Health New England

FULLY FUNDED PLANS ONLY

April 18, 2016

RE: Semi-Annual Notice of Changes

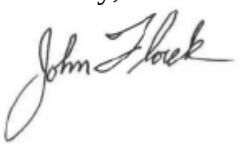
Dear Health New England Member:

Health New England (HNE) is making some changes to your Plan, most of which become effective July 1, 2016.

I have enclosed an amendment to your HNE 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

AMENDMENT 02-2016

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, 2016, unless noted below.

The EOC is amended as follows.

Benefit, Program, or Requirement	Description
Explanations of Benefits (EOBs) Are Now Provided Online	Health New England no longer routinely mails EOBs to members. We now provide EOBs in electronic format. We provide EOBs on our secure member portal at my.HealthNewEngland.org. You can print an EOB from the portal. Or, if you wish to have EOBs sent to you, you can log onto the portal and change your mailing preferences. You can also request paper copies of your EOBs by calling Member Services at (800) 310-2835.
Pharmacy Benefit Manager OptumRx	Health New England's pharmacy benefit manager, Catamaran, has combined with OptumRx. Your prescription drug benefit will now be administered by OptumRx. Your prescription drug benefit has not changed. You can continue to use the same ID card and go to the same pharmacies.
Zostavax® Vaccine for the Prevention of Shingles	**Section 3 – Covered Benefits – Preventive Care** Zostavax® vaccine for the prevention of shingles (herpes zoster) is covered **only** for members 60 years of age and older. **Effective July 1, 2016**
Services Related to Screening Colonoscopies and Sigmoidoscopies	**Section 3 – Covered Benefits – Preventive Care** **Preparation prescriptions related to the In-Plan screening colonoscopies and sigmoidoscopies – Clarification** Health New England covers **only generic** prep prescriptions with no member cost sharing. Brand name prescriptions are covered subject to your plan's cost sharing for deductible and copays. **Consultation prior to In-Plan screening colonoscopies and sigmoidoscopies** There is no member cost sharing for the consult prior to these screening procedures. **Effective January 1, 2016**

Benefit, Program, or Requirement	Description
Sleep Studies by Out-of-Plan Providers Note: This applies to PPO and POS plans.	**Section 3 – Covered Benefits – Sleep Studies** Sleep studies done by Out-of-Plan providers will not be covered if you do not have Prior Approval. Also, supplies related to the study will not be covered if you do not have Prior Approval. **Effective July 1, 2016**
Ambulance Services from Out-of-Plan Providers	**Section 3 – Covered Benefits – Ambulance and Transportation Services** The following is added to the EOC: For ground ambulance services, Health New England covers only the ambulance transport and mileage. Health New England will not cover ancillary supplies or services *when billed as separate line items* as a part of ground ambulance services. Examples of these supplies and services are: ECG Tracing, drugs, intubation, and measuring of oxygen in the blood. **Effective July 1, 2016**
Behavioral Health Treatment	**Section 3 – Covered Benefits – Behavioral Health (Mental Health and Substance Abuse Services) – What is Covered and What is Not Covered** The following item listed under *"What is Covered"*: • Acute Residential Treatment (ART) Is replaced with: • Community Based Acute Treatment program (CBAT) CBAT is a short term, intensive, structured 24 hour community based program. The typical length of stay is from 1 to 14 days. CBAT is used as a clinically appropriate diversion to inpatient hospitalization. Sometimes it is used as a step down from an inpatient hospitalization. Health New England has clinical review criteria for admissions to CBAT programs. Notification is required. **Effective February 1, 2016**
Treatment at Out-of-Plan Facilities 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 from either: • The Commission on Accreditation of Rehabilitation Facilities (CARF), or • The Joint Commission for Accreditation of Hospital Organizations (JACHO) certification **Effective July 1, 2016**

Benefit, Program, or Requirement	Description
Benefit Exclusions	**Section 4 – Exclusions and Limitations** **Clarification** The following are added to the list of Exclusions: • Digital tomosynthesis (3D mammography) • Marijuana for medical use
Children's Preventive Dental Services Note: Does not apply to groups with 50 or fewer employees and non-group contracts.	Health New England no longer offers coverage for Children's Preventive Dental services (for children under age 12). The Altus benefit is a preventive dental benefit which covers only the following services for children under age 12: • Initial oral examination – once per dentist • Periodic exams – once every six months • X-rays of entire mouth – once every 60 months or five years • Bitewing X-rays – once every six months when needed • Single tooth X-ray – as needed • Routine cleaning, scaling, and polishing of teeth – once every six months • Fluoride treatments – once every six months The Comprehensive Altus EHB pediatric dental benefit offered to Small Groups and Individuals remains in place. (This is a benefit for children under the age of 19.) **Effective on plan renewal on or after July 1, 2016**

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, 2016
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):**	• First line: Two of the following: quetiapine, olanzapine, risperidone and ziprasidone
	Second Line Drug:	• Aripiprazole
Before HNE will cover:	**Step Therapy Drug(s)**	• Fanapt • Latuda • Paliperidone ER • Rexulti • Saphris
You must try:	**First line Drug(s):**	• Two of the following: quetiapine, olanzapine, risperidone and ziprasidone
Before HNE will cover:	**Step Therapy Drug(s)**	• Aripiprazole
You must try:	**First line Drug(s):**	• Clozapine
Before HNE will cover:	**Step Therapy Drug(s)**	• Clozapine ODT
You must try:	**First line Drug(s):**	• Risperidone
Before HNE will cover:	**Step Therapy Drug(s)**	• Risperidone ODT
You must try:	**First line Drug(s):**	• Acyclovir 5% ointment
Before HNE will cover:	**Step Therapy Drug(s)**	• Denavir cream
You must try:	**First line Drug(s):**	• Metronidazole 0.75% and Finacea gel
Before HNE will cover:	**Step Therapy Drug(s)**	• Mirvaso gel • Noritate cream
You must try:	**First line Drug(s):**	• Four generic antifungal products
Before HNE will cover:	**Step Therapy Drug(s)**	• Ertaczo cream • Ketoconazole foam • Oxistat cream • Oxistat lotion • Vusion ointment

Prescription Drug Coverage *Note: Tier 1 – lowest copay; Tier 2 – mid copay level; Tier 3 highest copay level*		
You must try:	**First line Drug(s):**	• Tretinoin and Adapalene
Before HNE will cover:	**Step Therapy Drug(s)**	• Aczone gel • Azelex cream • Differin lotion • Epiduo gel • Fabior foam • Tretinoin micro 0.04% and 0.1% • Veltin gel • Ziana gel
You must try:	**First line Drug(s):**	• High dose Atorvastatin
Before HNE will cover:	**Step Therapy Drug(s)**	• Vytorin
You must try:	**First line Drug(s):**	• Irbesartan or Irbesartan/HCTZ and Valsartan or Valsartan/HCTZ
Before HNE will cover:	**Step Therapy Drug(s)**	• Azor • Benicar or Benicar HCT • Candesartan or Candesartan/HCTZ • Eprosartan • Tekamlo • Tekturna or Tekturna HCT • Telmisartan or Telmisartan/HCTZ • Telmisartan/Amlodipine • Teveten HCT • Tribenzor

Tier Assignments
The following drugs are changing Copay Tier assignment effective July 1, 2016.

Drug Name	Tier before 7/1/16	Tier on or after 7/1/16
Androgel 1.62%	Tier 2	Tier 3
Azelex cream	Tier 2	Tier 3
Daraprim	Tier 2	Tier 3

Quantity Limit Additions
Starting July 1, 2016, Health New England will add the Quantity Limits to the drugs listed below.

Drug Name	Quantity Limit per 30 day supply (unless otherwise specified)
• Acitretin 10mg • Acitretin 17.5mg • Methylergonovine	30 capsules/tablets
• Acitretin 25mg	60 capsules
• Picato gel	0.015% gel: 3 units 0.05% gel: 2 units

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)
Starting July 1, 2016, Health New England will add the Quantity Limits to the drugs listed below.

Drug Name	Quantity Limit per 30 day supply (unless otherwise specified)
• All lice kits	1 kit
• Acyclovir ointment • Denavir cream	5 grams
• Tretinoin micro gel	20 grams
• Aczone gel • Azelex cream • Mirvaso gel • Oxistat lotion • Tazorac cream • Tazorac gel • Veltin gel • Ziana gel	30 grams
• Epiduo gel	45 grams
• Fabior foam • Ketoconazole foam • Vusion ointment	50 grams
• Differin lotion • Malathion lotion • Permethrin lotion • RA Lice liquid	59 ML
• Ertaczo cream • Lidocaine 5% ointment • Noritate cream • Oxistat cream • Panretin gel • Permethrin cream • Sorilux foam	60 grams
• Diclofenac 3% gel • Voltaren gel	100 grams
• Ulesfia lotion	227 grams
• Lice Killing Shampoo	236 ML

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

New Prior Authorizations

Effective July1, 2016, the following drugs will require Prior Authorization.

- All compounded medications that cost $40 and above will require prior authorization.
- Daraprim
- Virazole
- Targretin gel and capsules
- Zostavax for members under 60 years of age

Medications Not Covered

Effective July 1, 2016 the follow drugs will not be covered because Formulary alternatives are available.

- Acanya gel: Not covered, use separate agents: clindamycin and benzoyl peroxide
- Carac cream: Not covered, formulary alternative: fluorouracil cream
- Renovo patch: Not covered, formulary alternative: over the counter capsaicin cream
- Lidocaine 3% lotion: Not covered, formulary alternative: lidocaine gel
- Lidorx gel: Not covered, formulary alternative: lidocaine gel
- Veltrix cream: Not covered, formulary alternative: lidocaine cream
- Eurax cream: Not covered, formulary alternative: permethrin cream
- Neo-synalar cream: Not covered, formulary alternative: fluocinonide cream
- Alcortin gel: Not covered, formulary alternative: econazole cream

Plan Exclusions

Effective July 1, 2016, the drugs listed below are **not** a Covered Benefit.

- Neutrasal will be excluded.
- Clindagel will be excluded. Alternative: Clindamycin
- Edarbi will be excluded. Alternative: Irbesartan or Valsartan
- Edarbyclor will be excluded. Alternative: Irbesartan/HCTZ or Valsartan/HCTZ
- Equetro will be excluded. Alternative: Carbamazepine
- Fenofibrate 120mg will be excluded. Alternative: Fenofibrate 130mg
- Fluoxetine 60mg tablets will be excluded. Alternative: 3 capsules of Fluoxetine 20mg capsules
- Minocin kit will be excluded. Alternative: Minocycline immediate release
- Minocycline SR 45, 90, 145mg tablets will be excluded. Alternative: Minocycline immediate release
- Proventil will be excluded. Alternative: Proair or Ventolin
- Retin-A micro will be excluded. Alternative: Tretinoin
- Silenor will be excluded. Alternative: Zaleplon or Zolpidem
- Solodyn will be excluded. Alternative: Minocycline immediate release
- Versacloz will be excluded. Alternative: Clozapine ODT
- Zegerid packets will be excluded. Alternative: Omeprazole

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

Compound Drugs

A multi-ingredient compound medication is a mixture of agents that have to be mixed by a trained pharmacist. A multi-ingredient compound that contains any of the following compound agents is not a Covered Benefit.

- Diltiazem tablets
- Lamotrigine tablets
- Meloxicam tablets
- Lidocaine/Prilocaine ointment