Health New England

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
Genetic Testing	**Section 3 – Covered Benefits – Genetic Testing** The text below is added to the description of the benefit for genetic testing. HNE limits certain genetic tests to once per lifetime of the member. These are tests where the results will never change on subsequent testing. **Clarification**
Durable Medical Equipment, Prosthetic Equipment and Medical and Surgical Supplies from Out-of-Plan Providers Please note: This applies only if you are covered by a PPO or POS plan.	**Section 3 – Covered Benefits – Durable Medical Equipment, Prosthetic Equipment and Medical and Surgical Supplies** Prior Approval is required for: • Durable Medical Equipment • Prosthetic Equipment • Medical and surgical supplies 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. 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 **The following applies only if your PPO plan has In-Plan benefits for PHCS (Private Healthcare Systems) providers.** If you use a PHCS provider, please have them follow the above Prior Approval and claims procedures for Out-of-Plan Providers. **Clarification**

Benefit, Program, or Requirement	Description
Durable Medical Equipment, Prosthetic Equipment and Medical and Surgical Supplies – Covered items	**Section 3 – Covered Benefits – Durable Medical Equipment, Prosthetic Equipment and Medical and Surgical Supplies** The items below are added to the list of items covered by Health New England. • Ostomy supplies (including adhesives and adhesive removers) • External urinary catheters • Power Operated Vehicles if medical criteria are met. **Section 4 – Exclusions and Limitations** The item below is removed from the list of exclusions. • External urinary catheters **Clarification**
Durable Medical Equipment, Prosthetic Equipment and Medical and Surgical Supplies – Compression Stockings	**Section 3 – Covered Benefits – Durable Medical Equipment, Prosthetic Equipment and Medical and Surgical Supplies** Health New England will cover up to 3 pairs of compression stockings per Calendar Year when Medically Necessary. **Effective January 1, 2019**
Durable Medical Equipment, Prosthetic Equipment and Medical and Surgical Supplies – Clarification	**Section 3 – Covered Benefits – Durable Medical Equipment, Prosthetic Equipment and Medical and Surgical Supplies** In the list of what is not covered, the item "Saunders Lumbar Hometrac®" is replaced with the item below. • Home lumbar traction **Clarification**
Nutritional Support (Does not apply to PPO or POS plans.)	**Section 3 – Covered Benefits – Nutritional Support** The text below is added to the HMO EOC. 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. **Effective January 1, 2019**
Health New England's Wellness Reimbursement Program	**Section 3 – Special Programs and Discounts** 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. **Effective for expenses incurred on or after January 1, 2019**

<table>
<tr><th>Benefit, Program, or Requirement</th><th>Description</th></tr>
<tr><td>Clarification to Exclusions and Limitations</td><td>
Section 4 – Exclusions and Limitations

Items in the list of “Exclusions” are replaced as shown below.
<table>
<tr><th>Item</th><th>Replacement Item</th></tr>
<tr><td>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>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>Services by Health Diagnostic Laboratory, Inc.</td><td>Services by non-standard labs (for example Health Diagnostic Laboratory, Inc.)</td></tr>
<tr><td>Specialty clothing for specific medical conditions</td><td>Specialty clothing for specific medical conditions (for example compression vests for the treatment of behavioral issues associated with behavioral disorders)</td></tr>
</table>
Clarification
</td></tr>
<tr><td>Services Not Covered</td><td>
Section 4 – Exclusions and Limitations

The item below is added the list of items not covered by Health New England.
• Hippotherapy (the use of horseback riding as a therapeutic or rehabilitative treatment)

Clarification
</td></tr>
<tr><td>Stretta® treatment</td><td>
Section 5 – Claims and Utilization Management Procedures

The item below is removed from the list of services and procedures that require Prior Approval.
• Stretta® treatment for gastroesophageal reflux disease (GERD)

Section 4 – Exclusions and Limitations

The item below is added to the list of exclusions.
• Stretta® treatment for gastroesophageal reflux disease (GERD)

Effective January 1, 2019
</td></tr>
</table>

<table>
<tr><th>Benefit, Program, or Requirement</th><th>Description</th></tr>
<tr><td>Services and Procedures that Require Prior Approval – Items added</td><td>Section 5 – Claims and Utilization Management Procedures

The items below are added to the list of “Services and Procedures that Require Prior Approval.” This is effective December 1, 2018.
• 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

The item below is added to the list of “Services and Procedures that Require Prior Approval.” This is effective August 1, 2018.
• Fecal microbiota transplant</td></tr>
<tr><td>Services and Procedures that Require Prior Approval – Services reviewed by eviCore</td><td>Section 5 – Claims and Utilization Management Procedures

The text below is added for these services:
• Diagnostic Imaging
• Genetic testing
• Sleep studies

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.

Clarification</td></tr>
<tr><td>Services and Procedures that Require Prior Approval – Clarifications</td><td>Section 5 – Claims and Utilization Management Procedures

Items in the list of “Services and Procedures that Require Prior Approval” are replaced as shown below.

<table><tr><th>Item</th><th>Replacement Item</th></tr><tr><td>Mobi-C Artificial Cervical Disc</td><td>Artificial Intervertebral Cervical Disc</td></tr><tr><td>Sacral nerve stimulation for urinary incontinence</td><td>Sacral nerve stimulation and percutaneous tibial nerve stimulation for urinary incontinence</td></tr><tr><td>Scleral lenses</td><td>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></table>
Clarification</td></tr>
</table>

Benefit, Program, or Requirement	Description
Coverage for Disabled Child Dependents	**Section 7 – Eligibility – Disabled Child Dependents** The text below replaces the text in the EOC and Amendment 01-2017. **What happens if my child is disabled when he or she turns 26?** HNE will continue coverage for a Dependent if: • 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 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. **Clarification**

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	*Prior Auth thru MagellanRX*
Doxepin cream	*Prior Auth thru Optum*

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***