



**FULLY FUNDED PLANS ONLY**

April 19, 2019

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,

Liane Comeau  
Sales Manager

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).



## AMENDMENT 02-2019

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, 2019, unless noted below.

The EOC is amended as shown below.

Benefit, Program, or Requirement	Description
<b>Sleep study limit removed</b>	<p><b>Section 3 – Covered Benefits – Sleep Studies</b></p> <p>The limit of two sleep studies per Calendar Year is removed.</p> <p><b>Effective July 1, 2019</b></p>
<b>Maternity admissions to Out-of-Plan and PHCS hospitals (applies to PPO and POS plans only)</b>	<p><b>Section 3 – Covered Benefits – Maternity Care</b></p> <p>For all PPO and POS plans the following is added to the EOC.</p> <p style="padding-left: 40px;">Maternity admissions to Out-of-Plan hospitals require Prior Approval. Without Prior Approval, you may have a Reduction of Benefit.</p> <p>For PPO plans that have In-Plan benefits for PHCS providers, the following is added to the EOC.</p> <p style="padding-left: 40px;">Maternity admissions to PHCS hospital require Prior Approval. Without Prior Approval, you may have a Reduction of Benefit.</p> <p><b>Clarification</b></p>
<b>Mobile services through Dispatch Health</b>	<p><b>Section 3 – Covered Benefits – Other Services</b></p> <p>The following is added to the EOC.</p> <p><b>Mobile Services</b></p> <p style="padding-left: 40px;">In areas where available, HNE covers mobile medical services through Dispatch Health when ordered by your provider. Dispatch Health is comprised of mobile medical teams equipped with technology and tools to treat specific medical conditions. Member cost is the same as you would pay for a visit to a Specialist. If your plan has a deductible, it may apply to some services. Dispatch Health is not intended to replace your PCP. All services provided by Dispatch Health must be medically necessary.</p> <p><b>Effective November 6, 2018</b></p>

Benefit, Program, or Requirement	Description
<b>Compression stockings</b>	<p><b>Section 3 – Covered Benefits – Other Services – Durable Medical Equipment, Prosthetic Equipment, and Medical and Surgical Supplies</b></p> <p>The following is added to the EOC.</p> <p>Health New England will cover up to three pairs of Medically Necessary compression stockings per Calendar Year. Prior Approval is required.</p> <p><b>Effective October 1, 2018</b></p>
<b>Wigs (scalp hair prostheses)</b>	<p><b>Section 3 – Covered Benefits – Other Services – Wigs (Scalp Hair Prostheses)</b></p> <p>The following replaces the benefit description under “Wigs (Scalp Hair Prostheses).”</p> <p>HNE covers wigs (scalp hair prostheses) worn for hair loss due to the treatment of any form of cancer or leukemia. HNE covers one prosthesis per Calendar Year. Your Cost Sharing is shown in the Summary of Benefit Chart in Appendix A. Your cost will be less if you use a provider in the network of HNE’s DME Benefit Manager, Northwood. A Northwood provider will submit a claim for you. Or, you can pay for a wig from any provider and submit a request to HNE Member Services for reimbursement. Requests for reimbursement must include:</p> <ul style="list-style-type: none"> <li>• Proof of payment</li> <li>• A written statement from our doctor that the wig is Medically Necessary.</li> </ul> <p><b>Clarification</b></p>
<b>Human leukocyte antigen testing limit removed</b>	<p><b>Section 3 – Covered Benefits – Human Organ Transplants and Bone Marrow Transplants</b></p> <p>The following is removed from the EOC.</p> <p>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.</p> <p>The following is added to the EOC.</p> <p>Human leukocyte antigen testing of histocompatibility locus antigen. This is covered for a Member when needed to establish the Member’s bone marrow transplant donor suitability. HNE covers the costs of testing for A, B, or DR antigens, or any combination of those. All other uses of HLA testing are covered when Medically Necessary.</p> <p><b>Effective July 1, 2019</b></p>

Benefit, Program, or Requirement	Description
<b>Transgender health services</b>	<p><b>Section 3 – Covered Benefits</b></p> <p>The following is added to the EOC.</p> <p><b>Transgender Health Services</b></p> <p>The Plan covers transgender health services in accordance with HNE’s clinical guidelines. To receive a copy of HNE’s guidelines for gender reassignment please call HNE Member Services at (800) 310-2835. You can also access the guidelines on our website at <a href="http://healthnewengland.org">healthnewengland.org</a>. Click on Members, under Member Resources click on Learn More, then click on “Behavioral Health/Medical Policies.” Coverage includes:</p> <ul style="list-style-type: none"> <li>• behavioral health benefits</li> <li>• pharmaceutical coverage (e.g., for hormone replacement therapies)</li> <li>• coverage for medical visits or laboratory services</li> <li>• coverage for reconstructive surgical procedures related to sex reassignment</li> <li>• coverage of routine, chronic or urgent non-transition services</li> </ul> <p>Benefits for transgender health services are in addition to other benefits provided under the Plan. HNE does not consider transgender health services to be reconstructive surgery to correct a physical functional impairment or cosmetic services. Coverage for reconstructive surgery or cosmetic services is limited to the services described in the “Exclusions and Limitations” section of this EOC.</p> <p><b>Clarification</b></p>
<b>Behavioral health and substance abuse disorder services available through Health New England’s telehealth provider Teladoc®</b>	<p><b>Section 3 – Covered Benefits – Behavioral Health and Substance Use Disorder Services</b></p> <p>Health New England is adding a benefit for phone or online video visits for behavioral health and substance use disorder issues through Teladoc. Teladoc providers are experienced:</p> <ul style="list-style-type: none"> <li>• psychiatrists</li> <li>• psychologists</li> <li>• therapists</li> <li>• social workers</li> </ul> <p>This benefit is available to members age 18 and older for non-emergency issues. Your cost is the same as you would pay for a visit to your primary care provider (PCP) or \$40, whichever is less. Depending on your plan, a deductible may apply.</p> <p>All visits must be scheduled. Once you have set up an account, you can schedule a visit using your online account or Teladoc’s mobile app. You will be able to see provider profiles for providers in your state, and set up a time to see the provider you select.</p> <p>To set up your account with Teladoc visit <a href="http://member.teladoc.com/hne">member.teladoc.com/hne</a>. For general questions or for help in setting up your account, you can call Teladoc at (800) Teladoc or (800) 835-2362.</p> <p>Please note: These telehealth services are only available through Teladoc.</p> <p><b>Effective July 1, 2019</b></p>

Benefit, Program, or Requirement	Description
Suit therapy	<p><b>Section 4 – Exclusions and Limitations – Exclusions</b></p> <p>The following is added to the list of services Health New England does not cover.</p> <ul style="list-style-type: none"> <li>Suit therapy or the home use of a suit therapy device to treat any condition including, but not limited to, cerebral palsy or other neuromuscular conditions</li> </ul> <p><b>Effective July 1, 2019</b></p>

**Prescription Drug Coverage****Note: Tier 1 – lowest copay; Tier 2 – mid copay level; Tier 3 highest copay level****Step Therapy Drug changes effective July 1, 2019**

For Health New England (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.

All new Step therapy requirements apply only to new prescriptions.

<b>You must try:</b>	<b>First Line Drug(s):</b>	<ul style="list-style-type: none"> <li>Sildenafil</li> </ul>
<b>Before HNE will cover:</b>	<b>Step Therapy Drug(s):</b>	<ul style="list-style-type: none"> <li>Tadalafil</li> <li>Vardenafil</li> <li>Vardenafil ODT</li> </ul>
<b>You must try:</b>	<b>First Line Drug(s):</b>	<ul style="list-style-type: none"> <li>Anoro and Stiolto</li> </ul>
<b>Before HNE will cover:</b>	<b>Step Therapy Drug(s):</b>	<ul style="list-style-type: none"> <li>Bevespi</li> </ul>
<b>You must try:</b>	<b>First Line Drug(s):</b>	<ul style="list-style-type: none"> <li>Spiriva and Incruse</li> </ul>
<b>Before HNE will cover:</b>	<b>Step Therapy Drug(s):</b>	<ul style="list-style-type: none"> <li>Tudorza</li> </ul>

**Quantity Limit Additions**

Starting July 1, 2019, Health New England will add Quantity Limits to the drugs listed below.

<b>Drug Name</b>	<b>Quantity Limit per 30 day supply (unless otherwise specified)</b>
<ul style="list-style-type: none"> <li>Adapalene cream and gel</li> <li>Soolantra</li> </ul>	45 grams
<ul style="list-style-type: none"> <li>Aprepitant</li> </ul>	6 capsules
<ul style="list-style-type: none"> <li>Estradiol patches</li> </ul>	8 patches

**Tier Changes Effective July 1, 2019**

<b>Drug Name</b>	<b>Tier before 7/1/19</b>	<b>Tier on or after 7/1/19</b>
<ul style="list-style-type: none"> <li>Menopur</li> </ul>	Tier 2	Tier 3

**Effective July 1, 2019, the Following Medications Are Not Covered  
See Below for Covered Formulary Alternatives**

- Lorzone: Alternative is cyclobenzaprine**
- Tizanidine capsules. Alternative is tizanidine tablets**