

AMENDMENT 01-2012

This is an Amendment to your Health New England, Inc. Explanation of Coverage (EOC). Please keep it 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 as of January 1, 2012, unless noted below.

The EOC is amended as follows:

Benefit, Program or Requirement	Description
Inquiries and Grievances Section (Effective Immediately)	<p>In the section <i>Review Process</i>, under the heading <i>Expedited Review Process: For Urgent, Inpatient, or Immediately Needed Services</i>, the following is added:</p> <p>“You have the right to file an expedited external review at the same time as you file an expedited appeal request with HNE. You can find more information about expedited external reviews later in this section.”</p> <p>In the section <i>External Appeal Process</i>, the following changes are made:</p> <ul style="list-style-type: none">• If HNE has denied your clinical appeal, you may ask for an external appeal. You must ask for an external review within <i>four months</i> [emphasis added] after you receive HNE’s final decision on your appeal. NOTE: Time frame changed from 45 days to four months.• The independent review panel will notify you of its decision on your external appeal within 60 <i>calendar</i> [emphasis added] days of receiving your request. NOTE: Time frame changed from 60 business days to 60 calendar days.• If the review panel agrees to handle your request as an expedited external review, it will decide the request within <i>four</i> [emphasis added] business days. NOTE: Time frame changed from 5 business days to 4 business days.
Durable Medical Equipment (DME)	<p>The following item is being removed from the DME Exclusion list (<i>What is not Covered</i>) and added to the DME Prior Approval list:</p> <ul style="list-style-type: none">• Speech generating devices
Prior Approval List	<p>The following items are added to the Prior Approval List. These services are not covered on or before December 31, 2011</p> <ul style="list-style-type: none">• Dermal injections for treatment of facial lipodystrophy syndrome• Gastric Electrical Stimulation for specific diagnoses

Benefit, Program or Requirement	Description
Therapeutic/molded shoes and shoe inserts.	<p>The following items, covered for diabetics only, no longer require Prior Approval: Therapeutic/molded shoes and shoe inserts. Coverage for footwear and inserts is limited to one of the following per Calendar Year:</p> <ul style="list-style-type: none"> One pair of custom-molded shoes (including inserts provided with those shoes) and two additional pairs of inserts; or One pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with those shoes). <p>To be covered:</p> <ul style="list-style-type: none"> The treating doctor must certify the need for these shoes and inserts They must be prescribed by a podiatrist or other qualified doctor You must get them from a podiatrist, orthotist, prosthetist, or pedorthist

Prescription Drug Coverage

(Please disregard the following sections if your HNE plan does not include a prescription drug benefit.)

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

Step Therapy:

For HNE to cover the Step Therapy drugs listed here, you first must try one of the corresponding First Line drugs. If HNE has paid a claim for the First Line drug within the previous 180 days, 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):	<ul style="list-style-type: none"> venlafaxine XR capsules venlafaxine ER tablets
Before HNE will cover:	Step Therapy Drug(s):	<ul style="list-style-type: none"> Pristiq <p>Note: Applies to new prescriptions only</p>
You must try:	First Line Drug(s):	<ul style="list-style-type: none"> risperidone
Before HNE will cover:	Step Therapy Drug(s):	<ul style="list-style-type: none"> Invega <p>Note: Applies to new prescriptions only</p>

Prescription Drug Coverage

(Please disregard the following sections if your HNE plan does not include a prescription drug benefit.)

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

You must try:	First Line Drug(s):	<ul style="list-style-type: none"> tamsulosin generic alpha blockers
	Step Therapy Drug(s):	<ul style="list-style-type: none"> alfuzosin Cardura XL <p>Note: Applies to new prescriptions only</p>
Before HNE will cover:	First Line Drug(s):	<ul style="list-style-type: none"> latanoprost
	Step Therapy Drug(s):	<ul style="list-style-type: none"> Lumigan <p>Note: Applies to new prescriptions only</p>

Tier Assignments

The following Prescription Drugs are changing Copay Tier Assignment

Drug Name	Tier on or before 12/31/11	Tier on or after 1/1/12
Avodart®	Tier 3	Tier 2
Pancreaze®	Tier 2	Tier 3
Pancrease MT®	Tier 2	Tier 3
Viokase®	Tier 2	Tier 3