effective on plan renewal on or after January 1, 2014** HNE's coverage for Cancer Clinical Trials is expanded. HNE will cover patient care items and services for clinical trials for cancer or other life threatening diseases or conditions. The clinical trial must be a "Qualified Clinical Trial" as defined by Massachusetts or federal law. Other requirements and exclusions in the EOC still apply.
Children's Preventive Dental **<u>NOTE</u>: Applies only to certain plans offered to groups with 50 or fewer eligible employees, and to certain non-group contracts.**	**Effective on plan renewal on or after January 1, 2014** Coverage for Children's Preventive Dental services (for children under age 12) is replaced by coverage for Pediatric Dental Services (for children under age 19). You will receive a "Certificate of Coverage" and a "Summary & Schedule of Covered Dental Procedures" from Altus Dental that explains this coverage.
Low Protein Food Products for inherited disease of amino acids and organic acids	**Effective on plan renewal on or after January 1, 2014** HNE has removed the dollar limit for the coverage of low protein food products. These products must be Medically Necessary. Prior Approval is still required.

Benefit, Program, or Requirement	Description
Wigs (Scalp Hair Prostheses) for hair loss due to the treatment of any form of cancer or leukemia	**Effective on plan renewal on or after January 1, 2014** HNE will cover one wig per Calendar Year. This coverage is only for wigs worn for hair loss due to the treatment of any form of cancer or leukemia. Any Member Cost Sharing that is applied to Durable Medical Equipment (DME) will apply to wigs.
Clarification: Human Leukocyte Antigen Testing	HNE does not cover human leukocyte antigen testing for individuals who are not HNE members.
Preventive and Wellness Services and Chronic Disease Management **<u>NOTE</u>: Applies only to groups with 50 or fewer eligible employees and to non-group contracts**.	**Effective on plan renewal on or after January 1, 2014** HNE will reimburse you for three wellness visits **per family** per benefit period (usually a year) as follows: • Wellness visits are one hour visits for acupuncture or for massage therapy. • The acupuncturist or massage therapist you visit must be licensed to provide the type of service you receive. • This benefit is for a **total** of three visits **per family** per benefit period. For example, you or your family may have three visits for acupuncture **or** three visits for massage **or** one visit for acupuncture and two visits for massage **or** two visits for acupuncture and one visit for massage. • For reimbursement you must send us an HNE Wellness Benefit Reimbursement Form along with proof of your payment.
Services and Procedures that require Prior Approval	The following items are added to the Prior Approval list: • INFUSE® Bone Graft • Endothelial Keratoplasty • Stretta® treatment for gastroesophageal reflux disease (GERD) • Implantable miniature ocular telescope • Radiofrequency ablation for chronic spinal pain
Massachusetts Office of Patient Protection	The Office of Patient Protection (OPP) accepts consumer complaints and manages the external review process for Member Appeals. ("Inquiries and Grievances" section of the EOC.) This office is now under the Health Policy Commission. • Telephone number remains: 800.436.7757 • Fax number remains: 617.624.5046 • Website has changed to: mass.gov/hpc/opp/ • Email has changed to: HPC-OPP@state.ma.us • Address has changed to: Health Policy Commission Office of Patient Protection Two Boylston Street, 6th Floor Boston, MA 02116

Benefit, Program, or Requirement	Description
Enrollment Section of the EOC **(Changes effective on plan renewal on or after January 1, 2014)**	**Under the heading "When can a Subscriber enroll?"** The period of time a subscriber has to enroll is changed. • This change applies only to Subscribers enrolling through a group. All references to " 31 days" are changed to "30 days." **Under the heading "Are there any times when I can enroll outside of the above time periods?"** The period of time a Subscriber can enroll outside of those time periods is changed. • This change applies only to Subscribers enrolling through a group. This period of time is changed to 30 days. **Under the heading "What happens if I am already enrolled but then acquire a new Dependent or marry?"** The period of time to enroll a new Dependent is changed. • If the Subscriber is enrolled as an individual, the period of time is changed to 60 days. • If the Subscriber is enrolled through a group, the period of time is changed to 30 days. **Under the heading "If I am already enrolled and my Dependent moves into HNE's Services Area, does my Dependent becomes eligible for coverage?"** The period of time to enroll a Dependent who moves into HNE's Service Area is changed. • If the Subscriber is enrolled as an individual, the period of time is changed to 60 days. • If the Subscriber is enrolled through a group, the period of time is changed to 30 days. **Under the heading "How do I enroll?"** The period of time to submit the required forms and information to HNE is changed. • This change applies only to Subscribers enrolling through a group. This period of time is changed to 30 days.
Eligibility – HMO Plans Only	"Residency Requirement" in the "Eligibility" section of the EOC is changed to the following: **<u>Residency Requirement</u>** You must live within the HNE Service Area. This rule does not apply to a Dependent child who is enrolled as a full-time student.

Benefit, Program, or Requirement	Description
Eligibility Section of the EOC **(Changes effective on plan renewal on or after January 1, 2014)**	**Under the heading "Dependents"** The period of time a Subscriber has to enroll a child for whom he or she has been named legal guardian is changed. • If the Subscriber is enrolled as an individual, the period of time is changed to 60 days. • If the Subscriber is enrolled through a group, the period of time is changed to 30 days. **Under the heading "Adopted Dependents"** The period of time a Subscriber has to enroll a child he or she has adopted or is trying to adopt is changed. • If the Subscriber is enrolled as an individual, the period of time is changed to 60 days. • If the Subscriber is enrolled through a group, the period of time is changed to 30 days.
Termination of Participation – Group coverage only	Under "Termination of Participation" in the "Termination" section of the EOC, the following change is made. "Your eligibility for Plan benefits ends on the last day of the month in which your employment ends with the Group." Is replaced by: "Your eligibility for Plan benefits ends as of the date specified by your employer."
Prescription Drugs through Mail Order (Please disregard if your HNE plan does not include a mail order prescription drug benefit.)	**Catamaran Home Delivery Member Update** Health New England (HNE) and Catamaran Home Delivery would like to take this opportunity to provide you with updated contact information when using Catamaran Home Delivery services. We hope this reminder will make it easy for you to contact our Catamaran Home Delivery team of Member Service Representatives. They are specially trained on the HNE mail order program and will be able to assist you with all of your pharmacy Home Delivery needs. • When contacting Catamaran Home Delivery please dial **800.763.0044, option 5** to speak to one of our Member Service Representatives. We are available Monday – Friday, 8 am to 10 pm Eastern Standard Time and Saturday, 8 am to 5 pm Eastern.

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 copayments 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. Follow the appeal procedures outlined in your Explanation of Coverage for more information about filing an appeal.*