Health New England

FULLY FUNDED PLANS ONLY

October 14, 2016

RE: Semi-Annual Notice of Changes

Dear Health New England Member:

Health New England is making some changes to your Plan, most of which become effective January 1, 2017.

I have enclosed an amendment to your Health New England Explanation of Coverage. This amendment outlines changes to certain benefits and programs that are part of the standard benefit plan. Please read the information carefully and keep it with your membership materials for future reference.

If you have any questions, please feel free to call Member Services at (413) 787-4004 or (800) 310-2835. Our staff is available Monday through Friday, 8:00 a.m. to 6:00 p.m. We will be happy to help you.

Sincerely,

John Florek
Member Services 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).

Health New England

AMENDMENT 01-2017

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, 2017, unless noted below.

The EOC is amended as follows.

Benefit, Program, or Requirement	Description
Inpatient rehabilitation services	**Section 3 – Covered Benefits – Inpatient Care** Health New England will limit coverage for inpatient rehab. The limit will be 60 days per member per calendar year. All care must be Medically Necessary. **Effective on your plan renewal on or after January 1, 2017**
Treatment for Lyme disease	**Prescription Drug Coverage** Health New England will cover long term antibiotic therapy for the treatment of Lyme disease. **Effective immediately**
New program for the safe use of short acting opioid medications	**Prescription Drug Coverage** Health New England is implementing a program to help with the safe use of short acting opioid analgesics (certain drugs for pain). Examples of these drugs are oxycodone and hydrocodone with acetaminophen. The program includes limits to the maximum day supply allowed within a period of time. Health New England will help members understand the safe use of these drugs through educational mailings. 47.1 **Effective January 1, 2017**
Medications to treat Attention Deficit Hyperactivity Disorder (ADHD)	**Prescription Drug Coverage** In accordance with Massachusetts state law, prescriptions for medications to treat ADHD can be filled for up to a 60-day supply. You can fill this prescription for a 60-day supply at a participating retail pharmacy or through Health New England's mail order vendor. **Effective immediately**

Benefit, Program, or Requirement	Description
Eligibility for children turning 26 years old	**Section 7 – Eligibility – Dependents** A dependent child of the subscriber or of the subscriber's spouse can be covered until the end of the month in which the child turns age 26. **Clarification**
Coverage for disabled child dependents	**Section 7 – Eligibility – Disabled Child Dependents** Eligibility for Disabled Child Dependents age 26 and over is ending. Health New England will cover a dependent child of the subscriber or of the subscriber's spouse only until the end of the month in which the child turns age 26. **If Health New England currently covers your child age 26 or older as a Disabled Child Dependent, we will continue to cover that dependent on your plan as long as he or she continues to qualify as a Disabled Child Dependent.** HNE's Chief Medical Officer (CMO) will decide if a dependent continues to qualify. At reasonable intervals, HNE may require proof of disability and dependency. **Effective January 1, 2017**
Coverage for PHCS providers in Worcester County	**Please note:** The following applies only if you are covered by a PPO plan with In-Plan benefits for PHCS (Private Healthcare Systems) providers. **Section 1 – How the Plan Works** The Health New England Service Area consists of these Massachusetts counties: • Berkshire • Franklin • Hampden • Hampshire • Worcester Services by PHCS providers in the five counties in our Service Area who are not contracted with Health New England are covered at the Out-of-Plan level of coverage. Services by PHCS providers outside of those five counties are covered at the In-Plan level of coverage. **Clarification**

Benefit, Program, or Requirement	Description

Vision care services for children with small group or non-group coverage.	**Please note:** The following applies only if you are covered though the Health Connector or a small group, or if you have an individual policy (not through a group). A small group has 50 or fewer eligible employees as defined by the Affordable Care Act (ACA).
	
	Pediatric Vision Care Services
	
	Children under the age of 19 are covered for the vision care services listed below. These services and materials are covered at no cost when you use EyeMed In-Network providers.
	
	• Exam with dilation as necessary
	• Designated frames
	• Standard plastic lenses:
	  • Single vision
	  • Bifocal
	  • Trifocal
	  • Lenticular
	  • Standard progressive lenses
	• Lens options:
	  • UV treatment
	  • Tint (solid and gradient)
	  • Standard plastic scratch coating
	  • Standard Polycarbonate
	  • Photochromatic / Transitions plastic
	• Contact lenses *(materials only)*
	  • Extended wear disposables (up to a 6-month supply of monthly or 2 week disposables, single vision spherical or toric contact lenses)
	  • Daily wear / disposables (up to a 3-month supply of daily disposable, single vision spherical contact lenses
	  • Conventional (1 pair from a selection of provider designated contact lenses)
	  • Medically Necessary contact lenses
	
	Frequency limit for exams, lenses or contact lenses, and frames: Once every 12 months.
	
	This benefit is administered by EyeMed. To find an EyeMed provider call toll free (844) 203-2074. Or visit eyemed.com and select the ACCESS network in the Provider Search. EyeMed also provides limited coverage for certain other services as well as reimbursement for some services by Out-of-Network providers.
	
	Important note: Routine eye exams for children under age 19 will be covered with $0 Copay only if you use an EyeMed In-Network provider. Routine vision exams by Health New England providers who are not EyeMed providers will not be covered for children under age 19.
	
	Effective on your plan renewal on or after January 1, 2017

Benefit, Program, or Requirement	Description
Removal of impacted teeth - services for members with small group or non-group coverage.	**Please note:** The following applies only if you are covered though the Health Connector or a small group, or if you have an individual policy (not through a group). A small group has 50 or fewer eligible employees as defined by the Affordable Care Act (ACA). **Section 3 – Covered Benefits – Emergency Dental Services and Non-Dental Oral Surgery** The following is **removed** from the list of "What is Not Covered": • Removal of impacted teeth If you have impacted teeth removed in an oral surgeon's office, you do not need prior approval. If it is done in an outpatient facility, you must have prior approval for the facility and anesthesia charges. **Effective January 1, 2017**
Chiropractic services for members with small group or non-group coverage.	**Please note:** The following applies only if you are covered though the Health Connector or a small group, or if you have an individual policy (not through a group). A small group has 50 or fewer eligible employees as defined by the Affordable Care Act (ACA). **Chiropractic Services Rider to the EOC** The limit of 12 visits per year is removed. All services must be Medically Necessary. **Effective on your plan renewal on or after January 1, 2017**

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, 2017
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.

You must try:	**First line Drug(s):**	• Tretinoin cream and Adapalene cream
Before HNE will cover:	**Step Therapy Drug(s)**	• Adapalene 0.1% lotion • Adapalene 0.3% gel
You must try:	**First line Drug(s):**	• High dose of Atorvastatin and Rosuvastatin
Before HNE will cover:	**Step Therapy Drug(s)**	• Altoprev • Livalo
You must try:	**First line Drug(s):**	• Sumatriptan, Naratriptan, Rizatriptan and Zolmitriptan tablets
Before HNE will cover:	**Step Therapy Drug(s)**	• Almotriptan • Frovatriptan • Relpax
You must try:	**First line Drug(s):**	• Two of the following: Gabapentin, TCA's, Venlafaxine or Duloxetine
Before HNE will cover:	**Step Therapy Drug(s)**	• Gralise
You must try:	**First line Drug(s):**	• Azelastine and Epinastine eye drops
Before HNE will cover:	**Step Therapy Drug(s)**	• Lastacaft • Pazeo
You must try:	**First line Drug(s):**	• Omeprazole, Pantoprazole, Nexium OTC and Lansoprazole
Before HNE will cover:	**Step Therapy Drug(s)**	• Dexilant • Prevacid Solutab
You must try:	**First line Drug(s):**	• Zolpidem and Eszopiclone
Before HNE will cover:	**Step Therapy Drug(s)**	• Rozerem

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

Step Therapy Changes (continued from previous page)		
You must try:	**First line Drug(s):**	• Loperamide, Diphenoxylate/atropine and Xifaxan 550mg
Before HNE will cover:	**Step Therapy Drug(s)**	• Viberzi
You must try:	**First line Drug(s):**	• Montelukast and Zafirlukast
Before HNE will cover:	**Step Therapy Drug(s)**	• Zyflo • Zyflo CR
You must try:	**First line Drug(s):**	• Proair HFA
Before HNE will cover:	**Step Therapy Drug(s)**	• Ventolin
You must try:	**First line Drug(s):**	• Avonex and Copaxone
Before HNE will cover:	**Step Therapy Drug(s)**	• Rebif

Tier Changes Effective January 1. 2017		
Drug Name	**Tier before 1/1/17**	**Tier on or after 1/1/17**
Avonex	Tier 3	Tier 2
Betaseron	Tier 3	Tier 2
Copaxone 20mg	Tier 3	Tier 1
Enbrel	Tier 2	Tier 3
Rebif	Tier 2	Tier 3

Quantity Limit Additions
Starting January 1, 2017, Health New England will add Quantity Limits to the drugs listed below.

Drug Name	**Quantity Limit per 30 day supply (unless otherwise specified)**
• Bystolic 2.5mg, 5mg, 10mg • Emsam • Gralise 300mg	30 capsules/tablets/patches
• Bystolic 20mg	60 tablets
• Zyflo & Zyflo CR	120 tablets
• Pazeo drops	2.5 mL
• Lumigan drops	5 mL
• Dihydroergotamine nasal	8 mL

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

Quantity Limit Additions (continued from previous page)	
• Mupirocin cream	15 grams
• Santyl ointment	90 grams
• Bionect cream	100 grams

New Prior Authorizations (PA) Required Effective January 1, 2017

- Cialis for BPH: *PA thru HNE*
- Alosetron: *PA thru Optum*
- Dulera*: PA thru Optum*
- Evzio**:** *PA thru Optum*
- Northera: *PA thru Optum*
- Aralast NP, Glassia, Prolastin, Prolastin-C, Zemaira: *PA thru Magellan RX*
- Blincyto, Inflectra, Lumizyme, Myozyme: *PA thru Magellan RX*

Medications Not Covered
Effective January 1, 2017 the follow medications are not covered. Formulary alternatives are listed below.

- Aloquin: *Alternative is hydrocortisone*
- Amrix: *Alternative is cyclobenzaprine*
- Analpram-HC: *Alternative is hydrocortisone*
- Aplenzin: *Alternative is bupropion ER*
- Cambia: *Alternative is diclofenac*
- Diclofenac 3% gel: *Alternative is fluorouracil*
- Eletone: *Alternative is hydrocortisone*
- Ergomar: *Alternative is sumatriptan*
- Forfivo XL: *Alternative is bupropion ER*
- Glatopa 20mg: *Alternative is Copaxone 20mg*
- PruMyx: *Alternative is hydrocortisone*
- Syprine: *Alternative is Depen*
- Vectical: *Alternative is calcipotriene*
- Zipsor: *Alternative is diclofenac*
- Zorvolex: *Alternative is diclofenac*

Medications Not Covered
Effective January 1, 2017 the follow medications are not covered. Use separate agents.

- Calcipotriene/betamethasone
- Dymista

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

Plan Exclusions

Effective January 1, 2017, the drugs listed below are **not** a Covered Benefit.

- Cuprimine: *Alternative is Depen*
- Generic Fortamet XR tablets: *Alternative is Generic Glucophage XR*
- Methergine: *Alternative is methylergonovine*
- Omeprazole/sodium bicarbonate tablets: *Alternative is omeprazole*
- Dermazene
- VSL DS #3