Health New England

FULLY FUNDED PLANS ONLY

April 20, 2017

RE: Semi-Annual Notice of Changes

Dear Health New England Member:

Health New England is making some changes to your Plan, which become effective July 1, 2017 unless otherwise noted.

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 02-2017

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 July 1, 2017, unless noted below.

The EOC is amended as follows.

Benefit, Program, or Requirement	Description
Medical and drug treatments for HIV associated lipodystrophy syndrome	**Section 3 – Covered Benefits** Health New England covers medical and drug treatments to correct or repair disturbances of body composition caused by HIV associated lipodystrophy syndrome. These include, but are not limited to: • Reconstructive surgery, such as suction assisted lipectomy • Other restorative procedures • Dermal injections or fillers for reversal of facial lipoatrophy syndrome Health New England requires a statement from your treating doctor that the treatment is needed to correct, repair or lessen the effects of lipodystrophy syndrome that is associated with HIV. Prior Approval by Health New England is required for these treatments. Member cost sharing will be the same as for other medical benefits under the plan. **Effective November 8, 2016**
Treatment at Out-of-Plan Facilities – Clarification Note: this applies to PPO and POS plans.	**Section 3 – Covered Benefits – Behavioral Health (Mental Health and Substance Abuse Services)** The following applies for inpatient and outpatient facilities: In addition to a state license, Out-of-Plan facilities must have certification for the ***specific level of care requested*** from either: • The Commission on Accreditation of Rehabilitation Facilities (CARF), or • The Joint Commission **Clarification**

Benefit, Program, or Requirement	Description
Breast reduction surgery	**Section 4 – Exclusions and Limitations – Cosmetic Services** The following is removed from the list of services that Health New England does not cover: • Breast reduction for male enlarged breasts Health New England will cover this surgery if it meets our clinical review criteria. You must have Prior Approval from Health New England. **Effective April 1, 2017**
Prior Approval for Genetic Testing	**Section 3 – Genetic Testing** Health New England will continue to require Prior Approval for all genetic testing. As of October 1, 2017, this Prior Approval process will be managed through eviCore. eviCore is the vendor that we also use for Prior Approval of high cost imaging, sleep studies and sleep study supplies. Your provider will be able to access eviCore via web portal or telephone for any genetic testing needs. **Effective October 1, 2017**
New program for the safe use of long acting opioid medications	**Prescription Drug Coverage** Health New England is implementing a program to help with the safe use of long acting opioid analgesics (certain drugs for pain). Examples of these drugs are OxyContin and morphine extended release. 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. **Effective October 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 July 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):**	• Serevent diskus
Before HNE will cover:	**Step Therapy Drug(s)**	• Brovana • Perforomist
You must try:	**First line Drug(s):**	• One of the following: Invokana, Invokamet or Invokamet XR **AND** • One of the following: Synjardy, Jardiance
Before HNE will cover:	**Step Therapy Drug(s)**	• Glyxambi • Farxiga • Xigduo XR
You must try:	**First line Drug(s):**	• One of the following: Januvia, Janumet or Janumet XR **AND** • One of the following: Jentadueto, Jentadueto XR, Tradjenta
Before HNE will cover:	**Step Therapy Drug(s)**	• Nesina • Kazano • Oseni • Kombiglyze XR • Onglyza
You must try:	**First line Drug(s):**	• Nasacort OTC and Azelastine 0.1% nasal spray
Before HNE will cover:	**Step Therapy Drug(s)**	• Beconase AQ • Budesonide nasal spray RX • Mometasone nasal spray • Omnaris • Qnasl • Veramyst • Zetonna • Olopatadine nasal spray

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

Tier Changes Effective July 1. 2017

Drug Name	Tier before 7/1/17	Tier on or after 7/1/17
• Perforomist	Tier 2	Tier 3
• Invokana • Invokamet • Jardiance • Synjardy • Trulicity	Tier 3	Tier 2

Quantity Limit Additions
Starting July 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)
• Horizant • Invokana • Vraylar • Tolterodine ER	30 tablets/capsules
• Precision test strips	250 strips
• Rhinocort OTC	1 bottle
• Vraylar therapy pack	1 therapy pack per lifetime

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

• **Onfi tablets and suspension** • **Androderm, Androgel 1.62%, Axiron, Fortesta, Striant**	*Prior Authorization thru OptumRX*
Aldurazyme, Cinqair, Darzalex, Empliciti, Imlygic, Kanuma, Naglazyme, Nucala, Onivyde, Portrazza, Supprelin LA, Yondelis	*Prior Authorization thru MagellanRX*
All hemophilia medications	*Prior Authorization thru MagellanRX*

Plan Exclusions
Effective July 1, 2017, the drugs listed below are **not** a Covered Benefit.

- **Locoid, all forms**: *Alternative is hydrocortisone cream*
- **Riomet solution**: *Alternative is metformin tablets*
- **Targadox tablets**: *Alternative is doxycycline*
- **Wellbutrin XL tablets**: *Alternative is bupropion XL*

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

Medications Not Covered

Effective July 1, 2017 the follow medications are not covered. Formulary alternatives are listed below.

- **Alogliptin tablets**: *Alternative is Januvia*
- **Alogliptin/metformin tablets**: *Alternative is Janumet*
- **Alogliptin/pioglitazone tablets**: *Alternative is pioglitazone/metformin*
- **Antara capsules**: *Alternative is fenofibrate*
- **Cephalexin tablets**: *Alternative is cephalexin capsules*
- **Fluorouracil 0.5% cream**: *Alternative is fluorouracil 5% cream*
- **Inderal XL capsules**: *Alternative is atenolol*
- **Innopran XL capsules**: *Alternative is atenolol*
- **Lipofen capsules**: *Alternative is fenofibrate*
- **Naprelan tablet**s: *Alternative is naproxen*
- **Pandel cream**: *Alternative is hydrocortisone cream*
- **Prilosec powder**: *Alternative is omeprazole suspension*
- **Rayos tablets**: *Alternative is prednisone tablets*
- **Selrx shampoo**: *Alternative is selenium sulfide shampoo*
- **Tanzeum**: *Alternative is Byetta*
- **Zenzedi tablets**: *Alternative is dextroamphetamine*
- **Zolpidem SL**: *Alternative is zolpidem tablets*
- **Zuplenz film**: *Alternative is ondansetron tablets*