Health New England

FULLY FUNDED PLANS ONLY

April 15, 2022

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 Health New England Explanation of Coverage. We will notify our subscribers of this amendment with the next edition of our member newsletter. If you have any questions, please call us at (413) 233-3535.

Sincerely,

Michael Gauvin
Sales Manager

Encl: Amendment 01-2022

Health New England complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health New England cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Health New England cumpre as leis de direitos civis federais aplicáveis e não exerce discriminação com base na raça, cor, nacionalidade, idade, deficiência ou sexo.

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0 (TTY: 711). Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0 (TTY: 711). Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0 (TTY: 711).

#. Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

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

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

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

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

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

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

If you believe you've been wrongly billed, you can report this to the Massachusetts Division of Insurance (DOI). You can submit a complaint at this website: https://www.mass.gov/how-to/filing-an-insurance-complaint or you may call (617) 521-7794. You may also file a complaint with the federal government at https://www.cms.gov/nosurprises/consumers.

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

Health New England

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 July 1, 2022, unless noted below.

The EOC is amended as shown below.

Benefit, Program, or Requirement	Description
Balance Billing by Out of Plan Providers	**Section 1 – Introduction – Balance Billing by Out-of-Plan Providers** The text for Balance Billing by an Out of Plan Provider is replaced with the following. **Your Rights and Protections Against Surprise Medical Bills (Effective January 1, 2022)** When you get emergency care or get treated by an Out-of-Plan provider at an In-Plan hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. ***What is "balance billing" (sometimes called "surprise billing")?*** When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. "Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-Plan providers may bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than In-Plan costs for the same service and might not count toward your annual out-of-pocket limit. "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care. For example, when you have an emergency or when you schedule a visit at an In-Plan facility but are unexpectedly treated by an Out-of-Plan provider. ***You are protected from balance billing for.*** **Emergency services** If you have an emergency medical condition and get emergency services from an Out-of-Plan provider or facility, the most the provider or facility may bill you is your plan's In-Plan cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give

written consent and give up your protections not to be balanced billed for these post-stabilization services.

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

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

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

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

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

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

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

Count any amount you pay for emergency services or Out-of-Plan services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you can report this to the Massachusetts Division of Insurance (DOI). You can submit a complaint at this website: https://www.mass.gov/how-to/filing-an-insurance-complaint. Or you may call (617) 521-7794. You may also file a complaint with the federal government at https://www.cms.gov/nosurprises/consumers.

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

Clarification

Benefit, Program, or Requirement	Description
Member Cost Sharing – Deductible	**Section 1 – Introduction – Your Payment Responsibilities** **Definitions – Deductible** The following is added to the EOC. Payments for services through the use of coupon programs do not count towards your Deductible. **Clarification**
Outpatient Short Term Rehabilitation Services	**Section 3 – Covered Benefits – Outpatient Care – Outpatient Short Term Rehabilitation Services** The following replaces the final bullet under "*What Is Not Covered*". Health New England does not cover Occupational and Physical Therapy services for children with developmental delays that are covered by MGL Chapter 71B in Massachusetts (referred to as Chapter 766) or C.G.S.A. § 10-76a through 10-76g, inclusive, in Connecticut, unless such services are Medically Necessary (as defined in Section 15 of this EOC) and meet Health New England's clinical criteria for such services. Members should obtain services available under Massachusetts law (by seeking a Chapter 766 evaluation) or under Connecticut law. See Section 7 of this EOC. **Section 4 – Exclusions and Limitations** The following replaces these numbered paragraphs in Section 4 of the EOC listing Exclusions from coverage. 7. Services provided pursuant to MGL Chapter 71B in Massachusetts (referred to as "Chapter 766") or services provided under C.G.S.A. § 10-76a through 10-76g, inclusive, in Connecticut, if such services are not Medically Necessary (as defined in Section 15 of this EOC) and do not meet Health New England's clinical criteria. Such services can include the following. • Adaptive physical education • Physical and occupational therapy • Educational services or testing, except services covered under the benefit for Early Intervention services • Services for problems of school performance • Psychological counseling • Speech and language therapy • Transportation Members should try to obtain services available under state law. A member or parent should seek an evaluation under Chapter 766 or Connecticut law if you believe your child may be disabled. This includes the following. • Physical disability • Intellectual disability (Continued on next page)

Benefit, Program, or Requirement	Description
	• Learning problem • Behavioral Problem 11. Educational services or testing, except services covered under the benefit for Early Intervention services. These are examples of excluded services. • School or sports related physical exams • Services for problem of school performance • Job retraining • Vocational and driving evaluations • Therapy to restore function for a specific occupation • Transportation **Effective July 1, 2022**
Birthing Centers	**Section 3 – Covered Benefits - Maternity Care** The following text is added to the EOC. Effective July 1, 2022, Member Cost Sharing for inpatient maternity care applies to care at an In-Plan birthing center. **Effective July 1, 2022**
Autism Spectrum Disorder	**Section 3 – Covered Benefits – Outpatient Care – Autism Spectrum Disorder** The following replaces the language under "*What is Not Covered*". Services related to ASD provided under an individualized education program, whether provided by school personnel or by third-party contractors or vendors at the direction of school personnel. **Effective July 1, 2022**
Services Related to COVID-19	**Section 3 – Covered Benefits – Other Services** The following text is added to the EOC. Health New England will cover the following services related to COVID-19. • Emergency Services • Inpatient Services • Cognitive rehabilitation services • Diagnostic and laboratory services • Medically Necessary testing • Immunizations This applies to both In-Plan and Out-of-Plan providers at no cost share. **Effective July 1, 2022**

<table>
<tr><th>Benefit, Program, or Requirement</th><th>Description</th></tr>
<tr><td>Reduction of Benefit (applies to PPO and POS plans only)</td><td>
Section 5 – Claims and Utilization Management Procedures – Prior Approval Process
The following has been added to the EOC.

Prior Approval from HNE is needed before receiving certain services from an Out-of-Plan or PHCS provider. A list of these services may be found in the previous section, “Services and Procedures that Require Prior Approval.” The chart below shows the effect on your benefits if Prior Approval is required but not received.

<table>
<tr><td>If Prior Approval is:</td><td>Then the benefits are:</td></tr>
<tr><td>• Required and approved by HNE</td><td>• Covered at full benefit</td></tr>
<tr><td>• Required and denied</td><td>• Not covered, may be appealed</td></tr>
<tr><td>• Not requested, but would have been covered if requested</td><td>• Covered after a Reduction of Benefits is applied*</td></tr>
<tr><td>• Not requested, would not have been covered if requested</td><td>• Not covered, may be appealed</td></tr>
</table>

*HNE will reduce the amount paid towards your coverage if Prior Approval is not received. You will be responsible for the unpaid balance of the bills. This is called a Reduction of Benefits. Please note that if a Reduction is applied due to failure to receive Prior Approval, HNE will reach out to the provider for information after the service has been performed.

Your provider may approve a treatment for you; however, you should check with HNE before the procedure that the provider has obtained Prior Approval from HNE.

Clarification
</td></tr>
<tr><td>External Review Process</td><td>
Section 6 – Inquires and Grievances – External Appeal Process
The following is removed from the EOC.

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.

And is replaced with.

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

Clarification
</td></tr>
</table>

Prescription Drug Coverage- Commercial

Effective July 1, 2022, the following brand name medications are not covered except with Prior Authorization by Health New England. Generics are preferred.

Allegra and Allegra D 12 and 24hr	**Dilantin capsules**	**Sandimmune capsules**
Anaprox tablets	**Dilantin chewable**	**Sandimmune solution**
Arranon solution	**Dilantin suspension**	**Tegretol tablets**
Carbatrol tablets	**Docetaxel infusion**	**Tegretol XR**
Claritin D 12 and 24 hr	**Hycodan tablets**	**Tegretol suspension**
Cloderm cream	**Istodax solution**	**Trileptal tablets**
Depakote tablets	**Lithobid tablets**	**Trileptal suspension**
Depakote extended release	**Neoral capsules**	**Vasostrict solution**
Depakote sprinkle capsules	**Prograf capsules**	**Zyrtec D**

Effective July 1, 2022, the following medications require Prior Authorization through Optum

- **Cromolyn concentrated solution**
- **Cromolyn inhalation solution**
- **Cystadane**
- **Cystagon**
- **Dificid**
- **Fluvastatin capsules and extended release tablets**
- **Fluvoxamine extended release**
- **Katerzia suspension**
- **Livalo**
- **Miglustat**
- **Sodium phenylbutyrate**
- **Zileuton extended release and Zyflo**

Effective July 1, 2022, the following medications are not covered.
See below for covered Formulary alternatives

- **Carvedilol extended release.** ***Alternative is carvedilol immediate release***
- **Clocortolone cream.** ***Alternative is triamcinolone cream***
- **Imipramine capsules.** ***Alternative is imipramine tablets***
- **Nisoldipine extended release tablets.** ***Alternative is amlodipine***
- **Perphenazine/amitriptyline.** ***Alternative is amitriptyline and perphenazine separately***
- **Texacort solution.** ***Alternative is hydrocortisone solution***

Effective July 1, 2022, the following medications are OTC (over the counter) and are not covered

- **Genteal tear gel**
- **Systane gel**