FULLY FUNDED PLANS ONLY

October 20, 2014

RE: Semi-Annual Notice of Changes

Dear HNE Member:

Health New England (HNE) is making some changes to your Plan, most of which become effective January 1, 2015.

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 5:00 p.m. We will be happy to help you.

Sincerely,

John Florek
Member Services Manager

AMENDMENT 01-2015

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, 2015, unless noted below.

The EOC is amended as follows:

Benefit, Program, or Requirement	Description
Exclusions and Limitations	**Section 4 – Exclusions and Limitations** Effective June 20, 2014, this item is **removed** from the list of *Exclusions*: • Gender reassignment operations and treatments
Services and Procedures that require Prior Approval	**Section 5 – Claims and Utilization Management Procedures** Effective June 20, 2014, this item is **added** to the list of *Services and Procedures that Require Prior Approval*: • Gender reassignment operations and treatments Effective September 10, 2014, this item is **added** to the list of *Services and Procedures that Require Prior Approval*: • Mobi-C Artificial Cervical Disc The Mobi-C Artificial Cervical Disc was not a covered benefit prior to September 10, 2014. Effective December 1, 2014, this item is **added** to the list of *Services and Procedures that Require Prior Approval*: • Preimplantation Genetic Diagnosis (PGD)
Clarification: Corrective Intraocular Lenses	Corrective intraocular lenses are not covered by HNE. Toric lenses are an example of the type of lenses not covered by HNE.

Benefit, Program, or Requirement	Description
Low-dose Computed Tomography Screening for Lung Cancer	Effective January 1, 2015 HNE covers screening for lung cancer with low-dose computed tomography. The screening is covered only for adults ages 55 to 80. Members must be in a high risk category for developing lung cancer. The screening must be approved by the vendor HNE uses to review high cost imaging services. These services can be best provided at a facility with a lung cancer program. HNE has determined which facilities have such a program. When the screening is done at one of these facilities, the Member will not be responsible for a Deductible or Copay. If the screening is done at any other facility, the services will be covered subject to any Deductible and Copay your plan may have. You can contact Member Services to find out what facilities HNE has specified for these services.
Time limits for HNE's Response to Complaints and Appeals	**Section 6 – Inquiries and Grievances** The time limit within which HNE must respond to complaints and appeals is changed from "30 ***business*** days" to "30 ***calendar*** days." This applies to: • Complaints • Benefit appeals (pre-service and post-service) • Clinical appeals (pre-service and post-service) • Time extensions you agree to. For example you may agree to a time extension related to a signed release for medical records. • New time limits when HNE offers to reconsider a decision. This change is effective March 14, 2014.
Clarification: Reimbursement for Covered Services Received from Out-of-Plan Providers	If you have paid for Covered Services from an Out-of-Plan Provider and want to be reimbursed, you must submit a claim to HNE. To submit a claim you must use a "Member Reimbursement Medical Claim Form." Instructions for submitting a claim are on the Claim Form. To get a Claim Form, visit hne.com or call Member Services. HNE may require you to supply documents that show the services you received were Medically Necessary and/or Covered Services under your plan. If HNE determines that the services you received were not Covered Services or were not Medically Necessary, we may deny coverage. If HNE denies coverage, you will be responsible for the cost of the services. Please note: If you have an HMO plan, you are covered for services from Out-of-Plan Providers only in an emergency or when you have Prior Approval from HNE for the services.

Benefit, Program, or Requirement	Description
Cost Estimator for Services & Out-of-Pocket Costs	HNE now has a way for you to get information on estimated costs for health care services. You can also get an estimate of what you will pay for those services. Available information includes: • The estimated or maximum allowed amount or charge for a proposed admission, procedure or service. • The estimated amount you will be responsible to pay for a proposed admission, procedure, or service. This includes any Deductible, Copay, Coinsurance, facility fee or other amount you pay. This will be based on the information HNE has at the time the request is made. The service must be a Medically Necessary covered benefit. If the health care services are then provided, you will not be required to pay more than the estimated amount for Member responsibility. However, if unforeseen services arise out of the proposed admission, procedure or service, you may have additional cost sharing as required by your HNE plan. To get cost estimates for health care services you can: • Call Member Services toll free at 800.310.2835. TTY/TTD users call 800.439.2370. • Email us at memberservices@hne.com. • Go to hnedirect.com and log on as a Member.
This applies only to: **Plans with Coverage for Pediatric Dental Services for Children under age 19**	There is an In-Network Out-of-Pocket Maximum for dental services for children under age 19. This is the most each covered person will pay for all covered services received from a participating dentist in a plan year. This maximum is changing. The new maximum will be $350 for one Member and $700 for two or more Members. This change is effective when your policy renews on or after January 1, 2015.
This applies only to: **High Deductible Health Plans (HDHP). It does not apply to the HNE Catastrophic Plan.**	Each year, the Internal Revenue Service (IRS) decides the minimum Deductible level for qualified High Deductible Health Plans (HDHP). Based on this, HNE will increase the embedded Deductible for these plans to $2,600. This will ensure your plan remains qualified. The embedded Deductible is the most any one family member on a family plan must pay before the Plan will pay benefits for that member. The overall family Deductible will remain at $4,000. The Deductible for an individual on an individual plan will remain at $2,000. This change is effective when your policy renews on or after January 1, 2015.

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, 2015:
For 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.

You must try:	**First Line Drug(s):**	• sumatriptan, naratriptan, and rizatriptan
Before HNE will cover:	**Step Therapy Drug(s):**	• Relpax Note: Applies to new prescriptions only
You must try:	**First Line Drug(s):**	• sumatriptan, naratriptan, and rizatriptan
Before HNE will cover:	**Step Therapy Drug(s):**	• Frova Note: Applies to new prescriptions only
You must try:	**First Line Drug(s):**	• sumatriptan, naratriptan, and rizatriptan
Before HNE will cover:	**Step Therapy Drug(s):**	• Axert Note: Applies to new prescriptions only
You must try:	**First Line Drug(s):**	• sumatriptan and naratriptan
Before HNE will cover:	**Step Therapy Drug(s):**	• rizatriptan Note: Applies to new prescriptions only
You must try:	**First Line Drug(s):**	• sumatriptan and naratriptan
Before HNE will cover:	**Step Therapy Drug(s):**	• zolmitriptan Note: Applies to new prescriptions only
You must try:	**First Line Drug(s):**	• sumatriptan nasal spray
Before HNE will cover:	**Step Therapy Drug(s):**	• Zomig Nasal Spray Note: Applies to new prescriptions only
You must try:	**First Line Drug(s):**	• sumatriptan , naratriptan, rizatriptan, and zolmitriptan
Before HNE will cover:	**Step Therapy Drug(s):**	• Sumatriptan Nasal Spray Note: Applies to new prescriptions only

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):**	• metformin er
Before HNE will cover	**Step Therapy Drug(s):**	• Glumetza Note: Applies to new prescriptions only
You must try:	**First Line Drug(s):**	• omeprazole, pantoprazole, and Nexium OTC
Before HNE will cover:	**Step Therapy Drug(s):**	• Nexium RX
You must try:	**First Line Drug(s):**	• omeprazole, pantoprazole, and Nexium OTC
Before HNE will cover:	**Step Therapy Drug(s):**	• Dexilant
You must try:	**First Line Drug(s):**	• omeprazole, pantoprazole, and Nexium OTC
Before HNE will cover:	**Step Therapy Drug(s):**	• Kapidex
You must try:	**First Line Drug(s):**	• omeprazole, pantoprazole, and Nexium OTC
Before HNE will cover:	**Step Therapy Drug(s):**	• omeprazole sodium bicarb
You must try:	**First Line Drug(s):**	• omeprazole, pantoprazole, and Nexium OTC
Before HNE will cover:	**Step Therapy Drug(s):**	• Prevacid Solutab
You must try:	**First Line Drug(s):**	• omeprazole, pantoprazole, and Nexium OTC
Before HNE will cover:	**Step Therapy Drug(s):**	• rabeprazole
You must try:	**First Line Drug(s):**	• Epi-pen
Before HNE will cover:	**Step Therapy Drug(s):**	• Auvi-Q
You must try:	**First Line Drug(s):**	• High-dose atorvastatin or simvastatin or Crestor
Before HNE will cover:	**Step Therapy Drug(s):**	• Zetia Note: Applies to new prescriptions only
You must try:	**First Line Drug(s):**	• At least one generic topical steroid
Before HNE will cover:	**Step Therapy Drug(s):**	• Elidel Note: Applies to new prescriptions only

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):**	• At least one generic topical steroid
Before HNE will cover:	**Step Therapy Drug(s):**	• Protopic Note: Applies to new prescriptions only
You must try:	**First Line Drug(s):**	• Isotretinoin
Before HNE will cover:	**Step Therapy Drug(s):**	• Absorica Note: Applies to new prescriptions only
You must try:	**First Line Drug(s):**	• Cialis or Viagra
Before HNE will cover:	**Step Therapy Drug(s):**	• Staxyn Note: Applies to new prescriptions only
You must try:	**First Line Drug(s):**	• Polyethylene Glycol generic products
Before HNE will cover:	**Step Therapy Drug(s):**	• Suclear Note: Applies to new prescriptions only
You must try:	**First Line Drug(s):**	• Diclofenac
Before HNE will cover:	**Step Therapy Drug(s):**	• Cambia Note: Applies to new prescriptions only
You must try:	**First Line Drug(s):**	• Diclofenac
Before HNE will cover:	**Step Therapy Drug(s):**	• Zipsor Note: Applies to new prescriptions only
You must try:	**First Line Drug(s):**	• Cyclobenzaprine
Before HNE will cover:	**Step Therapy Drug(s):**	• Amrix Note: Applies to new prescriptions only
You must try:	**First Line Drug(s):**	• Tramadol ER
Before HNE will cover:	**Step Therapy Drug(s):**	• Conzip Note: Applies to new prescriptions only
You must try:	**First Line Drug(s):**	• Morphine SR/ER
Before HNE will cover:	**Step Therapy Drug(s):**	• Exalgo Note: Applies to new prescriptions only

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):**	• Oxymorphone ER
Before HNE will cover:	**Step Therapy Drug(s):**	• Kadian Note: Applies to new prescriptions only
You must try:	**First Line Drug(s):**	• Clotrimazole
Before HNE will cover:	**Step Therapy Drug(s):**	• Oravig Note: Applies to new prescriptions only
You must try:	**First Line Drug(s):**	• Enalapril
Before HNE will cover:	**Step Therapy Drug(s):**	• Epaned Note: Applies to new prescriptions only
You must try:	**First Line Drug(s):**	• Ondansetron
Before HNE will cover:	**Step Therapy Drug(s):**	• Zuplenz Note: Applies to new prescriptions only
You must try:	**First Line Drug(s):**	• Methylpred
Before HNE will cover:	**Step Therapy Drug(s):**	• Rayos Note: Applies to new prescriptions only
You must try:	**First Line Drug(s):**	• Generic seasonale
Before HNE will cover:	**Step Therapy Drug(s):**	• Quartette Note: Applies to new prescriptions only

Tier Assignments
The following Prescription Drugs are changing Copay Tier Assignment

Drug Name	Tier on or before 12/31/14	Tier on or after 1/1/15
Elidel	Tier 2	Tier 3
Protopic	Tier 2	Tier 3
Linzess	Tier 3	Tier2

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

Quantity Limit Additions
Starting January 1, 2015, HNE will add the Quantity Limits to the drugs below.

Drug Name	Quantity Limit per 30 day supply
Blood Glucose Test Strips	250
Botox	Quantities limitations will vary based on diagnosis
Provigil/Modafinil	100 mg - 30 200 mg - 60
Focalin XR (dexmethylphenidate)	30
Adderall XR (amphetamine salts ER)	30
Methylphenidate ER Tablets	30
Vyvanse (lisdexamfetamine)	30
Ritalin LA (methylphenidate)	30
Concerta ER (methylphenidate ER Tablets)	30
Quillivant XR (methylphenidate er oral suspension)	1 bottle regardless of strength (covered for ages 6-9 years only)
Metadate CD (methylphenidate ER)	30
Daytrana (methylphenidate transdermal)	30
Tussicaps	14
Tussionex	240 ml
Opiate/narcotic containing cough/cold combination products	240 ml

Prior Authorizations

Seroquel XR (all strengths)

Plan Limitations effective January 1, 2015

- Opioid prescriptions will be limited to a 14 day supply when being prescribed in addition to Suboxone.
- Opioid prescriptions will be restricted to 3 fills per calendar year when being used in addition to Suboxone.

Plan Exclusions effective January 1, 2015

The following Prescription Drugs are **not** a Covered Benefit:

- Brand Name Pamelor

Compound drugs

A compound drug is a mixture of agents that have to be mixed by a trained pharmacist. The following compound agents and kits are **not** a Covered Benefit:

Compound Agents:

- Baclofen
- Bupivicaine
- Cyclopbenzaprine
- Diclofenac
- Flurbiprofen
- Gabapentin
- Ibuprofen
- Ketamine
- Ketoprofen
- Lidocaine
- Pentoxifyline

Compound Kits:

- Lidovir ointment
- Baclofen cream
- Cyclobenzaprine cream
- Ibuprofen cream
- Vopac 5 Cream
- Vopac GB Cream
- Ketoprofen Cream
- Lansoprazole suspension
- Lets
- Lidocaine Cream
- Naproxen Cream
- Omeprazole & sus syrspend
- Tramadol cream
- Vancomycin solution
- Amitriptylin
- AIF #2 Drug Cream Prep

Did you know you can save money on your allergy prescriptions?

Allergy treatment can be expensive since it is a chronic condition. However, many allergy medications are now available over-the-counter. Usually over-the-counter medications are not covered by your insurance. However, the over-the-counter version may be less costly to you.

Over the past few years, the majority of oral allergy medications like Claritin, Zyrtec, and Allegra became available in both generic forms and over-the-counter forms.

The generic versions of these drugs are just as good as the brand names and can save you a lot of money. We recommend shopping at large chain pharmacies or big discount stores like BJ's, Sam's Club and Costco. Many use these types of drugs as a loss leader. This means they barely mark the price up at all as a way to bring in customers.