



FULLY FUNDED PLANS ONLY

October 16, 2015

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,

A handwritten signature in black ink that reads "Nancy A. Petronio". The signature is written in a cursive style with a large, stylized initial "N".

Nancy A. Petronio
Sales Manager



AMENDMENT 01-2016

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.

Benefit, Program, or Requirement	Description
<p>Phone and on line video consultations through Teladoc™</p>	<p>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.</p> <p>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.</p> <p>To request a Teladoc consultation, call 800.Teladoc (800.835.2362) or visit Teladoc.com.</p> <p>Please note: Telehealth services are only available through Teladoc.</p> <p>Effective date: August 1, 2015</p>
<p>Services related to screening colonoscopies and sigmoidoscopies</p>	<p>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:</p> <ul style="list-style-type: none"> • Preparation prescriptions • Pathology services <p>Effective: Immediately</p>

Benefit, Program, or Requirement	Description
Sleep Studies and related Positive Airway Pressure devices	<p>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:</p> <ul style="list-style-type: none"> • CPAP (Continuous Positive Airway Pressure device) • BiPAP (Bi-level Positive Airway Pressure device) • Pressure Support Ventilator <p>Effective Date: February 1, 2016</p>
Nuclear Cardiac Imaging	<p>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.</p> <p>Effective Date: January 1, 2016</p>
Infertility Treatment	<p>Correction to Amendment 02-2015</p> <p>The following is removed from the list of covered infertility procedures:</p> <ul style="list-style-type: none"> • Frozen Embryo Transfer where the recipient is the medically infertile HNE Member
Infertility Treatment for Connecticut Residents	<p>Section 3 – Covered Benefits – Infertility Treatment</p> <p>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.</p> <p>Effective Date: January 1, 2016</p>
Substance Abuse Services – Clarification	<p>Clinical Stabilization Services (CSS) and Acute Treatment Services (ATS)</p> <p>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.</p> <p>PPO and POS members only If you use an Out-of-Plan facility, you must have Prior Approval.</p> <p>Services by a Licensed Alcohol and Drug Counselor I (LADC-I)</p> <p>HNE covers services by licensed alcohol and drug counselors who have a Massachusetts LACD-I level license.</p> <p>Effective Date: October 1, 2015</p>

Benefit, Program, or Requirement	Description
Services Not Covered – Clarification	<p>Section 4 – Exclusions and Limitations</p> <p>The following is added to the list of exclusions:</p> <ul style="list-style-type: none"> • Laser hair removal
Prior Approval for High Cost Infusion Drugs	<p>Section 5 – Claims and Utilization Management Procedures</p> <p>The following is added to the list of “Services and Procedures that Require Prior Approval”:</p> <ul style="list-style-type: none"> • 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. <p>Effective Date: January 4, 2016</p>
HMO Members – Residency Requirement Clarification	<p>Section 7 – Eligibility</p> <p>For HMO plans, the following replaces the text under “Residency Requirement”:</p> <p>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.</p>
If you or a family member is covered by more than one insurance	<p>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. <i>Please show all your health insurance cards to doctors, hospitals, pharmacies, and other health care providers at the time of your visit.</i> This will help with correct billing and payment for the services you receive.</p>

Prescription Drug Coverage

Note: Tier 1 – lowest copay; Tier 2 – mid copay level; Tier 3 highest copay level

Step Therapy Drug changes effective January 1, 2016

For HNE to cover the Step Therapy drugs listed here, you first must try the corresponding First Line drugs. If HNE has paid a claim for the First Line drug within the previous 180 or 360 days (depending on the First Line drug), then you are eligible for coverage of the Step Therapy drug.

The use of samples does not satisfy the requirements of documented usage of a First Line drug or medical necessity for a Step Therapy drug.

If it is Medically Necessary for you to use a Step Therapy drug before trying a First Line drug, then your doctor can contact HNE to request a medical review.

You must try: Before HNE will cover:	First line Drug(s):	<ul style="list-style-type: none"> • Azelastine AND epinastine
	Step Therapy Drug(s)	<ul style="list-style-type: none"> • Patanol • Pataday • Bepreve <p>Note: Applies to new prescriptions only.</p>
You must try: Before HNE will cover:	First line Drug(s):	<ul style="list-style-type: none"> • Sumatriptan nasal spray AND Zomig nasal spray
	Step Therapy Drug(s)	<ul style="list-style-type: none"> • Dihydroergotamine <p>Note: Applies to new prescriptions only.</p>
You must try: Before HNE will cover:	First line Drug(s):	<ul style="list-style-type: none"> • Sumatriptan, Naratriptan, Zolmitriptan, AND Rizatriptan
	Step Therapy Drug(s)	<ul style="list-style-type: none"> • Sumatriptan injection <p>Note: Applies to new prescriptions only.</p>
You must try: Before HNE will cover:	First line Drug(s):	<ul style="list-style-type: none"> • Generic Methylphenidate ER tablet or capsule AND Amphet/dexamphet XR
	Step Therapy Drug(s)	<ul style="list-style-type: none"> • Strattera • Dexmethylphenidate ER • Ritalin LA 10mg and 60mg • Vyvanse • Daytrana <p>Note: Applies to new prescriptions only.</p>

Tier Assignments

The following Drugs are changing Copay Tier Assignment.

Drug Name	Tier before 1/1/16	Tier on or after 1/1/16
Compounded Drugs	Tier 2	Tier 3

Prescription Drug Coverage*Note: Tier 1 – lowest copay; Tier 2 – mid copay level; Tier 3 highest copay level***Quantity Limit Additions**

Starting January 1, 2016, Quantity Limits will be added to the drugs listed below.

Drug Name	Quantity Limit per 30 day supply (unless otherwise specified)
Gralise	300mg: 180 600mg: 90
Synthroid	25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 150mcg, 175mcg, 300mcg: 45 112mcg, 125mcg, 137mcg, 200mcg: 60

Prior Authorizations

Effective January 4, 2016, the following drugs will require Prior Authorization through Magellan RX.

Abraxane	ElELYso	Kadcyla	Remodulin
Actemra	Entyvio	Kalbitor	Rituxan
Acthar HP	Erbitux	Keytruda	Ruconest
Adcetris	Fabrazyme	Krystexxa	Sandostatin Lar Depot
Alimta	Firazyr	Kyprolis	Simponi ARIA
Aloxi	Flebogamma	Lemtrada	Soliris
Aranesp	Flolan,Veletri	Marqibo	Stelara
Arzerra	Fusilev	Mircera	Sylvant
Avastin	Gammagard Liquid	Mozobil	Synribo
Beleodaq	Gammagard S/D	Myobloc	Treanda
Benlysta	Gammaked	Neulasta	Tysabri
Berinert	Gammaplex	Nplate	Vectibix
Bivigam	Gamunex-C	Octagam	Velcade
Botox	Gazyva	Opdivo	Vimizim
Carimune NF	Halaven	Orencia	Xgeva
Cerezyme	Herceptin	Perjeta	Xiaflex
CIMZIA	Hizentra	Privigen	Xofigo
Cinryze	HyQvia	Procrit/Epogen	Xolair
Cyramza	Intravenous Immune Globulin	Prolia	Yervoy
Dysport	Ixempra	Provenge	Zaltrap
Elaprase	Jevtana	Remicade	

Prescription Drug Coverage

Note: Tier 1 – lowest copay; Tier 2 – mid copay level; Tier 3 highest copay level

Plan Exclusions

Effective January 1, 2016, the drugs listed below are **not** a Covered Benefit.

- Diclegis Diclegis
- Doxycycline 40mg capsules will be excluded – Alternative: HNE allows two Doxycycline 20 tablets
- Doryx 50mg and 200mg will be excluded – Alternative: HNE allows doxycycline immediate release tablets
- Absorica will be excluded – Alternative: HNE allows Amnesteem, Claravis, Zenatane, or Myorisan
- Novolog will be excluded – Alternative: HNE allows Humalog
- Novolin will be excluded – Alternative: HNE allows Humulin
- Apidra will be excluded – Alternative: HNE allows Humalog
- Levemir will be excluded – Alternative: HNE allows Lantus
- Glumetza will be excluded – Alternative: HNE allows Metformin ER 500mg
- Hydrocodone/acetaminophen 7.5/300mg and 10/300mg will be excluded – Alternative: HNE allows hydrocodone/acetaminophen 7.5/325mg and 10/325mg

Compound Drugs

A compound drug is a mixture of agents that have to be mixed by a trained pharmacist. The following compound agents are **not** a Covered Benefit:

Compound Agents:

- Imipramine
- Tetracaine
- Prilocaine
- Meloxicam
- Orphenadrine