



FULLY FUNDED PLANS ONLY

October 24, 2018

RE: Semi-Annual Notice of Changes

Dear Health New England Member:

As we do two times each year, we are notifying you of changes to your plan. Some of these changes are driven by regulation, some aim to improve your experience, and others aim to control rising healthcare costs. Unless otherwise noted, these changes are effective January 1, 2019.

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,

A handwritten signature in black ink that reads "Brian P. Moody".

Brian P. Moody
Director of Service Operations

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 01-2019

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 January 1, 2019, unless noted below.

The EOC is amended as shown below.

Benefit, Program, or Requirement	Description
<p>Genetic Testing</p>	<p>Section 3 – Covered Benefits – Genetic Testing</p> <p>The text below is added to the description of the benefit for genetic testing.</p> <p>HNE limits certain genetic tests to once per lifetime of the member. These are tests where the results will never change on subsequent testing.</p> <p>Clarification</p>
<p>Durable Medical Equipment, Prosthetic Equipment and Medical and Surgical Supplies from Out-of-Plan Providers</p> <p>Please note: This applies only if you are covered by a PPO or POS plan.</p>	<p>Section 3 – Covered Benefits – Durable Medical Equipment, Prosthetic Equipment and Medical and Surgical Supplies</p> <p>Prior Approval is required for:</p> <ul style="list-style-type: none"> • Durable Medical Equipment • Prosthetic Equipment • Medical and surgical supplies <p>Prior Approval requests and claims are reviewed by Health New England’s Durable Medical Equipment Benefit Manager (DBM), Northwood Inc. If you use an In-Plan Provider, that provider will request Prior Approval and submit claims for you.</p> <p>If you use an Out-of-Plan Provider, you must have the provider fax an authorization request form to Northwood Inc. to request Prior Approval. This form is available online at www.northwoodinc.com. Go to ‘Providers’ and click on the Health New England program tab. The form can be faxed to Northwood at (877) 552-6551. If immediate service is needed, please have your provider contact Northwood at (877) 807-3701. Your provider can file claims with Northwood electronically or on paper. Paper claims should be sent to: Northwood, Inc. Attn: Health New England Claim P.O. Box 510 Warren, MI 48090-0510</p> <p>The following applies only if your PPO plan has In-Plan benefits for PHCS (Private Healthcare Systems) providers.</p> <p>If you use a PHCS provider, please have them follow the above Prior Approval and claims procedures for Out-of-Plan Providers.</p> <p>Clarification</p>

Benefit, Program, or Requirement	Description
Durable Medical Equipment, Prosthetic Equipment and Medical and Surgical Supplies – Covered items	<p>Section 3 – Covered Benefits – Durable Medical Equipment, Prosthetic Equipment and Medical and Surgical Supplies</p> <p>The items below are added to the list of items covered by Health New England.</p> <ul style="list-style-type: none"> • Ostomy supplies (including adhesives and adhesive removers) • External urinary catheters • Power Operated Vehicles if medical criteria are met. <p>Section 4 – Exclusions and Limitations</p> <p>The item below is removed from the list of exclusions.</p> <ul style="list-style-type: none"> • External urinary catheters <p>Clarification</p>
Durable Medical Equipment, Prosthetic Equipment and Medical and Surgical Supplies – Items not covered	<p>Section 3 – Covered Benefits – Durable Medical Equipment, Prosthetic Equipment and Medical and Surgical Supplies</p> <p>The item below is removed the list of covered items. It is added the list of what is not covered.</p> <ul style="list-style-type: none"> • Compression stockings <p>Effective January 1, 2019</p>
Durable Medical Equipment, Prosthetic Equipment and Medical and Surgical Supplies – Clarification	<p>Section 3 – Covered Benefits – Durable Medical Equipment, Prosthetic Equipment and Medical and Surgical Supplies</p> <p>In the list of what is not covered, the item “Saunders Lumbar Hometrac®” is replaced with the item below.</p> <ul style="list-style-type: none"> • Home lumbar traction <p>Clarification</p>
Nutritional Support (Does not apply to PPO or POS plans.)	<p>Section 3 – Covered Benefits – Nutritional Support</p> <p>The text below is added to the HMO EOC.</p> <p>Nutritional support items must be obtained from an In-Plan Provider, unless there is no In-Plan Provider who can supply them. If an item is not available from an In-Plan Provider, you may get the item from an Out-of-Plan Provider.</p> <p>Effective January 1, 2019</p>
Health New England’s Wellness Reimbursement Program	<p>Section 3 – Special Programs and Discounts</p> <p>The reimbursement you can get through Health New England’s Wellness Program will be increased to \$200 for an individual plan and \$400 for a family plan. The \$400 payment for a family plan can be split among family members on the plan. The maximum for each member on the plan is \$200.</p> <p>Effective for expenses incurred on or after January 1, 2019</p>

Benefit, Program, or Requirement	Description								
<p>Clarification to Exclusions and Limitations</p>	<p>Section 4 – Exclusions and Limitations</p> <p>Items in the list of “Exclusions” are replaced as shown below.</p> <table border="1" data-bbox="490 352 1464 961"> <thead> <tr> <th data-bbox="490 352 977 390">Item</th> <th data-bbox="977 352 1464 390">Replacement Item</th> </tr> </thead> <tbody> <tr> <td data-bbox="490 390 977 688"> Corrective intraocular Lenses, for example toric lenses Eye glasses, contact lenses, laser vision correction surgery and orthoptics. See “Limitations and Partial Exclusions” later in the section for some exceptions. </td> <td data-bbox="977 390 1464 688"> Eye glasses, conventional contact lenses used for vision correction, laser vision correction surgery, orthoptics, vision therapy, corrective intraocular lenses for treatment of astigmatism (for example toric lenses) – (See “Limitations and Partial Exclusions” later in the section for some exceptions.) </td> </tr> <tr> <td data-bbox="490 688 977 793"> Services by Health Diagnostic Laboratory, Inc. </td> <td data-bbox="977 688 1464 793"> Services by non-standard labs (for example Health Diagnostic Laboratory, Inc.) </td> </tr> <tr> <td data-bbox="490 793 977 961"> Specialty clothing for specific medical conditions </td> <td data-bbox="977 793 1464 961"> Specialty clothing for specific medical conditions (for example compression vests for the treatment of behavioral issues associated with behavioral disorders) </td> </tr> </tbody> </table> <p>Clarification</p>	Item	Replacement Item	Corrective intraocular Lenses, for example toric lenses Eye glasses, contact lenses, laser vision correction surgery and orthoptics. See “Limitations and Partial Exclusions” later in the section for some exceptions.	Eye glasses, conventional contact lenses used for vision correction, laser vision correction surgery, orthoptics, vision therapy, corrective intraocular lenses for treatment of astigmatism (for example toric lenses) – (See “Limitations and Partial Exclusions” later in the section for some exceptions.)	Services by Health Diagnostic Laboratory, Inc.	Services by non-standard labs (for example Health Diagnostic Laboratory, Inc.)	Specialty clothing for specific medical conditions	Specialty clothing for specific medical conditions (for example compression vests for the treatment of behavioral issues associated with behavioral disorders)
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<p>Services Not Covered</p>	<p>Section 4 – Exclusions and Limitations</p> <p>The item below is added the list of items not covered by Health New England.</p> <ul style="list-style-type: none"> • Hippotherapy (the use of horseback riding as a therapeutic or rehabilitative treatment) <p>Clarification</p>								
<p>Stretta® treatment</p>	<p>Section 5 – Claims and Utilization Management Procedures</p> <p>The item below is removed from the list of services and procedures that require Prior Approval.</p> <ul style="list-style-type: none"> • Stretta® treatment for gastroesophageal reflux disease (GERD) <p>Section 4 – Exclusions and Limitations</p> <p>The item below is added to the list of exclusions.</p> <ul style="list-style-type: none"> • Stretta® treatment for gastroesophageal reflux disease (GERD) <p>Effective January 1, 2019</p>								

Benefit, Program, or Requirement	Description								
Services and Procedures that Require Prior Approval – Items added	<p>Section 5 – Claims and Utilization Management Procedures</p> <p>The items below are added to the list of “Services and Procedures that Require Prior Approval.” This is effective December 1, 2018.</p> <ul style="list-style-type: none"> • Optune® treatment for glioblastoma • Bronchial thermoplasty for the treatment of severe asthma (This was not a covered benefit prior to 12/1/2018.) • Contact lenses <p>The item below is added to the list of “Services and Procedures that Require Prior Approval.” This is effective August 1, 2018.</p> <ul style="list-style-type: none"> • Fecal microbiota transplant 								
Services and Procedures that Require Prior Approval – Services reviewed by eviCore	<p>Section 5 – Claims and Utilization Management Procedures</p> <p>The text below is added for these services:</p> <ul style="list-style-type: none"> • Diagnostic Imaging • Genetic testing • Sleep studies <p>Requests for Prior Approval of these services will be reviewed by eviCore. You or your doctor can contact eviCore at (888) 693-3211. If you have any questions, please call Member Services at the number at the bottom of this page.</p> <p>Clarification</p>								
Services and Procedures that Require Prior Approval – Clarifications	<p>Section 5 – Claims and Utilization Management Procedures</p> <p>Items in the list of “Services and Procedures that Require Prior Approval” are replaced as shown below.</p> <table border="1" data-bbox="490 1207 1463 1549"> <thead> <tr> <th data-bbox="490 1207 977 1245">Item</th> <th data-bbox="977 1207 1463 1245">Replacement Item</th> </tr> </thead> <tbody> <tr> <td data-bbox="490 1245 977 1276">Mobi-C Artificial Cervical Disc</td> <td data-bbox="977 1245 1463 1276">Artificial Intervertebral Cervical Disc</td> </tr> <tr> <td data-bbox="490 1276 977 1381">Sacral nerve stimulation for urinary incontinence</td> <td data-bbox="977 1276 1463 1381">Sacral nerve stimulation and percutaneous tibial nerve stimulation for urinary incontinence</td> </tr> <tr> <td data-bbox="490 1381 977 1549">Scleral lenses</td> <td data-bbox="977 1381 1463 1549">Contact lenses used either to treat a disease of the eye or, or for replacement of a lens in the eye. The fitting of the lenses also requires Prior Approval.</td> </tr> </tbody> </table> <p>Clarification</p>	Item	Replacement Item	Mobi-C Artificial Cervical Disc	Artificial Intervertebral Cervical Disc	Sacral nerve stimulation for urinary incontinence	Sacral nerve stimulation and percutaneous tibial nerve stimulation for urinary incontinence	Scleral lenses	Contact lenses used either to treat a disease of the eye or, or for replacement of a lens in the eye. The fitting of the lenses also requires Prior Approval.
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Benefit, Program, or Requirement	Description
Coverage for Disabled Child Dependents	<p>Section 7 – Eligibility – Disabled Child Dependents</p> <p>The text below replaces the text in the EOC and Amendment 01-2017.</p> <p>What happens if my child is disabled when he or she turns 26?</p> <p>HNE will continue coverage for a Dependent if:</p> <ul style="list-style-type: none"> • The Dependent is totally disabled by a physical or mental condition • The disability prevents the Dependent from earning his or her own support, and • The disability is long-term or will go on indefinitely <p>HNE will continue the Dependent’s coverage until the disability ends. At reasonable intervals, HNE may require proof of disability and dependency. We may require that a doctor of HNE’s choice examine the Member. The disabled child must have been covered by HNE prior to reaching age 26 or must have had continuous group health coverage from the onset of the disability prior to joining HNE.</p> <p>Clarification</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, 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.

You must try:	First Line Drug(s):	• Olopatadine 0.2% and azelastine
Before HNE will cover:	Step Therapy Drug(s):	• Pazeo
You must try:	First Line Drug(s):	• Azelastine
Before HNE will cover:	Step Therapy Drug(s):	• Epinastine
You must try:	First Line Drug(s):	• azathioprine
Before HNE will cover:	Step Therapy Drug(s):	• Azasan

Quantity Limit Additions

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

Drug Name	Quantity Limit per 30 day supply (unless otherwise specified)
• Belsomra	30 tablets
• Emverm	6 chews per 21 days
• Fluocinonide cream	60 grams
• Lidocaine/Prilocaine	60 grams

New Prior Authorizations (PA) Required Effective January 1, 2019

Durolane, GelSyn-3, Genvisc 850, Hyalagan, Hymovis, Monovisc, Orthovisc, Supartz/Supartz FX, Synvisc, Synvisc-One, TriVisc, Visco 3, Vpriv	<i>Prior Auth thru MagellanRX</i>
Doxepin cream	<i>Prior Auth thru Optum</i>

Prescription Drug Coverage

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

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

- **Noritate cream. Alternative is metronidazole 0.75% cream**
- **Rayaldee. Alternative is calcitriol**
- **Utopic. Alternative is urea topical cream**
- **Veregen ointment. Alternative is imiquimod**
- **Zyclara. Alternative is imiquimod**

Plan Exclusions Effective January 1, 2019

- **Urelle. Alternative is urin d/s**
- **Uro-mp. Alternative is urin d/s**
- **Ustell. Alternative is urin d/s**
- **Uribel. Alternative is urin d/s**

