



Wellpoint

Medicare Extension

Member handbook for Medicare retirees

Wellpoint Medicare Extension Member Handbook

For Medicare retirees

Effective July 1, 2024 - June 30, 2025



Disclosure when Plan Meets Minimum Standards



*This health plan **meets the Minimum Creditable Coverage standards** and **will satisfy** the individual mandate that you have health insurance. Please see additional information below.*

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2008, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan meets the **Minimum Creditable Coverage standards** that became effective July 1, 2008, as part of the Massachusetts Health Care Reform Law. If you are covered under this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR THE MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2018. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIALS EACH YEAR TO DETERMINE WHETHER YOUR HEALTH PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling 617-521-7794 or visiting its website at www.mass.gov/orgs/division-of-insurance.

Interpreting and Translating Services

If you need a language interpreter when you call Wellpoint Member Services, a member service representative will access a language line and connect you with an interpreter who will translate your conversation with the representative.

If you use a TTY machine, you can reach Wellpoint by calling 711.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

Whom to Contact

Questions about medical or behavioral health coverage

Wellpoint

P.O. Box 4095
Woburn, MA 01888

▪ **Member Services:**

800-442-9300 / TTY: 711 (toll free)
7:30 a.m. to 6:00 p.m. (M-Th)
7:30 a.m. to 5:00 p.m. (F)

▪ **Email:**

contact.ma@wellpoint.com

▪ **Website:**

wellpointmass.com

If you call after business hours, you can leave a message. Member Services will return your call on the next business day.

For questions about:

- Benefits for a medical service or procedure
- Benefits for mental health or substance use disorder services
- Status of a medical or behavioral health claim
- Finding a doctor, hospital, or other healthcare provider
- These sections of this handbook:
 - Part 1: Getting Started (pages 11-24)
 - Part 2: Your Medical Benefits (pages 25-72)
 - Part 3: Your Behavioral Health Benefits (pages 73-88)
 - Part 4: Using Your Plan (pages 89-136)

Questions about prescription drug coverage

SilverScript

▪ **Customer Service:**

877-876-7214 / TTY: 711 (toll free)

▪ **Website:**

gic.silverscript.com

For questions about:

- Benefits for a prescription drug
- Status of a prescription drug claim
- Where to get prescriptions filled
- Which drugs are covered
- This section of this handbook:
 - Part 5: Your Prescription Drug Plan (pages 137-144)

If you have other questions, including questions about premiums or participation in any Group Insurance Commission (GIC) programs, please fill out the GIC's online contact form available at <https://www.mass.gov/forms/contact-the-gic>.

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Part 1:

Getting Started

Introducing Medicare Extension

For questions about any of the information in Part 1 of this handbook, please call Wellpoint Member Services at 800-442-9300.

Administered by



Chapter 1: First things first

Be sure to read this handbook carefully to learn about the benefits and features of your Plan.
If you have questions, see the contact information on page 3.

About this plan

Introducing the Medicare Extension plan

This handbook is a guide to benefits for you and your Medicare dependents covered under **Wellpoint Medicare Extension**.

Your Medicare Extension benefits are provided through the Group Insurance Commission (GIC), the state agency responsible for the design and payment of all benefits for state, participating municipalities and other governmental entities' employees and retirees. This Plan is funded by the Commonwealth of Massachusetts and administered by Wellpoint. Wellpoint provides most administrative services – including claims processing and member services – at its service center in Woburn, Massachusetts. Wellpoint is not the fiduciary or the insurer of Wellpoint Medicare Extension. The Group Insurance Commission determines eligibility, including geographic restrictions, for its plans.

The Medicare Extension plan supplements your Medicare coverage by providing you with comprehensive coverage for many health services including hospital stays, surgery, emergency care, preventive care, outpatient services and other medically necessary treatment. You can get services from any provider. Keep in mind, however, that benefits can differ depending on the service and the provider, and that not all services are covered by the Plan.

About your Medicare membership



You must be enrolled in Medicare Part A and Part B to be eligible for the Medicare Extension plan. If you let your Medicare coverage lapse, you will no longer be eligible for benefits under the Medicare Extension plan.

Do not enroll in a non-GIC Medicare Part D product. This plan includes Medicare Part D coverage. If you enroll in another Part D product, the Centers for Medicare and Medicaid Services (CMS) will disenroll you from your GIC coverage. This means that you will lose your GIC health, behavioral health, and prescription drug benefits.

This handbook is not a description of your Medicare benefits. For more information about Medicare, read the *Medicare & You* handbook, which is produced by Medicare and is available from your local Social Security office, or online at www.medicare.gov.

About this handbook

Benefits described in this handbook

This handbook looks at features and coverage for these types of benefits:

| | |
|-----------------------------------|---|
| Medical services | These benefits are administered by Wellpoint |
| Behavioral health services | These benefits, which cover mental health and substance use disorder services, are administered by Wellpoint in partnership with Carelon Behavioral Health |
| Prescription drugs | These benefits are separately administered by SilverScript |

A note about terms and definitions

Definitions for many of the terms used in this handbook appear in Chapter 14 (pages 127-136). You should also keep in mind that:

- ❑ The formal name of your plan is **Wellpoint Medicare Extension**. In this handbook and other plan materials, we usually refer to it as the **Medicare Extension plan**, **Medicare Extension**, or **the Plan**.
- ❑ We often use the abbreviation **GIC** for the **Group Insurance Commission**.
- ❑ If you have dependents covered under your plan, text that refers to **you** also applies to your dependents.
- ❑ **Medical services (medical care)** are those services covered by the medical benefits described in Part 2 (pages 25-72). **Behavioral health services** are services to treat mental health and substance use disorders, which are described in Part 3 (pages 73-88). When we're talking about both types of services together, we usually call them **healthcare services**.

Where to find information in this handbook

Part 1: Getting Started

Pages 11-24

- Overview information to help you get to know the health benefits administered by Wellpoint
- Features and advantages of Medicare Extension
- How to get the most out of your Medicare Extension coverage
- How costs and billing work

Part 2: Your Medical Benefits

Pages 25-72

- Information about preapproval reviews for medical necessity
- Medical services covered under this plan
- What your benefits are for preventive services

Part 3: Your Behavioral Health Benefits

Pages 73-88

- General information about your behavioral health benefits
- When and how to get behavioral health services preapproved, and which services need to be preapproved
- Mental health and substance use disorder services covered under this plan

Part 4: Using Your Plan

Pages 89-136

- How to understand and use the features of Medicare Extension
- Exclusions and limits on what's covered
- Descriptions of the different kinds of healthcare providers
- Information about claims, preapproval reviews, and other health plan concepts

Part 5: Your Prescription Drug Plan

Pages 137-144







- General information about your prescription drug benefits (administered by SilverScript)
- What your coverage is for prescription drugs
- Exclusions and limits on your prescription drug benefits

Part 6: Appendices

Pages 145-169

- Reference material and notices including GIC notices; state and federal mandates; member notices; and the index

Symbols used in this handbook

| What the handbook symbols mean | |
|---|--|
|  | Important information – This may have an impact on your benefits or costs. |
|  | No coverage, limited coverage, or benefit restriction – A full list of Plan exclusions and limitations appears in Chapter 10. |
|  | May need preapproval review – This service may need to be reviewed for medical necessity. |
|  | Use contracted suppliers – To get the best benefit for this service or product, use a Medicare supplier, if one is available. Otherwise, look for a Wellpoint contracted supplier. See page 24 to learn more. |
|  | Use Sydney Health – You can do this through the Sydney Health app (page 125). |
|  | Go to wellpointmass.com – This information can be found at our website. |

Do you have other health insurance?

If you or a family member has health coverage from an insurer other than Wellpoint, you may need to fill out and send an *Other Health Insurance (OHI)* form to Wellpoint.

Wellpoint needs this information to coordinate your benefits with other plans. To learn more about how this works, turn to “Coordinating benefits with other health plans (COB)” on pages 120-123.



Find this and other forms at [wellpointmass.com](https://www.wellpointmass.com).

You don't need to submit an OHI form if...

- ☐ You don't have coverage under any other health plans, *or*
- ☐ You do have other coverage, but it's from AARP, MassHealth, Medicare, or TRICARE, *or*
- ☐ You've already submitted an OHI form and your coverage hasn't changed.

You do need to submit an OHI form if...

- ☐ You're covered under another health plan, and that plan is not AARP, MassHealth, Medicare, or TRICARE, *and*
- ☐ You either haven't submitted an OHI form before or else the form you submitted previously needs to be updated.

About your ID card

Every Medicare Extension member will get a Wellpoint ID card. These cards have useful information about your benefits, as well as important telephone numbers you and your healthcare providers may need.

When you need healthcare services, tell your provider that you are a member of both Medicare **and** the Medicare Extension plan. Show your provider both your Medicare card and your Wellpoint ID card.



If you'd prefer to use an electronic ID card instead of a physical card, you can access yours through the Sydney Health app.



You can order replacement physical cards from [wellpointmass.com](https://www.wellpointmass.com).

Your prescription drug card is separate. SilverScript will send your prescription drug cards separately. Call SilverScript at 877-876-7214 if you have questions about your prescription drug card.

Some services may need preapproval review

In some circumstances, Wellpoint may need to preapprove a service – that is, review the service for medical necessity. This can be necessary if a service isn't covered by Medicare or if your Medicare benefits for that service have been exhausted. Your provider must notify Wellpoint if you are having a service that requires review.

For more information about preapproval reviews...

| | |
|--|-----------------|
| Medical services | See page 26 |
| Behavioral health services – Mental health and substance use disorder services | See pages 75-77 |

Getting the most out of Medicare Extension

For a description of the different kinds of providers mentioned in the table below, see “Types of healthcare providers” on pages 104-107.

Table 1. How to get the most out of Medicare Extension

| Tips on choosing providers | | See pages |
|---|--|----------------|
| Use providers who participate in Medicare | Your benefits are best when you use Medicare participating providers – providers who have agreed to accept Medicare’s payment as payment in full for covered services. If you get care outside of Massachusetts, participating providers will not balance bill you for charges over the Plan’s allowed amount, but other providers may do so. | 23 |
| Use contracted behavioral health providers | Contracted behavioral health providers won’t balance bill you for charges over the Plan’s allowed amount. | 74 |
| If you need care quickly, take advantage of walk-in clinics | You have a \$10 copay at walk-in clinics like urgent care centers and retail health clinics. At a hospital emergency room, you’ll owe a \$50 copay. | 42-43, 105-106 |
| ✓ Take advantage of the contracted supplier benefit | Some services, supplies and medical equipment have a contracted supplier benefit. Always use Medicare suppliers when they are available. If no Medicare supplier is available, there may be a Wellpoint contracted supplier you can use. In this handbook, the checkmark ✓ identifies services with a contracted supplier benefit. | 24 |
| Other ways to keep your costs down | | See pages |
| Get \$100 toward your fitness costs | We’ll reimburse you for up to \$100 of your costs toward a fitness activity. | 46 |
| Keep an eye on your bills | Don’t pay a bill before you’ve gotten payment notices (EOBs) from both Medicare and Wellpoint. If you’re not sure whether you owe a payment, give us a call. | 18 |

Chapter 2: About costs and billing

What member costs are (out-of-pocket costs)

Member costs are the costs that you pay toward your medical bills. Member costs may also be called **out-of-pocket costs**, **cost sharing**, or **member share**.

Medicare Extension members have two kinds of member costs. These costs are separate and unrelated; they apply in different situations and are for different services.

| Types of member costs | | See pages |
|-----------------------|--|-----------|
| Copays | A fixed amount you pay when you get certain healthcare services, like seeing your doctor for a sprained ankle. | 20 |
| Coinsurance | For some services, the Plan pays 80% and you pay the other 20%. The 20% that you owe is called coinsurance. | 20 |

How member costs work

Medicare pays its portion of your claims first. Then, because you are in Wellpoint's Medicare Extension plan, the remainder of the claim balance is sent to Wellpoint.

When Wellpoint gets the bill, we subtract any member costs you owe from the amount we pay to that provider. The copay, if there is one, gets subtracted first, then any coinsurance that applies. We'll send you an *Explanation of Benefits* (EOB), which is a statement that shows how the claim was paid and what member costs you owe, if any.

After getting payment from Wellpoint, your provider will bill you for any member costs – copays and/or coinsurance – that Wellpoint subtracted from its payment. (If you had any services from that provider that weren't covered by your Plan, the provider's bill may include those charges too.)

Wellpoint processes claims as they come in. This means that your claims may not get paid in the same order in which you got the medical services.

Limits on your out-of-pocket costs

The Plan limits some of the member costs you have to pay each year toward covered services. These limits are called **out-of-pocket (OOP) maximums**. Once you reach an out-of-pocket maximum, the Plan pays 100% of the allowed amounts for covered services for the rest of the calendar year. (To learn more about allowed amounts, see “About allowed amounts and Medicare-approved amounts” on page 21).

Out-of-pocket (OOP) maximums in this plan


There are three separate out-of-pocket maximums, each of which applies to different services:

- ☐ The **coinsurance limit** caps (limits) the amount of coinsurance you owe for medical services.
- ☐ The out-of-pocket maximum for **contracted behavioral health providers** limits your member costs when you get services from contracted providers.
- ☐ The out-of-pocket maximum for **non-contracted behavioral health providers** limits your member costs when you get services from non-contracted providers.

Table 2. How much are the out-of-pocket (OOP) maximums?

| How much are the OOP maximums? | |
|---|---------|
| Coinsurance limit | \$500 |
| OOP maximum with contracted behavioral health providers | \$1,000 |
| OOP maximum with non-contracted behavioral health providers | \$3,000 |

Costs that don't count toward your OOP maximums

 **Important!** The following costs don't apply to any out-of-pocket maximums:

- ☐ Prescription drug costs
- ☐ Premiums
- ☐ Balance bills (charges over the Plan's allowed amounts)
- ☐ Costs for health care that the Plan doesn't cover

About copays

A **copay** is a payment you owe at the time you get a service. For example, you pay a copay when you see your doctor for a sore throat, or when you go to the emergency room. You have copays for some medical services and for some behavioral health services. Services that have copays include:

- ☐ Doctor visits (page 39) – Copays apply both in person and through virtual care (telehealth)
- ☐ Urgent care centers and retail health clinic visits (page 42)
- ☐ Routine eye exams (page 44)
- ☐ Emergency room visits (page 42)
- ☐ Behavioral health outpatient services (Chapter 9)

About coinsurance

Coinsurance is your share of the cost of a covered service when the service isn't covered at 100%. For example, if the Plan pays 80% of the allowed amount for a service, you are responsible for paying the other 20%. As is true of all member costs, coinsurance is applied to any balance that remains after Medicare processes your claim.

How Medicare and Medicare Extension work together

 You must be enrolled in Medicare Part A and Part B to be eligible for the Medicare Extension plan. If you let your Medicare coverage lapse, you will no longer be eligible for benefits under the Medicare Extension plan.

Do not enroll in a non-GIC Medicare Part D product. This plan includes Medicare Part D coverage. If you enroll in another Part D product, the Centers for Medicare and Medicaid Services (CMS) will disenroll you from your GIC coverage. This means that you will lose your GIC health, behavioral health, and prescription drug benefits.

What the Medicare Extension plan covers

Medicare Extension covers all or part of any costs that Medicare does not pay for covered services. For example, if Medicare pays 80% of a claim, the Plan will pay some or all of the remaining 20%. The Plan also covers the Medicare Part A inpatient deductible, the Part B deductible, and Part B coinsurance.

Keep in mind... Medicare Part A provides benefits for hospital services, and Part B provides benefits for physician and other healthcare provider services.

Medicare Extension provides coverage for some services that Medicare doesn't cover, such as immunizations and hearing aids.

How benefits are determined between Medicare and Medicare Extension

When you submit a claim, Wellpoint determines your benefits as follows:

1. The claim is eligible for payment only if it is for a covered service under Medicare and/or the Medicare Extension plan.
2. The maximum amount that may be paid is the Medicare-approved amount or, if the service isn't covered by Medicare, Wellpoint's allowed amount (see the next topic).
3. Wellpoint subtracts any benefits that Medicare has paid from the original amount of the claim.
4. Medicare Extension benefits are applied to any remaining claim balance.

About allowed amounts and Medicare-approved amounts

Medicare sets an allowed cost – the **Medicare-approved amount** – for each service that it covers, and makes payments based on that amount. So, for example, if Medicare covers 80% of a service, it will pay up to 80% of the Medicare-approved amount for that service.

Wellpoint sets an **allowed amount** for each service that it covers. The allowed amount is the maximum amount that Wellpoint pays for a covered service. Wellpoint uses the Medicare-approved amount as its allowed amount for services covered by Medicare. For services not covered by Medicare, Wellpoint works with contracted providers to establish an allowed amount that Wellpoint and the provider have agreed to for that service in most cases.

With non-contracted providers, the Plan does not have a contractual agreement on the amount that can be billed for services. The amount the Plan pays may not be the same as the provider's charge, which is typically much higher than the actual cost of the service.

About balance billing

The allowed amount for a given service may not be the same as what a provider actually billed for that service. When a provider asks you to pay for charges above the allowed amount (that is, above the amount paid by insurance), it is called **balance billing**. The Plan doesn't cover balance bills, and balance bills don't count toward your coinsurance limit (page 19).

When you get care in Massachusetts

- ❑ **Medical providers** – Medical providers in Massachusetts are not allowed to balance bill you for charges over the allowed amount (Massachusetts General Law, Chapter 32A: Section 20). If a Massachusetts medical provider balance bills you, contact Wellpoint Member Services at 800-442-9300 for help.
- ❑ **Behavioral health providers** – Contracted behavioral health providers (providers who are in the Caredon Behavioral Health network) won't balance bill you. However, non-contracted behavioral health providers in Massachusetts may do so. Since the Plan doesn't cover balance bills, payment is your responsibility. If you need help finding a contracted provider, contact Wellpoint Member Services at 800-442-9300.

If you have a continuing relationship with a non-contracted behavioral health provider, you may make other payment arrangements with that provider in addition to the payments made by Wellpoint.

If you get care outside of Massachusetts

Outside of Massachusetts, providers may balance bill you for the difference between the Plan's allowed amount and the provider's charges. Since the Plan doesn't cover balance bills, payment is your responsibility.


To reduce your risk of being balance billed, we recommend always using Medicare participating providers when you need medical care. See the next topic to learn how a provider's payment arrangement with Medicare can affect your costs.

For behavioral health services, you won't be balance billed if you use contracted providers. See Part 3 (pages 73-88) for information about your behavioral health benefits.

How the providers you use can affect your costs

Providers, such as doctors and medical equipment suppliers, can have several different payment arrangements with Medicare. These arrangements determine how much Medicare pays the providers and what costs you will have to pay yourself.

- ❑ **Medicare enrolled providers** agree to do business with Medicare and accept Medicare payment. Medicare will only pay for services from enrolled providers. Enrolled providers have two different payment arrangements:
 1. **Medicare participating providers** (those who “accept Medicare assignment”) are enrolled providers who accept Medicare’s payment as payment in full for covered services.
 2. **Medicare non-participating providers** are enrolled providers who have not agreed to accept Medicare assignment. They may charge more than the Medicare-approved amount (within certain limits), and you are responsible for the additional cost.
- ❑ **Private contract providers** don’t do any business with Medicare at all. Medicare won’t pay for services from these providers, even if the service would otherwise be covered. These providers are required to have you sign a private contract (called an **Advance Beneficiary Notice of Noncoverage**, or **ABN**) to confirm that you will pay for the services yourself.

 **Important!** If you go to a private contract provider for a service that Medicare would otherwise cover, the plan’s allowed amount is only 20% of what Medicare would have paid to an enrolled provider. Your benefit is then applied to that allowed amount. You must pay the rest of the cost yourself.

For more information – See your *Medicare & You* handbook (available at www.medicare.gov) and other Medicare publications for additional information about how Medicare pays providers.

Table 3 illustrates how your benefits work for the three types of providers.

Table 3. How Medicare-provider arrangements affect benefits

| Type of provider | Claim amount | Allowed amount | Medicare pays | Wellpoint pays | You owe |
|--|--------------|----------------|---------------|-------------------|--------------------|
| Participating providers (those who accept Medicare assignment) | \$150 | \$100 | \$80 | \$20 | \$0 |
| Non-participating providers | \$150 | \$100 | \$80 | \$20 | \$50 ¹ |
| Private contract providers | \$150 | \$100 | \$0 | \$20 ² | \$130 ³ |

1. The amount of the claim left over after Medicare and Wellpoint have paid
2. Wellpoint pays only what it would have paid if you had used a participating provider
3. The amount of the claim that neither Medicare nor Wellpoint paid

When to use contracted suppliers

For certain services and supplies, you get the highest benefit when you use a contracted supplier. **Contracted suppliers** are Medicare suppliers, Wellpoint-contracted suppliers, or both who provide one or more of the following services and supplies:

- ☐ Durable medical equipment (DME)
- ☐ Home health care
- ☐ Home infusion therapy (including enteral/oral therapy)
- ☐ Medical/diabetic supplies
- ☐ Orthotics, prostheses and prosthetic devices

Medicare suppliers, when available, are the contracted suppliers for these services and supplies – that is, you'll get the highest benefit when you use a Medicare supplier.



Find Medicare suppliers at [medicare.gov](https://www.medicare.gov)

If there aren't any Medicare suppliers for the service or supply you need, there may be a Wellpoint contracted supplier you can use to get the best benefit.

Contracted suppliers are covered at 100% of the allowed amount. If you don't use a contracted supplier, the Plan covers 80% of the allowed amount and you owe the remaining 20% coinsurance. This is true even if you are using a non-contracted supplier because the item or service isn't available from a contracted supplier. If you live outside of Massachusetts, contracted suppliers won't balance bill you for charges over the allowed amount, but other suppliers may do so.



Find Wellpoint contracted suppliers at [wellpointmass.com](https://www.wellpointmass.com).



In this handbook, the checkmark lets you know when a service has a contracted supplier benefit.



Important! Non-contracted suppliers are covered at 80%, even if you are using the non-contracted supplier because the item isn't available from a contracted supplier.

Part 2:

Your Medical Benefits

Description of coverage for medical services

For questions about any of the information in Part 2 of this handbook,
please call Wellpoint Member Services at 800-442-9300.

Administered by



Chapter 3: Preapproval reviews for medical services

What are preapproval reviews?

Preapproval (also called **preauthorization**) confirms that a service you're getting is medically necessary and will be eligible for benefits. By getting a service preapproved, you can make sure that the service is covered under the Plan.

Benefits offered by Medicare and Wellpoint apply to services that are medically necessary. As the primary insurer, Medicare determines medical necessity for the services it covers. In most cases, Wellpoint does not separately review services that Medicare covers.

In some limited circumstances, such as when Medicare benefits have been exhausted or for services that Medicare doesn't cover, Wellpoint may review services for eligibility.

In most cases, your doctor will provide Wellpoint with the information necessary to review a service. If you need help with a preapproval, Wellpoint Member Services can contact your provider to make the arrangements.

Examples of medical services that may require review

Wellpoint may review a medical service if your Medicare benefits for the service have been exhausted or if it's a service that Medicare doesn't cover. Types of medical services that may need to be reviewed include:

- ☐ Inpatient admissions
- ☐ Durable medical equipment (DME)
- ☐ Enteral/oral therapy
- ☐ Home health care
- ☐ Surgeries such as organ transplants and gender reassignment

Preapprovals for behavioral health services – See pages 75-77 for information about preapprovals for behavioral health services.

Chapter 4: Summary of costs for medical services

Table 4. Summary of covered medical services

Important! To be covered, services must be medically necessary. Benefits are limited to the Plan's allowed amounts for the services (page 21).

| Service | Member costs | See page |
|---|--|----------|
| Ambulances | No member costs | 31 |
| Behavioral health services (mental health and substance use disorder) | See Part 3 (pages 73-88) for benefits information. | 73 |
| Bereavement counseling | 20% coinsurance (limited to \$1,500 for a family in a calendar year) | 51 |
| Cardiac rehab programs | No member costs | 32 |
| Chemotherapy | No member costs | 33 |
| Chiropractic care | No member costs (limited to 20 visits in a calendar year) | 33 |
| ✓ Diabetic supplies | <ul style="list-style-type: none"> ▪ Contracted suppliers: No member costs ▪ Non-contracted suppliers: 20% coinsurance | 38 |
| Dialysis | No member costs | 39 |
| Doctor visits (in person or through virtual care) | \$10 copay | 39 |
| Doctors – other services | | 39 |
| ▪ At an emergency room | No member costs | |
| ▪ Inpatient hospital care | No member costs | |
| ▪ Outpatient hospital care | \$10 copay | |
| Durable medical equipment (DME) | <ul style="list-style-type: none"> ▪ Contracted suppliers: No member costs ▪ Non-contracted suppliers: 20% coinsurance | 40 |
| Early intervention programs | No member costs (limited to \$5,200 for each child in a calendar year, with a lifetime limit of \$15,600 for each child) | 41 |

Important! To be covered, services must be medically necessary. Benefits are limited to the Plan's allowed amounts for the services (page 21).

| Service | Member costs | See page |
|--|--|----------|
| Emergency room visits | \$50 copay | 42 |
| Eye exams (routine) | \$10 copay (limited to one exam every 24 months) | 44 |
| Eyeglasses and contact lenses | No member costs (limited to first set within six months of the eye injury or cataract surgery) | 45 |
| Family planning services | No member costs | 45 |
| Fitness reimbursement | Reimbursed up to \$100 per member in a calendar year | 46 |
| Hearing aids | | 48 |
| ▪ Age 21 and under | No member costs (limited to \$2,000 for each impaired ear every 24 months) | |
| ▪ Age 22 and over | No member costs (limited to \$1,700 for each impaired ear every 24 months) | |
| Hearing exams | \$10 copay | 48 |
| ✓ Home health care | <ul style="list-style-type: none"> ▪ Contracted providers: No member costs ▪ Non-contracted providers: 20% coinsurance | 48 |
| ✓ Home infusion therapy | <ul style="list-style-type: none"> ▪ Contracted suppliers: No member costs ▪ Non-contracted suppliers: 20% coinsurance | 50 |
| Hospice care | No member costs | 50 |
| Immunizations (vaccines) | No member costs (you may have costs for the office visit) | 52 |
| Inpatient medical care | | 53 |
| ▪ At a hospital or rehab facility (semi-private room) | No member costs | |
| ▪ At a hospital or rehab facility (medically necessary private room) | The dollar difference between the semi-private room rate and the private room rate | |
| Lab and radiology services (X-rays) | | 56 |
| ▪ Emergency room | No member costs | |
| ▪ Inpatient hospital | No member costs | |
| ▪ Outpatient hospital | No member costs | |
| ▪ Non-hospital-owned facility | No member costs | |

Important! To be covered, services must be medically necessary. Benefits are limited to the Plan's allowed amounts for the services (page 21).

| Service | Member costs | See page |
|---|---|----------|
| Medical services, if not listed elsewhere | 20% coinsurance | 57 |
| Occupational therapy | <ul style="list-style-type: none"> ▪ If Medicare pays: No member costs ▪ If Medicare does <i>not</i> pay: 20% coinsurance | 58 |
| Outpatient hospital services, if not listed elsewhere | No member costs | 59 |
| ✓ Oxygen | <ul style="list-style-type: none"> ▪ Contracted suppliers: No member costs ▪ Non-contracted suppliers: 20% coinsurance | 59 |
| Personal Emergency Response Systems | | 60 |
| ▪ Installation | 20% coinsurance (limited to \$50 in a calendar year) | |
| ▪ Rental | No member costs (limited to \$40 a month) | |
| Physical therapy | <ul style="list-style-type: none"> ▪ If Medicare pays: No member costs ▪ If Medicare does <i>not</i> pay: 20% coinsurance | 60 |
| Prescription drugs | Benefits are administered by SilverScript. See Part 5 of this handbook, or call SilverScript at 877-876-7214 (toll free) for more information. | 137 |
| Preventive care <i>See Table 7 on page 69.</i> | No member costs | 61 |
| Prosthetics and orthotics | | 62 |
| ▪ Breast prosthetics | No member costs | |
| ▪ Other prosthetics and orthotics | <ul style="list-style-type: none"> ▪ If Medicare pays: No member costs ▪ If Medicare does <i>not</i> pay: 20% coinsurance | |
| Radiation therapy | No member costs | 63 |
| Radiology and imaging | | 56 |
| ▪ Emergency room | No member costs | |
| ▪ Inpatient hospital | No member costs | |
| ▪ Outpatient hospital | No member costs | |
| Retail health clinic visits | \$10 copay | 42 |

Important! To be covered, services must be medically necessary. Benefits are limited to the Plan's allowed amounts for the services (page 21).

| Service | Member costs | See page |
|---|---|----------|
| Skilled nursing and long-term care facilities | <ul style="list-style-type: none"> ▪ Days paid by Medicare: No member costs until Plan benefit limit is reached ▪ Days <i>not</i> paid by Medicare: 20% coinsurance until Plan benefit limit is reached Plan benefit limit is \$13,400 each calendar year | 53 |
| Speech therapy | No member costs | 64 |
| Surgery | | 65 |
| <ul style="list-style-type: none"> ▪ In Massachusetts | No member costs | |
| <ul style="list-style-type: none"> ▪ Outside Massachusetts | <ul style="list-style-type: none"> ▪ Medicare participating: No member costs ▪ Medicare non-participating: 20% of the difference between the Plan's allowed amount and the provider's charge | |
| Tobacco cessation counseling | No member costs (limited to 300 minutes in a calendar year) | 66 |
| Transplants | | 66 |
| <ul style="list-style-type: none"> ▪ At a Medicare-certified transplant facility | No member costs | |
| <ul style="list-style-type: none"> ▪ At other hospitals | 20% coinsurance | |
| Urgent care center visits | \$10 copay | 42 |

Chapter 5: Covered medical services

Allergy shots

Allergy shots are covered. Claims for allergy shots may separately itemize the shot itself, the allergy serum (in the shot), and the office visit (when the shots were given).

| Member costs | |
|------------------|-----------------|
| Shot (injection) | No member costs |
| Allergy serum | 20% coinsurance |
| Office visit | \$10 copay |

Ambulances and transportation

Ambulance transportation is covered in medical emergencies. Some examples of emergencies are stroke, heart attack, difficulty breathing, and severe pain. Covered emergency medical transportation may be by ground, air, or water ambulance, depending on the emergency situation.

| Member costs | |
|--------------------------|-----------------|
| Ambulance transportation | No member costs |

X Restrictions:

- The following restrictions apply to emergency ambulance transportation:
 - Based on the severity of your condition, no other form of transportation can safely transport you to the nearest facility.
 - Air or water ambulance is covered only when your medical condition is such that your health would be endangered by the time needed for ground transportation.
 - Emergency inter-facility transportation to the nearest appropriate facility may be necessary when your current facility is unable to treat your condition and the treatment is considered a medical emergency.
- All ambulance transportation must be medically necessary and must take you to the nearest appropriate hospital or facility.
- There is no coverage for transportation that is primarily for the convenience of the individual, individual's family, or physician.
- Transfers to a hospital that you prefer (e.g., to be closer to home) are not covered.
- Transportation in chair cars or vans is not covered.

Anesthesia

Anesthesia and its administration are covered when given for a covered procedure. Anesthesia for electroconvulsive therapy (ECT) is also covered.

| Member costs | |
|-----------------------------------|-----------------|
| Anesthesia and its administration | No member costs |

✕ Restrictions:

- Other charges associated with ECT are covered under your behavioral health benefit. See Part 3 of this handbook (pages 73-88) for benefits information.
- There is no coverage for anesthesia used for a non-covered procedure.

Autism spectrum disorders

Autism spectrum disorders are any of the pervasive developmental disorders as defined by the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, including autistic disorder, Asperger's disorder, and pervasive developmental disorders not otherwise specified.

Medical services for autism spectrum disorders are covered like any other physical condition. Coverage is subject to all pertinent provisions of the Plan, including use of participating providers, preapproval reviews, and provider payment methods. Medical services needed for diagnosis and treatment (such as occupational therapy) are covered as a medical benefit. Behavioral health services are covered as a behavioral health benefit (page 80).

Behavioral health services

Treatments for mental health and substance use disorder conditions are called **behavioral health services**. See Part 3 (pages 73-88) for benefits information.

Cardiac rehabilitation (rehab) programs

Cardiac rehab programs are professionally-supervised, multi-disciplinary programs to help people recover from cardiac events like heart attacks, heart surgery, and coronary procedures such as stenting and angioplasty. Covered cardiac rehab includes education and counseling services to help increase physical fitness, reduce cardiac symptoms, improve health, and reduce the risk of future heart problems.

| Member costs | |
|------------------------|-----------------|
| Cardiac rehab programs | No member costs |

A cardiac rehab program must:

- ❑ Be ordered by a physician
- ❑ Be operated by a licensed clinic or hospital
- ❑ Teach and monitor risk reduction, lifestyle adjustments, therapeutic exercise, proper diet, use of proper prescription drugs, self-assessment, and self-help skills
- ❑ Meet the generally accepted standards of cardiac rehab

This benefit covers the *active* rehabilitation phase of the program, which is usually three consecutive months.

✕ Restrictions:

- You must start the program within six months after your cardiac event.
- You can participate in only one cardiac rehab program after a cardiac event.
- There is no coverage for the *maintenance* phase of a cardiac rehab program. Coverage is for the *active* phase only.
- You are not covered for a cardiac rehab program if you have not had a cardiac event.

Chemotherapy

Chemotherapy is a covered service. The drugs used in chemotherapy may be administered by injection, infusion, or orally.

| | Member costs |
|------------|---|
| Outpatient | No member costs |
| Inpatient | Covered under the benefit for hospital admissions (page 53) |

Chiropractic care

The Plan covers up to 20 chiropractic visits each calendar year, when they are used on a short-term basis to treat neuromuscular and/or musculoskeletal conditions and when the potential for functional gain exists.

| | Member costs |
|-------------------|---|
| Chiropractic care | No member costs (limited to 20 visits in a calendar year) |

✕ Restrictions:

- Certain therapy services are not covered. These include, but are not limited to: acupuncture, aerobic exercise, craniosacral therapy, diathermy, infrared therapy, kinetic therapy, microwave therapy, paraffin treatment, Rolfing therapy, Shiatsu, sports conditioning, ultraviolet therapy, and weight training.
- Group chiropractic care is not covered.

- Services provided by a chiropractor are considered chiropractic care, not physical therapy.
- Massage therapy and services provided by a massage therapist or neuromuscular therapist are not covered.

Circumcision

Circumcision is covered for newborns up to 30 days from birth.

| Member costs | |
|--------------|-----------------|
| Circumcision | No member costs |

Cleft lip and cleft palate

The treatment of cleft lip and cleft palate in children under 18 is covered if the treating physician or surgeon certifies that the services are medically necessary and are specifically for the treatment of the cleft lip or palate. Coverage is subject to all pertinent provisions of the Plan, including use of participating providers, preapproval reviews, and provider payment methods.

Benefits include:

- ☐ Audiology
- ☐ Medical
- ☐ Nutrition services
- ☐ Oral and facial surgery
- ☐ Speech therapy
- ☐ Surgical management and follow-up care by oral and plastic surgeons

The following benefits are available if they are not otherwise covered by a dental plan:

- ☐ Dental services
- ☐ Orthodontic treatment and management
- ☐ Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy

X Restrictions:

- There is no coverage for dental and orthodontic treatment covered by the member's dental plan.

Clinical trials (clinical research studies)

The Plan covers patient care services provided as part of a qualified clinical trial studying potential treatments for cancer. Patient care services include items and services provided when you are enrolled in a qualified clinical trial consistent with your diagnosis and the study protocol. Coverage is subject to all pertinent provisions of the Plan including medical necessity review, use of participating providers, preapproval reviews, and provider payment methods.

The Plan covers patient care services provided within the trial only if it is a **qualified clinical trial** according to state law:

- ☐ The clinical trial is to study potential treatments for cancer.
- ☐ The clinical trial has been peer reviewed and approved by one of the following:
 - The United States National Institutes of Health (NIH)
 - A cooperative group or center of the NIH
 - A qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants
 - The United States Food and Drug Administration (FDA) pursuant to an investigational new drug exemption
 - The United States Departments of Defense or Veterans Affairs
 - With respect to Phase II, III and IV clinical trials only, a qualified institutional review board
- ☐ The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that experience.
- ☐ With respect to Phase I clinical trials, the facility must be an academic medical center (or an affiliated facility) at which the clinicians conducting the trial have staff privileges.
- ☐ The member meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial.
- ☐ The member has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards.
- ☐ The available clinical or pre-clinical data provide a reasonable expectation that the member's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial.
- ☐ The clinical trial does not unjustifiably duplicate existing studies.
- ☐ The clinical trial must have a therapeutic intent and must, to some extent, assume the effect of the intervention on the member.

The following services for cancer treatment are covered under this benefit:

- ❑ All services, including donor services, that are medically necessary for treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the Plan.
- ❑ The allowed cost, as determined by the Plan, of an investigational drug or device that has been approved for use in the clinical trial studying potential treatments for cancer to the extent it is not paid for by its manufacturer, distributor or provider, regardless of whether the FDA has approved the drug or device for use in treating your particular condition.

X Restrictions:

- There is no coverage for any clinical research trial other than a qualified clinical trial studying potential treatments for cancer.
- Patient care services do not include any of the following:
 - An investigational drug or device, except as noted above
 - Non-healthcare services that you may be required to receive as a result of participation in the clinical trial
 - Costs associated with managing the research of the clinical trial
 - Costs that would not be covered for non-investigational treatments
 - Any item, service or cost that is reimbursed or furnished by the sponsor of the trial
 - The costs of services that are inconsistent with widely accepted and established national or regional standards of care
 - The costs of services that are provided primarily to meet the needs of the trial including, but not limited to, covered tests, measurements, and other services that are being provided at a greater frequency, intensity or duration.
 - Services or costs that are not covered under the Plan

Dental services

Because Wellpoint Medicare Extension is a medical plan, not a dental plan, the Plan does not provide benefits for dental care. However, medical services that include treatment related to dental care are sometimes eligible for benefits. The Plan will only consider charges for dental care in the following situations:

- ❑ **Emergency treatment** from a dentist within 72 hours of an accidental injury to the mouth and sound natural teeth. Treatment must take place in an acute care setting (not a dentist's office) and is limited to trauma care, the reduction of pain and swelling, and any otherwise covered non-dental surgery and/or diagnostic X-rays.
- ❑ **Oral surgery for non-dental medical treatment** – such as procedures to treat a dislocated or broken jaw or facial bone, and the removal of benign or malignant tumors – is covered like any other surgery.

- ❑ **If you have a serious medical condition** (such as hemophilia or heart disease) that makes it necessary to have your dental care performed safely in a hospital, surgical day care unit, or ambulatory surgery center, only the following procedures are covered:
 - Extraction of seven or more teeth
 - Gingivectomies (including osseous surgery) of two or more gum quadrants
 - Excision of radicular cysts involving the roots of three or more teeth
 - Removal of one or more impacted teeth
- ❑ **Cleft lip or palate** (page 34) – The following services are covered specifically for the treatment of cleft lip or palate, if not otherwise covered by a dental plan:
 - Dental services
 - Orthodontic treatment
 - Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic or prosthetic treatment

✕ **Restrictions:**

- There is no coverage for any services provided in a dentist's office.
- Facility fees, anesthesia and other charges related to non-covered dental services are not covered.
- Dentures, dental prosthetics and related surgery are not covered.
- Braces and other orthodontic treatment, including treatment done to prepare for surgery, are not covered.
- Treatment of temporomandibular joint (TMJ) disorder is limited to the initial diagnostic examination, initial testing and medically necessary surgery.

Diabetes care

Coverage for diabetes care applies to services prescribed by a doctor for insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes. Covered services include outpatient self-management training and patient management, as well as nutritional therapy.

Patient management refers to outpatient education and training for a person with diabetes, given by a person or entity with experience in treating diabetes. It is done in consultation with your physician, who must certify that the services are part of a comprehensive care plan related to your condition. The services must also be needed to ensure therapy or compliance, or to give you the skills and knowledge necessary to successfully manage your condition.

Diabetes self-management training and patient management, including nutritional therapy, may be conducted individually or in a group. It must be provided by an education program recognized by the American Diabetes Association or by a Certified Diabetes Educator® (CDE®). Coverage includes all educational materials for the program.

Benefits are available in the following situations:

- ☐ You are initially diagnosed with diabetes
- ☐ Your symptoms or condition change significantly, requiring changes in self-management
- ☐ You need refresher patient management
- ☐ You are prescribed new medications or treatment

Screenings for Type 2 and gestational diabetes are covered as preventive services (Chapter 6).

Diabetic supplies and equipment

Diabetic supplies and equipment are covered when prescribed by a doctor for insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes.

| Member costs | |
|---------------------|---|
| ✓ Diabetic supplies | <ul style="list-style-type: none">▪ Contracted suppliers: No member costs▪ Non-contracted suppliers: 20% coinsurance |

The following supplies and equipment are covered under your medical benefit:

- ☐ Blood glucose monitors, including voice synthesizers for blood glucose monitors for use by legally blind persons
- ☐ Insulin infusion devices
- ☐ Insulin measurement and administration aids for the visually impaired
- ☐ Insulin pumps and all related supplies
- ☐ Laboratory tests, including glycosylated hemoglobin (HbA1c) tests, urinary protein/microalbumin and lipid profiles
- ☐ Lancets and lancet devices
- ☐ Syringes and all injection aids
- ☐ Test strips for glucose monitors
- ☐ Therapeutic shoes for the prevention of complications associated with diabetes
- ☐ Urine test strips

Diabetes drugs (such as insulin and prescribed oral agents) are covered under your prescription drug plan. In addition, if you buy diabetic supplies at a pharmacy, the supplies may also be covered under your prescription drug plan. See Part 5 of this handbook (pages 137-144).

✕ Restrictions:

- Coverage for therapeutic shoes is limited to one pair each year.
- Special shoes purchased to accommodate orthotics or to wear after foot surgery are not covered.

✓ **Use Medicare suppliers or Wellpoint contracted suppliers** (page 24) – Use a Wellpoint contracted supplier if there is no Medicare supplier available.



Look for Medicare suppliers at [medicare.gov](https://www.medicare.gov). Find Wellpoint contracted suppliers at [wellpointmass.com](https://www.wellpointmass.com).



Important! Non-contracted suppliers are covered at 80%, even if you are using the non-contracted suppliers because the item isn't available from a contracted suppliers .

Dialysis

Dialysis treatment, including hemodialysis and peritoneal dialysis, is covered.

| Member costs | |
|--------------|-----------------|
| Dialysis | No member costs |

✕ Restrictions:

- There is no coverage for transportation to dialysis appointments.
- There is no coverage for hemodialysis to treat a behavioral health condition.

Doctor and other medical provider services

Medically necessary services from a licensed medical provider are covered when that provider is acting within the scope of his or her license. The services must be provided in a hospital, clinic, professional office, home care setting, long-term care setting, or other medical facility.

| Member costs | |
|--|-----------------|
| Provider visits – In person or through virtual care (telehealth) | \$10 copay |
| Emergency room care | No member costs |
| Inpatient hospital care | No member costs |
| Outpatient hospital care | \$10 copay |

Covered providers include any of the following acting within the scope of their licenses or certifications:

- ☐ Certified nurse midwives
- ☐ Chiropractors

- ☐ Dentists
- ☐ Nurse practitioners
- ☐ Optometrists
- ☐ Physician assistants
- ☐ Physicians
- ☐ Podiatrists

X Restrictions:

- There is no coverage for physicians to be available in case their services are needed (for example, a stand-by physician in an operating room). The Plan only pays providers for the actual delivery of medically necessary services.

Durable medical equipment (DME)

Durable medical equipment (DME) is equipment and supplies – such as wheelchairs, crutches, oxygen and respiratory equipment – that is ordered by a doctor for daily or extended use. The Plan covers medically necessary DME if the item meets all of the following requirements:



- ☐ Designed primarily for therapeutic purposes or to improve physical function
- ☐ Able to withstand repeated use
- ☐ Provided in connection with the treatment of disease, injury or pregnancy
- ☐ Ordered by a physician
- ☐ Provided by a DME supplier

| Member costs | |
|---------------------------------|--|
| Durable medical equipment (DME) | <ul style="list-style-type: none"> ■ Contracted suppliers: No member costs ■ Non-contracted suppliers: 20% coinsurance |

The Plan covers rental or purchase depending on the item, its use, and the expected total cost.

X Restrictions:

- The 20% coinsurance doesn't count toward the coinsurance limit.
- Coverage is limited to medically necessary equipment that meets the requirements listed above. Types of equipment that are not covered under the DME benefit include:
 - Equipment intended for athletic or recreational use (e.g., exercise equipment, wheelchairs for sports)
 - Items intended for environmental control or home modification (e.g., electronic door openers, air cleaners, dehumidifiers, elevators, ramps, stairway lifts)

- Added, non-standard features or accessories (e.g., hand controls for driving, transit systems that secure wheelchairs in moving vehicles, wheelchair customizations)
 - Items specifically designed to be used outdoors (e.g., special wheelchairs for beach access, equipment for use on rough terrain)
 - Items that serve as backup by duplicating other equipment (e.g., a manual wheelchair as backup for a powered wheelchair)
 - Equipment upgrades or replacements for items that function properly or that can be repaired
- There is no coverage for personal items that could be purchased without a prescription (e.g., air conditioners, arch supports, bed pans, blood pressure cuffs, commodes, computer-assisted communications devices, corrective shoes, heating pads, hot water bottles, incontinence supplies, lift or riser chairs, non-hospital beds, orthopedic mattresses, shower chairs, telephones, televisions, thermal therapy devices, whirlpools).
 - Compression stockings are covered up to a limit of four pairs within a 365-day period.
 - The Plan will not cover any rental charges that exceed the purchase price of an item.
- ✓ **Use Medicare suppliers or Wellpoint contracted suppliers** (page 24) – Use a Wellpoint contracted supplier if there is no Medicare supplier available.
-  Look for Medicare suppliers at [medicare.gov](https://www.medicare.gov). Find Wellpoint contracted suppliers at [wellpointmass.com](https://www.wellpointmass.com).
-  **Important!** Non-contracted suppliers are covered at 80%, even if you are using the non-contracted suppliers because the item isn't available from a contracted suppliers .

Early intervention programs

Coverage is provided for medically necessary early intervention services for children from birth until their third birthday.

Early intervention services include occupational, physical and speech therapy, nursing care and psychological counseling. These services must be provided by licensed or certified healthcare providers working within an early intervention services program approved by the Massachusetts Department of Public Health, or under a similar law in other states.

| Member costs | |
|-----------------------------|--|
| Early intervention programs | No member costs (limited to \$5,200 for each child in a calendar year, with a lifetime limit of \$15,600 for each child) |

Emergency care / urgent care

If you are facing a medical or behavioral health emergency, go to the nearest emergency department or call 911 (or the local emergency medical services number). Keep emergency numbers and your doctors' phone numbers in a place that's easy to reach.

The Plan covers emergency room and urgent care services from various types of providers.

| Member costs | |
|-----------------------------|---|
| Hospital emergency room | \$50 copay (waived if admitted to the hospital) |
| Urgent care center visits | \$10 copay |
| Retail health clinic visits | \$10 copay |
| Medical practice visits | \$10 copay |

An **emergency** is an illness or medical condition, whether physical or behavioral, characterized by symptoms of sufficient severity that the absence of prompt medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- ☐ Serious jeopardy to physical and/or mental health
- ☐ Serious impairment to bodily functions
- ☐ Serious dysfunction of any bodily organ or part
- ☐ In the case of pregnancy, a threat to the safety of a member or her unborn child

Some examples of illnesses or medical conditions requiring emergency care are severe pain, a broken leg, loss of consciousness, vomiting blood, chest pain, difficulty breathing, or any medical condition that is quickly worsening.


Urgent care refers to services you get when your health is not in serious danger but you need medical attention right away. Some conditions you might seek urgent care for are listed in Table 5.

Table 5. Example conditions for urgent care

| When you might want to get urgent care | |
|---|--|
| <ul style="list-style-type: none"> ▪ Cough ▪ Sore throat ▪ Minor fever, cold or flu ▪ Nausea, vomiting, or diarrhea ▪ Back pain ▪ Muscle strain or sprain ▪ Ear or sinus pain ▪ Mild headache | <ul style="list-style-type: none"> ▪ Minor allergic reactions ▪ Bumps, cuts, and scrapes ▪ Minor burn or rash ▪ Burning with urination ▪ Eye swelling, pain, redness or irritation ▪ Animal bites ▪ Stitches ▪ X-rays or lab tests |

For urgent care, your member costs are lower if you go to a walk-in clinic instead of a hospital emergency department. **Walk-in clinics** are sites that offer medical care on a walk-in basis, so no appointment is needed. Although walk-in clinics have a variety of different names, they fall into four general categories. These four categories differ based on the services they offer and how they bill for their services.

- ❑ **Medical practices** – Some doctors' offices offer services to walk-in patients. They offer the services you'd expect to get at a primary care practice.
- ❑ **Retail health clinics** are located in retail stores or pharmacies. They offer basic services like vaccinations and treatment for colds or mild sinus infections.
- ❑ **Urgent care centers** are independent, freestanding locations that treat conditions that should be handled quickly but that aren't life-threatening. They often do X-rays, lab tests and stitches.
- ❑ **Hospitals** – Some hospitals have walk-in clinics within or associated with their emergency departments.

 **Important!** A facility's name isn't always a guide to how it bills or what your member costs will be. For example, a walk-in clinic that calls itself an urgent care center may bill as a hospital emergency room or a medical practice, instead of as an urgent care center. Before you use a walk-in clinic, you may want to ask how your visit will be billed. As the benefits chart shows, how your visit is billed determines how much you owe.

X Restrictions:

- Charges for non-emergency services received at an emergency room are covered under the appropriate plan benefit. For example, a non-emergency CT scan would be covered under the radiology benefit (described on page 56) rather than the emergency room benefit.


Enteral/oral therapy

Prescription and nonprescription enteral/oral formulas are covered only when ordered by a physician for the medically necessary treatment of malabsorption disorders caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

Enteral therapy is prescribed nutrition that is administered through a tube that has been inserted into the stomach or intestines. **Oral therapy** is administered by mouth.

| Member costs | |
|-------------------------------|--|
| ✓ Enteral/oral therapy | <ul style="list-style-type: none"> ▪ Contracted suppliers: No member costs ▪ Non-contracted suppliers: 20% coinsurance |

✕ Restrictions:

- The 20% coinsurance doesn't count toward the coinsurance limit.
- ✓ **Use Wellpoint contracted suppliers** (page 24) – Enteral/oral therapy from a Wellpoint contracted supplier is covered at 100% of the allowed amount. From non-contracted suppliers, enteral/oral therapy is covered at 80%, so you owe 20% coinsurance.
-  Find Wellpoint contracted suppliers at [wellpointmass.com](https://www.wellpointmass.com).

Eye care

The Plan covers routine eye exams once every 24 months. Other eye care services are covered if you have eye problems due to a medical condition.

| Member costs | |
|---|--|
| Routine eye exams Refraction/glaucoma testing | \$10 copay (limited to one exam every 24 months) |
| Eye care office visits When medically necessary | \$10 copay |
| Vision therapy | \$10 copay |

Routine eye exams can be performed by an ophthalmologist or optometrist. They include the following parts:

- ❑ **Eye health** – This part of a routine eye exam checks the health of your eyes, such as testing for glaucoma, when you are not experiencing any eye problems.
- ❑ **Vision (visual acuity)** – Eye exams that diagnose vision or treat vision problems are called *refraction*, or *refractive eye exams*. These exams measure how well you can see and whether you need your vision corrected. Visual acuity problems (*refractive errors*) include astigmatism, near-sightedness, far-sightedness, and aging-related blurry vision.

The Plan covers office visits (typically, with an ophthalmologist) for the monitoring and treatment of medical conditions that can harm the eyes. These include conditions such as diabetes, glaucoma, keratoconus, cataracts and macular degeneration.

✕ Restrictions:

- Routine eye exams consist of checking eye health and visual acuity only. Other testing – such as visual fields, ophthalmoscopy or ophthalmic diagnostic imaging – is not considered routine and is not covered.
- There is no coverage for surgery or supplies to correct refractive errors (visual acuity problems). Non-covered services include orthoptics for vision correction, radial keratotomy, and other laser surgeries. Refractive errors include astigmatism, myopia (near-sightedness), hyperopia (far-sightedness), and presbyopia (aging-related blurry vision).


Eyeglasses and contact lenses

Generally, the Plan does not cover eyeglasses or contact lenses. However, a set of eyeglasses or contact lenses is covered after an eye injury or cataract surgery. You must purchase the eyeglasses or contact lenses within six months of the surgery. Standard frames and lenses, including bifocal and trifocal lenses, are covered.

| Member costs | |
|--------------------------------------|--|
| Eyeglasses and contact lenses | No member costs (limited to the first set within six months of eye injury or cataract surgery) |

Restrictions:

- Eyeglasses and contact lenses are only covered within six months after an eye injury or cataract surgery. Coverage applies to the initial lenses only.
- There is no coverage for deluxe frames or specialty lenses such as progressive or transitional lenses, tinted lenses, anti-reflective coating or polycarbonate lenses.

 **Important!** Medicare only pays for contact lenses or eyeglasses from Medicare suppliers, no matter who submits the claim (you or the supplier). If you don't use a Medicare supplier, the Plan covers only 20% of the allowed amount. You must pay the rest of the cost yourself.

 Look for Medicare suppliers at [medicare.gov](https://www.medicare.gov).

Family planning

Family planning services, including office visits and procedures for the purpose of contraception, are covered.

| Member costs | |
|---------------------------------|-----------------|
| Family planning services | No member costs |

Covered services include:

- ☐ Fitting for a diaphragm or cervical cap
- ☐ Insertion, re-insertion, or removal of an IUD or Levonorgestrel (Norplant)
- ☐ Injection of progesterone (Depo-Provera)
- ☐ Office visits, including evaluations, consultations, and follow-up care
- ☐ Voluntary female sterilization (tubal ligation)
- ☐ Voluntary male sterilization (vasectomy)
- ☐ Voluntary termination of pregnancy (abortion)

FDA-approved contraceptive drugs and devices are available through your prescription drug plan (see Part 5 of this handbook).

Fitness reimbursement

You can get reimbursed for up to \$100 per member on costs associated with participation in a fitness activity. The fitness reimbursement is paid to the plan enrollee upon proof of payment.

| Member costs | |
|------------------------------|--|
| Fitness reimbursement | Costs are reimbursed up to \$100 per member each calendar year |

To receive the fitness reimbursement, you must attest to participating in physical activity an average of four or more times per month, and you must submit proof of payment toward an eligible activity. Eligible costs include:

- ☐ Gyms, health clubs, fitness centers, Boys & Girls Clubs of America, dance studios, martial arts centers, etc.
- ☐ Classes and programs such as yoga, Pilates, spin, Zumba, and gymnastics (either in-person or online)
- ☐ Organizations and leagues designed for fitness activities (e.g., sports teams, hiking, bowling, etc.)
- ☐ Personal trainers (either in-person or online)

Use the *Fitness Reimbursement* form to submit your request for this reimbursement.



Download the *Fitness Reimbursement* form from [wellpointmass.com](https://www.wellpointmass.com).

X Restrictions:

- Although any family members may have fitness memberships, the total reimbursement is paid to the plan enrollee only.
- Ineligible costs include beach or country club memberships or dues; fees for one-day events; annual or day passes (such as for skiing); spas or spa services; personal or home fitness equipment.

Foot care (routine)

Routine foot care, such as nail trimming and callus removal, is not covered unless a medical condition affecting the lower limbs (such as diabetes or peripheral vascular disease of the lower limbs) makes the care medically necessary.

- ☐ If you are ambulatory, medical evidence must document an underlying condition causing vascular compromise, such as diabetes.
- ☐ If you are not ambulatory, medical evidence must document a condition that is likely to result in significant medical complications in the absence of such treatment.

| | Member costs |
|-------------------|--------------|
| Routine foot care | \$10 copay |

X Restrictions:

- Arch supports, such as Dr. Scholl's inserts, are not covered.

Gender affirmation (reassignment) services

Services for treatment associated with gender affirmation (reassignment) are covered like any other physical condition. Coverage is subject to all pertinent provisions of the Plan including medical necessity, use of participating providers, preapproval reviews, benefit limitations, and provider payment methods.

Medical services needed for diagnosis and treatment are covered under your medical benefit. Behavioral health services are covered as a behavioral health benefit (Part 3 of this handbook).

Covered services include:

- ❑ Breast/chest ("top") and genital/reproductive organ ("bottom") surgeries
- ❑ Electrolysis (hair removal) when part of surgical preparation
- ❑ Facial reconstruction procedures, such as tracheal shaving
- ❑ Surgical repair and fertility preservation coverage, including up to 12 months of storage

For a list of specific covered services, contact Wellpoint Member Services at 800-442-9300.

X Restrictions:

- Fertility storage (storage of sperm or eggs) is limited to a maximum of 12 months.
- Surgical reversal of original procedure is not covered.

Gynecology exams

Gynecological exams, including Pap smears, are covered as a preventive service. Other medically necessary gynecology services are covered under the benefit for office visits.

| | Member costs |
|-----------------------------|-----------------|
| Annual exam, with Pap smear | No member costs |
| Office visits | \$10 copay |

Hearing aids

Hearing aids are covered to correct a member’s hearing loss that has been documented through testing.

| Member costs | |
|------------------|--|
| Age 21 and under | No member costs (limited to \$2,000 for each impaired ear every 24 months) |
| Age 22 and over | No member costs (limited to \$1,700 for each impaired ear every 24 months) |

X Restrictions:

- Over-the-counter (OTC) hearing aids are not covered.
- Ear molds are not covered, except when needed for hearing aids for members age 21 and under.
- Hearing aid batteries are not covered.
- Replacement hearing aids are covered only if you have not reached the benefit limit, and if:
 - You need a new hearing aid prescription because your medical condition has changed, or
 - The hearing aid no longer works properly and cannot be repaired

Hearing exams

Expenses for hearing exams for the diagnosis of speech, hearing and language disorders are covered. These exams are typically provided by a physician or a licensed audiologist. The exam must be administered in a hospital, clinic or private office.

| Member costs | |
|---------------------------------|-----------------|
| Office visit | \$10 copay |
| Hearing screenings for newborns | No member costs |

X Restrictions:

- Services provided through schools are not covered.

Home health care

Home health care includes any skilled services and supplies provided by a Medicare-certified home health care agency or **visiting nurse association (VNA)** on a part-time, intermittent, or visiting basis.

Benefits for home health care are available when:

- ❑ Your doctor prescribes a **plan of care** – that is, a written order outlining services to be provided in the home – that will be administered by a home health care agency or VNA. The home health agency or VNA must meet any applicable licensing requirements.
- ❑ The services and supplies are provided in a non-institutional setting while you are housebound as a result of injury, disease or pregnancy.

The plan of care is subject to review and approval by the Plan.

| Member costs | |
|---------------------------|--|
| ✓ Home health care | <ul style="list-style-type: none"> ▪ Contracted providers: No member costs ▪ Non-contracted providers: 20% coinsurance |

The following services are covered if they are provided (or supervised) by a healthcare provider acting within the scope of his or her license:

- ❑ Medical social services provided by a licensed medical social worker
- ❑ Nutritional consultation by a registered dietitian
- ❑ Part-time, intermittent home health aide services consisting of personal care and help with activities of daily living
- ❑ Physical, occupational, speech and respiratory therapy by the appropriately licensed or certified therapist
- ❑ Durable medical equipment (DME) is covered under the DME benefit if the equipment is a medically necessary component of an approved plan of care

✗ **Restrictions:**

- There is no coverage for homemaking services or custodial care.
- There is no coverage for private duty nursing.
- There is no coverage for services received from someone who is in your immediate family. Your immediate family consists of you, your spouse and your children, as well as the brothers, sisters and parents of both you and your spouse. This includes any service that a provider may perform on himself or herself.
- There is no coverage for services received from anyone who shares your legal residence.

✓ **Use Wellpoint contracted providers** (page 24) – Home health services from a Wellpoint contracted provider are covered at 100% of the allowed amount. From non-contracted providers, home health services are covered at 80%, so you owe 20% coinsurance.



Find Wellpoint contracted providers at [wellpointmass.com](https://www.wellpointmass.com).

Home infusion therapy

Home infusion therapy is the administration of intravenous, subcutaneous or intramuscular therapies provided in a residential, non-institutional setting. To be considered for coverage, home infusion therapy must be delivered by a company that is licensed as a pharmacy and is qualified to provide home infusion therapy.

| Member costs | |
|-------------------------|--|
| ✓ Home infusion therapy | <ul style="list-style-type: none"> ▪ Contracted suppliers: No member costs ▪ Non-contracted suppliers: 20% coinsurance |

✗ Restrictions:

- The 20% coinsurance doesn't count toward your coinsurance limit.
 - You must get subcutaneous and intramuscular drugs through your prescription drug plan.
- ✓ **Use Wellpoint contracted suppliers** (page 24) – Home infusion therapy from a Wellpoint contracted supplier is covered at 100% of the allowed amount. From non-contracted suppliers, home infusion therapy is covered at 80%, so you owe 20% coinsurance.



Find Wellpoint contracted suppliers at [wellpointmass.com](https://www.wellpointmass.com).

Hospice and end-of-life care

Hospice provides multidisciplinary care to address the physical, social, emotional, and spiritual needs of persons likely to live six months or less. Hospice care has many benefits: better quality of life, better coping for you and your family, and longer survival time at home.

Hospice benefits are payable for covered services when a physician certifies (or re-certifies) that you have a medical prognosis of six months or less to live. The services must be furnished under a written plan of hospice care, established by a Medicare-certified hospice program, and periodically reviewed by the hospice's medical director and interdisciplinary team. Concurrent palliative chemotherapy and radiation therapy are permitted.

If you have a medical prognosis of greater than six months to live, but you have symptoms like severe pain or difficulty breathing, the Plan covers **palliative care** (page 60). Palliative care is focused on relieving pain or other symptoms of illness and improving the quality of life for patients and their families.

| Member costs | |
|------------------------|--|
| Hospice care | No member costs |
| Bereavement counseling | 20% coinsurance (limited to \$1,500 for a family in a calendar year) |

The Plan covers the following hospice services:

- ☐ Part-time, intermittent nursing care or home health aide services provided by or supervised by a registered nurse
- ☐ Physical, respiratory, occupational and speech therapy from an appropriately licensed or certified therapist
- ☐ Medical social services
- ☐ Medical supplies and medical appliances
- ☐ Drugs and medications prescribed by a physician and charged by the hospice
- ☐ Laboratory services
- ☐ Physician services
- ☐ Transportation to the place where you will be receiving covered hospice services
- ☐ Counseling provided by a physician, psychologist, clergy member, registered nurse, or social worker
- ☐ Dietary counseling from a registered dietitian
- ☐ Respite care in a hospital, a skilled nursing facility, a nursing home, or in the home. **Respite care** services are services given to a hospice patient to relieve the family or primary care person from caregiving functions.
- ☐ Bereavement counseling for family members (or for other persons specifically named by the person getting hospice care), within twelve months of death. Services must be provided by a physician, psychologist, clergy member, registered nurse, or social worker.

X Restrictions:

- The 20% coinsurance for bereavement counseling doesn't count toward the coinsurance limit.
- Respite care is limited to a total of five days.
- Bereavement counseling is limited to \$1,500 per family. Additional bereavement services may be available under the behavioral health benefit (pages 73-88).
- No hospice benefits are payable for services not listed in this section, nor for any service furnished by a volunteer, or for which no charge is customarily made.

Immunizations (vaccines)

Immunizations (vaccines) recommended by the U.S. Preventive Services Task Force are covered at 100%, according to the preventive care schedule (Chapter 6).

| Member costs | |
|----------------------|---|
| At a doctor's office | No member costs (but you may owe member costs for the office visit) |
| At a travel clinic | No member costs |
| At a pharmacy | Covered under your prescription drug plan |

X Restrictions:

- Unless you are pregnant, there is no coverage for blood tests (titers) to determine if you need an immunization. See **Immunization titers** on page 97.

Infertility treatment

Non-experimental infertility procedures are covered. These procedures are recognized as generally accepted and/or non-experimental by the American Fertility Society and the American College of Obstetrics and Gynecology. **Infertility** occurs when a member demonstrates infertility according to one of the following definitions:

- ❑ The inability of opposite-sex partners under the age of 35 to achieve conception after at least 12 months of unprotected intercourse.
- ❑ The inability of opposite-sex partners to achieve conception after six months of unprotected intercourse when the female partner (partner with a uterus and ovaries) trying to conceive is age 35 or older.
- ❑ The inability of a member with a uterus and ovaries, with or without an opposite sex partner, to achieve conception after at least six trials of medically supervised artificial insemination.
- ❑ The inability of a member with a uterus and ovaries, with or without an opposite-sex partner, to achieve conception after at least three trials of medically supervised artificial insemination over a six-month period of time when the member with a uterus and ovaries who is trying to conceive is age 35 or older.

If a pregnancy ends in miscarriage, the time spent trying to conceive (prior to the pregnancy) is counted as part of the window as defined above.

The Plan provides benefits for the following procedures:

- ❑ In vitro fertilization and embryo placement (IVF-EP)
- ❑ Artificial insemination (AI), also known as intrauterine insemination (IUI)
- ❑ Cryopreservation of eggs as a component of covered infertility treatment.
- ❑ Gamete intrafallopian transfer (GIFT)

- ❑ Intracytoplasmic sperm injection (ICSI) for the treatment of male factor infertility
- ❑ Natural ovulation intravaginal fertilization (NORIF)
- ❑ Preimplantation genetic testing (PGT)
- ❑ Sperm, egg and/or inseminated egg procurement and processing, from yourself or from a donor, to the extent that these costs are not covered by a donor's insurer, if any
- ❑ Zygote intrafallopian transfer (ZIFT)

Other charges associated with covered infertility services – such as laboratory, physician and surgery costs – are covered under the appropriate plan benefit. For example, any medically necessary lab tests would be covered under the benefit for lab tests.

X Restrictions:

- There is no coverage if the inability to conceive results from either voluntary sterilization or normal aging (menopause).
- Experimental infertility procedures are not covered.
- The Plan does not pay people to donate their eggs or sperm.
- Reversal of voluntary sterilization is not covered.
- Shipping costs, such as the cost of shipping eggs or sperm between clinics, are not covered.
- Procurement and processing of sperm, eggs, and/or inseminated eggs are covered only for the treatment of infertility.
- Infertility services provided as part of gender affirmation (reassignment) treatment (page 47) do not need to meet the definition of infertility described in this section.
- Storage fees for storing or banking sperm, eggs, and/or inseminated are limited to a maximum of 12 months in storage.
- The Plan does not pay people to be surrogates (gestational carriers) for Wellpoint members, and there is no coverage for medical services, including in vitro fertilization, for a surrogate who is not a Wellpoint member.
- Facility fees are only covered at a licensed hospital or ambulatory surgery center.
- There is no coverage for infertility procedures that don't meet the above definition of infertility.

Inpatient medical care (hospital admissions)

The Plan covers hospital services when you are admitted to an inpatient facility. Facilities that provide inpatient hospital care include acute care hospitals, rehabilitation facilities, long-term care facilities, and skilled nursing facilities. Coverage for inpatient hospital services includes all medically necessary services and supplies.

The benefit for hospital services depends on the type of facility you go to and the type of care you get:

- ❑ **Acute care hospitals** are medical centers and community hospitals that provide treatment for a severe illness, for conditions caused by disease or trauma, and for recovery from surgery. These hospitals deliver intensive, 24-hour medical and nursing care.
- ❑ **Rehabilitation (rehab) facilities** are specialized hospitals that provide rehab services to restore basic functioning (such as walking or sitting upright) that was lost due to illness or injury. Patients in these facilities have a good potential for recovery and are able to participate in a rehab program that includes therapy services for three to five hours a day.
- ❑ **Long-term care facilities** are specialized hospitals that treat patients who need further care for complex medical conditions but that no longer require the services of a traditional hospital. These patients' needs are mostly medical and their ability to participate in rehab is limited.
- ❑ **Skilled nursing facilities** provide lower intensity rehab and medical services. Patients in these facilities have continuing medical needs that require skilled nursing care, but do not need daily physician care. Some of these patients may or may not require rehab, while others may need long-term custodial care (see "Restrictions," later in this section).

| At a hospital or rehab facility | | Member costs |
|---|--|--|
| Inpatient services (semi-private room) | | No member costs |
| Inpatient services (medically necessary private room) | | The dollar difference between the semi-private room rate and the private room rate |
| At a skilled nursing or long-term care facility | | Member costs |
| Inpatient services | | <ul style="list-style-type: none"> ▪ For days paid by Medicare: No member costs until Plan benefit limit is reached ▪ For days <i>not</i> paid by Medicare: 20% coinsurance until Plan benefit limit is reached <p>The Plan benefit limit is \$13,400 each calendar year</p> |

Table 6 lists examples of the services and supplies covered under the benefit for inpatient care.

Table 6. Examples of covered inpatient services**Examples of covered inpatient services and supplies**

- | | |
|---|--|
| <ul style="list-style-type: none"> ▪ Room and board ▪ Intensive care/coronary care ▪ Physician and nursing services ▪ Surgery ▪ Anesthesia, radiology and pathology ▪ Dialysis ▪ Physical, occupational and speech therapy ▪ Diagnostic tests, radiology and labs ▪ Durable medical equipment ▪ Medically necessary services and supplies charged by the hospital | <ul style="list-style-type: none"> ▪ Pre-admission testing ▪ Ancillary items and services, such as: <ul style="list-style-type: none"> ▫ Infusions and transfusions ▫ Devices that are an integral part of a surgical procedure such as hip joints, skull plates and pacemakers ▫ Drugs, medications, solutions, biological preparations, and supplies ▫ Use of special rooms, like operating rooms ▫ Use of special equipment |
|---|--|

The Plan covers inpatient hospital stays covered by Medicare. If you exhaust your Medicare benefits for inpatient hospital care, Wellpoint will review your case to determine eligibility for continued benefits. See pages 110-111 for a description of how Wellpoint reviews inpatient admissions and other services.

X Restrictions:

- There is no coverage for custodial care. **Custodial care** is a level of care that is chiefly designed to assist with activities of daily living and cannot reasonably be expected to greatly restore health or bodily function.
- Private rooms are covered only if medically necessary.
- There is no coverage for private duty nursing.
- The Plan does not pay for donated blood.
- Convenience items such as telephone, radio and television are not covered.
- Services that are considered experimental or investigational are not covered.
- Devices that are not directly involved in the surgery, such as artificial limbs, artificial eyes or hearing aids may be covered under a different benefit, such as prosthetics.
- There is no coverage for charges for services that are not medically necessary.
- Whether or not Medicare pays, the coinsurance for skilled nursing facilities and long-term care facilities doesn't count toward the coinsurance limit.

Laboratory services (lab work) and radiology

Lab work and radiology services (such as X-rays) are covered when prescribed by a physician.

Radiology services include **high-tech imaging**, which are tests such as MRIs, CT scans and PET scans that give a more comprehensive view of the human body than plain film X-rays. Many of these tests also subject members to significantly higher levels of radiation compared to plain film X-rays and are also much more expensive.

| Lab work and radiology | Member costs |
|--|-----------------|
| Emergency room | No member costs |
| Hospital inpatient | No member costs |
| Hospital outpatient or non-hospital-owned facility | No member costs |

Long-term care facilities

Long-term care facilities are specialized hospitals that treat patients who need further care for complex medical conditions but that no longer require the services of a traditional hospital. Services at long-term care facilities are covered under the inpatient benefit (pages 53-55).

Maternity services

Maternity services are covered like any other physical condition. Coverage is subject to all pertinent provisions of the Plan, including use of participating providers, preapproval reviews, and provider payment methods. Medical services needed for diagnosis and treatment are covered under your medical benefit.

Maternity care is often billed as a global (all-inclusive) service. When this is the case, you owe an office visit copay for the first visit but not for subsequent visits with the original doctor. However, services from other providers are not covered within the global service arrangement. Those services are billed separately and additional member costs (copays and coinsurance) may apply.

Medical care outside the U.S.

The Plan covers emergency services you get outside of the United States.

Wellpoint reimburses non-U.S. emergency services at 100% of the charges, after any copay amounts that apply, according to the exchange rate that was in effect on the date of service as found on www.oanda.com. The claim is paid based on these converted amounts.


To receive payment for emergency services outside the U.S., you must file a claim for each service. Wellpoint will pay eligible benefits via check or EFT (electronic funds transfer) directly to you. It is your responsibility to use that payment to reimburse the foreign provider directly.

Your claim must include written proof of the service and of your payment, as described on page 108. If your bill has information in a foreign language, please provide a translation, if possible.

Restrictions:

- There is no coverage for elective services received outside the U.S.
- Ambulance transportation is covered only in an emergency, and only for transportation to the nearest facility that can treat the condition.
- There is no coverage for ambulance transportation, including air ambulance, to a specified or preferred facility if a nearer facility can provide treatment.
- Repatriation expenses are not covered.

Medical services (if not listed elsewhere)

 **Important!** This section applies only to covered medical services that aren't addressed elsewhere in this chapter. Be sure to check the index to see if the benefits for a particular service are described in a different section.

| Member costs | |
|---|-----------------|
| Covered medical services (if not listed elsewhere) | 20% coinsurance |

Neuropsychological (neuropsych) testing

Neuropsych testing is covered as a medical benefit when the testing is for a condition such as head injury, stroke or dementia, and when it is performed by a medical provider. When testing is for a condition like depression and is performed by a behavioral health provider, such as a psychiatrist, it is covered as a behavioral health benefit (see pages 85-86 for coverage details).

Occupational therapy

The Plan covers occupational therapy on a short-term basis when the potential for functional gain exists. One-on-one therapies are covered only when ordered by a physician and administered by a licensed occupational therapist or occupational therapy assistant (under the direction of an occupational therapist).

Occupational therapy is skilled treatment that helps individuals achieve independence with activities of daily living after an illness or injury not incurred during the course of employment. Services include:

- ❑ Treatment programs aimed at improving the ability to carry out activities of daily living
- ❑ Comprehensive evaluations of the home
- ❑ Recommendations and training in the use of adaptive equipment to replace lost function

| Member costs | |
|----------------------|---|
| Occupational therapy | <ul style="list-style-type: none"> ▪ If Medicare pays: No member costs ▪ If Medicare does <i>not</i> pay: 20% coinsurance |


✕ Restrictions:

- There is no coverage for:
 - Group occupational therapy
 - Sensory integration therapy
 - Occupational therapy to treat a chronic condition when that treatment is neither curative nor restorative
- Services provided through schools are not covered.

Office visits

Office visits with primary care and specialty care providers are covered. See “Doctor and other medical provider services” on page 39 for coverage information.

Outpatient hospital services (if not listed elsewhere)

 **Important!** This section applies only to outpatient services that aren't addressed elsewhere in this chapter. Be sure to check the index to see if the benefits for a particular outpatient service are described in a different section.

Outpatient hospital services are services provided by a hospital that are usually performed within a single day and don't require an overnight stay. However, an overnight stay for observation would be considered outpatient care if you are not actually admitted to the hospital.

| Member costs | |
|--|-----------------|
| Outpatient hospital services (if not listed elsewhere) | No member costs |

Oxygen


Oxygen and its administration are covered.


| Member costs | |
|--------------|--|
| ✓ Oxygen | <ul style="list-style-type: none"> ▪ Contracted suppliers: No member costs ▪ Non-contracted suppliers: 20% coinsurance |

✗ Restrictions:

- The 20% coinsurance doesn't count toward the coinsurance limit.
- Oxygen equipment required for use on an airplane or other means of travel is not covered.

✓ **Use Medicare suppliers or Wellpoint contracted suppliers** (page 24) – Use a Wellpoint contracted supplier if there is no Medicare supplier available.

 Look for Medicare suppliers at [medicare.gov](https://www.medicare.gov). Find Wellpoint contracted suppliers at [wellpointmass.com](https://www.wellpointmass.com).

 **Important!** Non-contracted suppliers are covered at 80%, even if you are using the non-contracted supplier because the item isn't available from a contracted supplier.

Palliative care

Palliative care is care that focuses on treating symptoms – like severe pain, or difficulty breathing – to make you more comfortable. It is not intended to cure underlying conditions.

Palliative care is covered like any other physical condition. Medical services are covered under your medical benefit. Coverage is subject to all pertinent provisions of the Plan, including use of participating providers, preapprovals, and provider payment methods.

Personal Emergency Response Systems (PERS)

Installation and rental of a personal emergency response system (PERS) are covered when a doctor's letter attesting to its medical necessity is included with the claim.

| Member costs | |
|-------------------|--|
| PERS installation | 20% coinsurance (limited to \$50 each calendar year) |
| PERS rental | No member costs (limited to \$40 a month) |

✕ Restrictions:

- The 20% coinsurance doesn't count toward the coinsurance limit.
- There is no coverage for the purchase of a PERS unit.

Physical therapy

The Plan covers physical therapy on a short-term basis when the potential for functional gain exists. One-on-one therapies are covered only when ordered by a physician and administered by a licensed physical therapist or physical therapy assistant (under the direction of a physical therapist).

Physical therapy is hands-on treatment to relieve pain, restore function and/or minimize disability resulting from disease or injury to the neuromuscular and/or musculoskeletal system, or the loss of a body part. Physical therapy may include direct manipulation, exercise, movement, and/or other physical modalities.

| Member costs | |
|------------------|---|
| Physical therapy | <ul style="list-style-type: none"> ■ If Medicare pays: No member costs ■ If Medicare does <i>not</i> pay: 20% coinsurance |

Physical therapy must be:

- ☐ Ordered by a physician
- ☐ For the treatment of an injury or disease
- ☐ The most appropriate level of service needed to provide safe and adequate care
- ☐ Appropriate for the symptoms, consistent with the diagnosis, and consistent with generally accepted medical practice and professionally recognized standards

X Restrictions:

- There is no coverage for:
 - Group physical therapy
 - Services provided by athletic trainers
 - Massage therapy and services provided by a massage therapist or neuromuscular therapist
 - Physical therapy to treat a chronic condition when that treatment is neither curative nor restorative
- Certain therapy services are not covered. These include, but are not limited to: acupuncture, aerobic exercise, craniosacral therapy, diathermy, infrared therapy, kinetic therapy, microwave therapy, paraffin treatment, Rolfing therapy, Shiatsu, sports conditioning, ultraviolet therapy, and weight training.
- Services provided by a chiropractor are considered chiropractic care, not physical therapy.
- Services provided through schools are not covered.

Prescription drugs

Benefits for most prescription drugs are administered by SilverScript. See Part 5 (pages 137-144) for benefits information.

Preventive care

The Plan covers preventive or routine office visits, physical exams and other related preventive services that are recommended by the U.S. Preventive Services Task Force.

Covered preventive services are covered at 100% of the allowed amount, without any member costs. Preventive exams are covered according to the schedule issued by Massachusetts Health Quality Partners.

The schedule and guidelines for covered preventive services appears in Chapter 6.

| Member costs | |
|-----------------|-----------------|
| Preventive care | No member costs |

X Restrictions:

- Not all preventive healthcare services are recommended for everyone. You and your doctor should decide what care is appropriate for you.
- Claims must be submitted with the appropriate preventive diagnosis and procedure codes in order to be paid at 100%.
- If you are treated for an existing illness, injury or condition during your preventive exam, you may have to pay member costs for those non-preventive services.

Prosthetics and orthotics

Prosthetics and orthotics, including braces, are covered if they are prescribed by a physician as medically necessary.

Prosthetics replace part of the body or replace all or part of the function of a permanently inoperative, absent, or impaired part of the body. Breast prosthetics and artificial limbs are prosthetics.

Orthotics are devices used to restrict, align or correct deformities and/or to improve the function of moveable parts of the body. They are often attached to clothing and/or shoes, may assist in movement, and are sometimes jointed. Orthotics include braces, splints and trusses.

| Member costs | |
|---|---|
| Breast prosthetics | No member costs |
| Orthopedic shoe with attached brace | No member costs |
| Other prosthetics and orthotics (including mastectomy bras) | <ul style="list-style-type: none"> ▪ If Medicare pays: No member costs ▪ If Medicare does <i>not</i> pay: 20% coinsurance |

X Restrictions:

- Orthotics must be:
 - Ordered by a physician
 - Custom molded and fitted to your body
 - Used only by you
- There is no coverage for replacement prosthetics and orthotics except when needed due to normal growth or pathological change (a change in your medical condition that requires a prescription change). Supporting documentation is required.
- The following items and services are not covered:
 - Arch supports (for example, Dr. Scholl's inserts)
 - Temporary or trial orthotics
 - Video tape gait analysis and diagnostic scanning
 - Orthopedic shoes that do not attach directly to a brace

Pulmonary rehabilitation (rehab) programs

Pulmonary rehab programs use a combination of education and exercise to help improve respiratory function in people diagnosed with breathing problems.

| Member costs | |
|--------------------------|-----------------|
| Pulmonary rehab programs | No member costs |

A pulmonary rehab program must:

- ☐ Be ordered by a physician
- ☐ Be operated by a licensed clinic or hospital
- ☐ Meet the generally accepted standards of pulmonary rehab

This benefit covers the active rehabilitation phase of the program, which is usually three consecutive months.

X Restrictions:

- To qualify for a pulmonary rehab program, you must have a diagnosed breathing problem such as chronic obstructive pulmonary disease (COPD) or pulmonary fibrosis.
- Pulmonary rehab programs are limited to 36 visits (three visits per week for 12 weeks).
- There is no coverage for the *maintenance* phase of a pulmonary rehab program. Coverage is for the *active* phase only.

Radiation therapy

Radiation therapy, including radioactive isotope therapy and intensity-modulated radiation therapy (IMRT), is a covered service.

| Member costs | |
|-------------------|-----------------|
| Radiation therapy | No member costs |

Rehabilitation (rehab) hospitals

Rehabilitation (rehab) facilities are specialized hospitals that provide rehab services to restore basic functioning (such as walking or sitting upright) that was lost due to illness or injury. Services at rehab hospitals are covered under the benefit for hospital admissions (pages 53-55).

Retail health clinics

Retail health clinics are clinics located in retail stores or pharmacies that offer basic medical services on a walk-in basis. See “Emergency care / urgent care” on pages 42-43 for coverage information.

Skilled nursing facilities

Skilled nursing facilities provide lower intensity rehab and medical services. Services at skilled nursing facilities are covered under the inpatient benefit (pages 53-55).

Sleep studies

Sleep studies are tests that monitor you while you sleep to find out if you have any breathing difficulties. These studies may be performed at a hospital, a freestanding sleep center, or at home.

| Member costs | |
|---------------|-----------------|
| Sleep studies | No member costs |

Speech therapy

Services for the diagnosis and treatment of speech, hearing and language disorders (speech-language pathology services) are covered when provided by a licensed speech-language pathologist or audiologist. The services must be ordered by a physician and provided in a hospital, clinic or private office.

| Member costs | |
|----------------|-----------------|
| Speech therapy | No member costs |

Covered speech therapy services include:

- ☐ Assessment of and remedial services for speech defects caused by either a physical disorder or by autism spectrum disorder
- ☐ Speech rehabilitation, including physiotherapy, following laryngectomy

X Restrictions:

- There is no coverage for:
 - Cognitive rehabilitation, except as related to COVID-19
 - Speech therapy to treat a chronic condition when that treatment is neither curative nor restorative
- Services provided through schools are not covered.

Surgery

The surgery benefit covers facility charges and surgeon fees for operative services including care before, during and after surgery.

| Member costs | |
|-----------------------|--|
| In Massachusetts | No member costs |
| Outside Massachusetts | <ul style="list-style-type: none"> ▪ Medicare participating: No member costs ▪ Medicare non-participating: 20% of the difference between the Plan's allowed amount and the provider's charge |

Reconstructive breast surgery for all stages of mastectomy are covered under this benefit. See page 158 for details.

X Restrictions:

- Coverage for reconstructive and restorative surgery – surgery intended to improve or restore bodily function or to correct a functional physical impairment that has been caused by either a congenital anomaly or a previous surgical procedure or disease – is limited to the following:
 - Correction of a functional physical impairment due to previous surgery or disease
 - Reconstruction of defects resulting from surgical removal of an organ or body part for the treatment of cancer. Such restoration must be within five years of the removal surgery.
 - Correction of a congenital birth defect that causes functional impairment for a minor dependent child
- Devices that are not directly involved in the surgery, such as artificial limbs, artificial eyes or hearing aids may be covered under a different benefit, such as prosthetics.
- Cosmetic services are not covered, with the exception of treatment for HIV-associated lipodystrophy and the initial surgical procedure to correct appearance that has been damaged by an accidental injury.
- Coverage for assistant surgeon services is limited, as follows:
 - The services of an assistant surgeon must be medically necessary.
 - The assistant surgeon must be a licensed provider (e.g., physician, physician assistant) acting within the scope of his or her license and trained in a surgical specialty related to the procedure.
 - The assistant surgeon serves as the first assistant surgeon to the primary surgeon during a surgical procedure.
 - Only one assistant surgeon is covered per procedure. Second and third assistants are not covered.
 - Interns, residents and fellows are not covered as assistant surgeons.

Tobacco cessation counseling

Counseling for tobacco dependence/smoking cessation is covered up to a limit of 300 minutes each calendar year. It is reimbursed up to the Plan's allowed amount.

| Member costs | |
|-------------------------------------|---|
| Tobacco cessation counseling | No member costs (limited to 300 minutes in a calendar year) |

A tobacco cessation program is a program that focuses on behavior modification while reducing the amount smoked over a number of weeks, until the quit, or cut-off, date. Tobacco cessation counseling can occur face-to-face or over the telephone, either individually or in a group.

Counseling may be provided by physicians, nurse practitioners, physician assistants, nurse-midwives, registered nurses and tobacco cessation counselors. Tobacco cessation counselors are non-physician providers who have completed at least eight hours of instruction in tobacco cessation from an accredited institute of higher learning. They must work under the supervision of a physician.

Tobacco cessation counseling can be billed directly to Wellpoint. However, if your provider is unable to bill the Plan directly, or does not accept insurance, you can submit your claim yourself.



Download claim forms from [wellpointmass.com](https://www.wellpointmass.com).

Nicotine replacement products are available at no cost through the prescription drug plan, but you must have a prescription. See Part 5 of this handbook for details.

X Restrictions:

- Tobacco cessation counseling is limited to 300 minutes each calendar year.

Transplants

Benefits are payable – subject to any copays, coinsurance and benefit limits – for necessary medical expenses incurred for the transplanting of a human organ.

| Member costs | |
|--|-----------------|
| At a Medicare-certified transplant facility | No member costs |
| At other hospitals | 20% coinsurance |

Clinical services personnel are available to support you and your family before the transplant procedure and through the recovery period. Clinical services can help with:

- ☐ Reviewing your ongoing needs
- ☐ Finding out about services while you await a transplant
- ☐ Getting information about your Medicare benefits
- ☐ Guiding you on home care plans, as appropriate

X Restrictions:

- The 20% coinsurance doesn't count toward the coinsurance limit.

Human organ donor services

Benefits are payable – subject to any copays, coinsurance and benefit limits – for necessary expenses incurred for delivery of a human organ (any part of the human body, excluding blood and blood plasma) and medical expenses incurred by a person in direct connection with the donation of an organ.

Benefits are payable for any person who donates a human organ to a person covered under the Plan, whether or not the donor is a member of the Plan.

The Plan also covers expenses for human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish the suitability of a bone marrow transplant donor. Such expenses consist of testing for A, B or DR antigens, or any combination thereof, consistent with the guidelines, criteria, and regulations established by the Massachusetts Department of Public Health.

Travel clinics

The Plan covers visits at travel clinics. Immunizations and their administration are also covered.

| | Member costs |
|--|---------------------|
| Travel clinic visits | No member costs |
| Immunizations at travel clinics | No member costs |

X Restrictions:

- Unless you are pregnant, there is no coverage for blood tests (titers) to determine if you need an immunization. See **Immunization titers** on page 97.

Urgent care

The Plan covers urgent care services. **Urgent care** refers to services you get when your health is not in serious danger but you need immediate medical attention. You can get urgent care services at various locations that offer walk-in medical care, but your member costs will vary. See “Emergency care / urgent care” on pages 42-43 to find out about the different types of providers that offer urgent care services.

Walk-in clinics

Walk-in clinics are sites that offer medical care on a walk-in basis, so no appointment is needed. See “Emergency care / urgent care” on pages 42-43 for information about the different types of walk-in clinics.

Wigs

Wigs are covered when hair loss is due to cancer or leukemia treatment.

| Member costs | |
|--------------|---|
| Wigs | 20% coinsurance (limited to \$350 in a calendar year) |


X Restrictions:

- There is no coverage if hair loss is due to anything other than cancer or leukemia treatment.

Chapter 6: Covered preventive services

The Plan covers preventive or routine office visits, physical exams, and other related preventive services listed in Table 7. Preventive exams are covered according to the schedule issued by Massachusetts Health Quality Partners.

The preventive services listed below are covered at 100% of the allowed amount. The table also shows gender, age, and frequency recommendations.

 **Important!** Your doctor must submit claims with preventive diagnosis and procedure codes to be covered at 100% as a preventive service. Preventive services don't include services to treat an existing condition. If, during your preventive visit, you get services to treat an existing condition, you may owe member costs for those services.

Please note that the preventive services listed here are not recommended for everyone. You and your doctor should decide what care is appropriate for you.

Table 7. Preventive care schedule

| Preventive service | Recommendations | | | |
|--|-----------------|---------|---------------|--|
| | Males | Females | Age | How often? |
| Abdominal aortic aneurysm screening | ■ | ■ | 65 and older | One time |
| Alcohol misuse screening and counseling | ■ | ■ | | Part of the preventive exam |
| Anemia screening | | ■ | | Part of the preventive exam |
| Anxiety screening | ■ | ■ | 8 to 18 years | Part of the preventive exam for children and adolescents |
| Blood pressure screening | ■ | ■ | | Part of the preventive exam |
| Bone density testing – Screening for osteoporosis | | ■ | 40 and older | Every 2 years |
| BRCA risk assessment and genetic counseling / testing – For breast cancer | | ■ | | One time |
| Breast cancer counseling and preventive medications | | ■ | | Part of the preventive exam |
| Breastfeeding counseling | | ■ | | Part of the preventive exam |
| Cardiovascular disease prevention – Nutritional and physical activity counseling | ■ | ■ | | For high-risk adults; part of the preventive exam |
| Chlamydia screening | | ■ | | Every 12 months |

| Preventive service | Recommendations | | | |
|---|-----------------|---------|--------------|--|
| | Males | Females | Age | How often? |
| Cholesterol screening | ■ | ■ | | Every 12 months |
| Colorectal cancer screening Includes colonoscopies, fecal occult blood testing, and other related services and tests Colonoscopies for members under age 45 are covered under limited circumstances (see page 93) | ■ | ■ | 45 and older | ■ Every 12 months for fecal occult blood test |
| Depression screening – Includes screening for perinatal depression (during and after pregnancy) | ■ | ■ | | Part of the preventive exam |
| Developmental and behavioral screening | ■ | ■ | | Part of the preventive exam for children |
| Diabetes screenings: ■ Type 2 diabetes ■ Gestational diabetes in pregnant women | ■ | ■ | | Part of the preventive exam |
| Domestic violence screening | | ■ | | For women of childbearing age; part of the preventive exam |
| Drug use screening | ■ | ■ | | Part of the preventive exam |
| Fluoride supplements – Starting at the age of primary tooth eruption | ■ | ■ | Up to age 5 | |
| Gonorrhea preventive medication | ■ | ■ | At birth | For newborns |
| Gonorrhea screening | | ■ | | Every 12 months |
| Gynecological exams | | ■ | | Every 12 months |
| Hearing screening | ■ | ■ | At birth | For newborns |
| Height, weight and body mass index (BMI) measurements | ■ | ■ | | Part of the preventive exam |
| Hepatitis B screening | ■ | ■ | | |
| Hepatitis C screening | ■ | ■ | | |
| HIV Pre-Exposure Prophylaxis (PrEP) – Includes medications, testing, monitoring, and adherence counseling | ■ | ■ | | Medications subject to your prescription drug benefit |
| HIV screening – For the virus that causes AIDS | ■ | ■ | | |

| Preventive service | Recommendations | | | |
|---|-----------------|---------|----------------|---|
| | Males | Females | Age | How often? |
| HPV (human papillomavirus) testing – For cervical cancer | | ■ | 30 and older | Every 5 years for women with normal cytology results |
| Hypothyroidism screening | ■ | ■ | At birth | For newborns |
| Immunizations | ■ | ■ | | |
| Iron supplements for anemia | ■ | ■ | 6 to 12 months | For at-risk babies |
| Lab tests – Other covered screening lab tests: <ul style="list-style-type: none"> ■ Hemoglobin ■ Urinalysis ■ Chemistry profile, including: <ul style="list-style-type: none"> ▫ Complete blood count (CBC) ▫ Glucose ▫ Blood urea nitrogen (BUN) ▫ Creatinine transferase alanine amino (SGPT) ▫ Transferase asparate amino (SGOT) ▫ Thyroid stimulating hormone (TSH) | ■ | ■ | | Part of the preventive exam |
| Lead exposure screening | ■ | ■ | | For children |
| Lung cancer scan – CT lung scan for adults who have smoked | ■ | ■ | 50-80 years | Every 12 months |
| Mammograms – Screening for breast cancer | | ■ | 35 and older | <ul style="list-style-type: none"> ■ Once between the ages of 35 and 40 ■ Yearly after age 40 |
| Nutritional counseling | ■ | ■ | | For children at high risk of obesity |
| Obesity screening and counseling | ■ | ■ | | Part of the preventive exam |
| Oral health assessment | ■ | ■ | | Part of the preventive exam for children |
| Pap smears – Screening for cervical cancer | | ■ | | Every 12 months |
| Phenylketonuria (PKU) screening | ■ | ■ | At birth | For newborns |

| Preventive service | Recommendations | | | |
|---|-----------------|---------|--------------|--|
| | Males | Females | Age | How often? |
| Preventive exams (children) | ■ | ■ | Up to age 19 | <ul style="list-style-type: none"> Four exams while the newborn is in the hospital Five exams until 6 months of age; then Every two months until 18 months of age; then Every three months from 18 months of age until 3 years of age; then Every 12 months from 3 years of age until 19 years of age |
| Preventive exams (adults) | ■ | ■ | 19 and older | Every 12 months |
| Prostate cancer screening – Digital rectal exam and PSA test | ■ | | 50 and older | <ul style="list-style-type: none"> Digital exam – Part of the preventive exam PSA test – Every 12 months |
| Rh incompatibility screening | | ■ | | For pregnant women |
| Sexually transmitted infections (STI) counseling | ■ | ■ | | Part of the preventive exam |
| Sickle cell disease screening | ■ | ■ | At birth | For newborns |
| Skin cancer behavioral counseling | ■ | ■ | | Part of the preventive exam |
| Syphilis screening | ■ | ■ | | |
| Tuberculosis screening | ■ | ■ | | |
| Urinary tract infections (UTI) screening – Asymptomatic bacteriuria | | ■ | | During pregnancy |
| Vision screening | ■ | ■ | | Part of the preventive exam for children |
| Vision screening (instrument-based) | ■ | ■ | 3-5 years | |

Part 3:

Your Behavioral Health Benefits

Description of coverage for mental health and
substance use disorder services

For questions about any of the information in Part 3 of this handbook,
please call Wellpoint Member Services at 800-442-9300.

Administered by



Chapter 7: Using your benefits for behavioral health

Coverage for behavioral health services

Behavioral health services are services that treat mental health and substance use disorder conditions. The Plan offers comprehensive benefits for behavioral health services. Wellpoint has partnered with **Carelon Behavioral Health** to establish access to experienced behavioral health providers.

As a Medicare Extension member, you can get services from any appropriately-licensed behavioral health provider, but your coverage is highest when you use providers who are contracted with Carelon Behavioral Health to provide services to Wellpoint members.



Important! When you choose to use a non-contracted provider, you can be balance billed for charges over the allowed amount (that is, above the amount the Plan paid). See page 22 to find out more about balance billing.

About behavioral health providers

Behavioral health providers treat mental health and substance use disorder conditions. These providers include many types of doctors and therapists, as well as hospitals and other facilities that offer behavioral health treatment.

Behavioral health providers who are contracted with Carelon Behavioral Health have gone through a credentialing process and must adhere to the quality standards that Wellpoint requires.

You can call the provider of your choice directly to schedule an appointment.



Look for contracted behavioral health providers at [wellpointmass.com](https://www.wellpointmass.com). You can also call Wellpoint Member Services at 800-442-9300 for help.

About provider licensing

Wellpoint will only pay claims if the providers are independently licensed in their specialty area, or are working in a facility or licensed clinic under the supervision of an independently-licensed provider. This is true for both contracted and non-contracted behavioral health providers.

In Massachusetts, the Department of Public Health (DPH) issues licenses to Massachusetts facilities that provide healthcare services. To be licensed, facilities must meet specific quality and safety standards.

Examples of accepted behavioral health licenses

- | | |
|----------------------------------|---|
| ▪ MD psychiatrist | ▪ BCBA (board-certified behavioral analyst) |
| ▪ PhD | ▪ LICSW (licensed social worker) |
| ▪ PsyD (doctorate in psychology) | ▪ LMHC (licensed mental health counselor) |
| ▪ EdD (doctorate in education) | ▪ LMFT (licensed marriage and family therapist) |
| | ▪ RNCS (registered nurse clinical specialist) |

About filing your claims

Some non-contracted providers may bill you for services instead of submitting claims to Wellpoint. If this happens, you will need to submit the claims yourself. See page 108 for instructions on how to submit claims to Wellpoint.

Getting preapproval for behavioral health services

Under some circumstances, such as for services that Medicare doesn't cover or when Medicare's benefits have been exhausted, behavioral health services may need to be preapproved. Preapproval review confirms that a service is eligible for benefits.

A service doesn't need preapproval if:

- ☐ The service is covered by Medicare, and
- ☐ You are using a Medicare participating provider.

Otherwise, you must meet the requirements listed in Table 8. If someone (you or your provider) doesn't notify Wellpoint when a preapproval review is required, your benefits may be reduced or not paid at all.

To get assistance with preapprovals 24 hours a day, seven days a week, your provider should call Wellpoint at 800-442-9300 (TTY: 711).

Preapprovals for behavioral health services

Table 8 lists behavioral health services that may need preapproval review if they are not covered by Medicare. Note that the preapproval requirements may be different for contracted and non-contracted providers.

What is a DPH-licensed provider? The Massachusetts Department of Public Health (DPH) issues licenses to Massachusetts facilities that provide health care services. To be licensed, facilities must meet specific quality and safety standards.

**Table 8. Behavioral health preapproval requirements
(if not covered by Medicare)**

| Behavioral health service | With contracted providers | With non-contracted providers |
|---|--|--|
| Inpatient services for mental health treatment | | |
| <ul style="list-style-type: none"> Acute residential treatment Inpatient psychiatric services | Needs preapproval | Needs preapproval |
| <ul style="list-style-type: none"> Community-based acute treatment (CBAT) Transitional care units (TCU) | <ul style="list-style-type: none"> In Massachusetts: Notify Wellpoint within 72 hours Outside Massachusetts: Needs preapproval | <ul style="list-style-type: none"> In Massachusetts: N/A Outside Massachusetts: Needs preapproval |
| <ul style="list-style-type: none"> Crisis stabilization units (CSU) | Needs preapproval for stays over 5 days | Needs preapproval for stays over 5 days |
| Inpatient services for substance use disorders (adults and adolescents) | | |
| <ul style="list-style-type: none"> Acute residential withdrawal management (ASAM level 3.7 detox) Clinical stabilization services (CSS) (ASAM level 3.5) Dual diagnosis acute treatment (DDAT) (ASAM level 3.5) Inpatient substance use disorder services, medically managed (ASAM level 4 detox) | <ul style="list-style-type: none"> In Massachusetts: Notify Wellpoint within 48 hours Outside Massachusetts: Needs preapproval | <ul style="list-style-type: none"> DPH-licensed providers in Massachusetts: Notify Wellpoint within 48 hours All other non-contracted providers: Needs preapproval |
| <ul style="list-style-type: none"> Crisis stabilization units (CSU) | Needs preapproval for stays over 5 days | Needs preapproval for stays over 5 days |

| Behavioral health service | With contracted providers | With non-contracted providers |
|--|--|--|
| Outpatient services (including office services) | | |
| <ul style="list-style-type: none"> ▪ Acupuncture withdrawal management ▪ Community support programs (CSP) ▪ Day treatment | N/A | Needs preapproval |
| <ul style="list-style-type: none"> ▪ Applied Behavior Analysis (ABA) ▪ Dialectical behavioral therapy (DBT) ▪ Family stabilization teams (FST) ▪ Partial hospitalization programs for mental health conditions (PHP) ▪ Psychiatric visiting nurse services ▪ Transcranial magnetic stimulation (TMS) | Needs preapproval | Needs preapproval |
| <ul style="list-style-type: none"> ▪ Partial hospitalization programs for substance use disorders (PHP) (ASAM level 2.5) | <ul style="list-style-type: none"> ▪ In Massachusetts: Notify Wellpoint within 48 hours ▪ Outside Massachusetts: Needs preapproval | <ul style="list-style-type: none"> ▪ In Massachusetts: Notify Wellpoint within 48 hours ▪ Outside Massachusetts: Needs preapproval |
| <ul style="list-style-type: none"> ▪ Intensive outpatient programs (IOP) ▪ Structured outpatient addictions programs (SOAP) | Notify Wellpoint within 48 hours | <ul style="list-style-type: none"> ▪ DPH-licensed providers in Massachusetts: Notify Wellpoint within 48 hours ▪ All other non-contracted providers: Needs preapproval |

Case management

Behavioral health case management is a program to help you or a family member with your mental health or substance use needs. The goal of the program is to help you be your best, and get the most out of treatment. The program is free for Wellpoint members, and you don't have to join if you don't want to.

What case managers do...

- Help organize care among your doctors, nurses, and social workers
- Give you information about mental health and substance use services and other community services
- Help you in getting the mental health and substance use services that work best for you
- Help you to follow the instructions from your doctor, nurse, or social worker
- Work with you to get help from local programs
- Help you with a plan to remember to take your medication
- With your permission, keep your primary care provider and psychiatrist updated on your progress

Case management can help if you...

- Have been in the hospital for mental health or substance use reasons
- Have trouble getting the care that works best for you
- Have mental health or substance use issues and also have medical issues
- Need support to help you follow your doctor, nurse, or social worker's advice
- Are pregnant or recently were pregnant and needed mental health or substance use services

Behavioral health case managers are experienced and licensed nurses, social workers, and mental health experts. To find out more about behavioral health care management, call Wellpoint at 800-442-8300 and ask to speak with a case manager.

Quality programs

Wellpoint and Carelon Behavioral Health work together to keep improving the quality of care and services provided for you. We want to ensure that every Wellpoint member receives safe, effective and responsive treatments to address their healthcare needs. We strive to:





- ☐ Ensure you receive timely service from us and our providers, and that you are satisfied.
- ☐ Ensure that our services are easy to access and meet your cultural needs.
- ☐ Improve any deficits in the services you receive.

You can find more information about Carelon's quality programs at www.carelonbehavioralhealth.com.

Chapter 8: Summary of costs for behavioral health services

Table 9. Summary of covered behavioral health services


Important! To be covered, services must be medically necessary. Benefits are limited to the Plan's allowed amounts for the services (page 21).

| Service | Member costs with contracted providers | Member costs with non-contracted providers | See page |
|--|--|---|----------|
|  Applied Behavior Analysis (ABA) | <ul style="list-style-type: none"> ▪ Visits 1-4: no member costs ▪ After 4: \$10 copay | <ul style="list-style-type: none"> ▪ Visits 1-15: 20% coinsurance ▪ After 15: 50% coinsurance | 80 |
| Emergency service programs (ESP) | No member costs | No member costs | 81 |
|  Inpatient care | No member costs | 20% coinsurance | 82 |
| Medication-assisted treatment (MAT) | No member costs | No member costs | 84 |
| Medication management (outpatient) | <ul style="list-style-type: none"> ▪ Visits 1-4: no member costs ▪ After 4: \$5 copay | <ul style="list-style-type: none"> ▪ Visits 1-15: 20% coinsurance ▪ After 15: 50% coinsurance | 84 |
|  Outpatient – office services | <ul style="list-style-type: none"> ▪ Visits 1-4: no member costs ▪ After 4: \$10 copay | <ul style="list-style-type: none"> ▪ Visits 1-15: 20% coinsurance ▪ After 15: 50% coinsurance | 85 |
|  Outpatient – other services | No member costs | 20% coinsurance | 86 |
| Substance use disorder assessment / referral | No member costs | No member costs | 88 |
| Therapy (outpatient) | | | 88 |
| ▪ Individual therapy | <ul style="list-style-type: none"> ▪ Visits 1-4: no member costs ▪ After 4: \$10 copay | <ul style="list-style-type: none"> ▪ Visits 1-15: 20% coinsurance ▪ After 15: 50% coinsurance | |
| ▪ Family therapy | <ul style="list-style-type: none"> ▪ Visits 1-4: no member costs ▪ After 4: \$10 copay | <ul style="list-style-type: none"> ▪ Visits 1-15: 20% coinsurance ▪ After 15: 50% coinsurance | |
| ▪ Group therapy | <ul style="list-style-type: none"> ▪ Visits 1-4: no member costs ▪ After 4: \$5 copay | <ul style="list-style-type: none"> ▪ Visits 1-15: 20% coinsurance ▪ After 15: 50% coinsurance | |

Chapter 9: Covered behavioral health services

Applied Behavior Analysis (ABA)


Applied Behavior Analysis (ABA) is a specialized therapy used in the treatment of autism spectrum disorders that focuses on improving appropriate behaviors and minimizing negative behaviors.

| | With contracted providers | With non-contracted providers |
|--|---|--|
|  Applied Behavior Analysis (ABA) | <ul style="list-style-type: none">▪ Visits 1-4: no member costs▪ After 4: \$10 copay | <ul style="list-style-type: none">▪ Visits 1-15: 20% coinsurance▪ After 15: 50% coinsurance |

ABA is administered by a licensed clinician, such as a board-certified behavior analyst (BCBA), working in association with a paraprofessional. The licensed clinician performs an assessment and develops a treatment plan which is carried out by the paraprofessional.

Restrictions:

- The paraprofessional carrying out the treatment plan must be supervised by a licensed clinician.
- If you have more than one office service from the same provider on the same day, you only owe one copay.

 **Applied Behavior Analysis (ABA) may need preapproval if not covered by Medicare.** Your provider should contact Wellpoint if you will be having ABA services that aren't covered by Medicare. See the preapprovals list on pages 79-81.

Autism spectrum disorders


Autism spectrum disorders are any of the pervasive developmental disorders as defined by the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, including autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.

Services for autism spectrum disorders are covered like any other behavioral health or physical condition. Coverage is subject to all pertinent provisions of the Plan, including use of participating providers, preapproval reviews, benefit limitations, and provider payment methods. Medical services needed for diagnosis and treatment are covered as a medical benefit.

Diagnosis and treatment of autism spectrum disorders may include (but are not limited to) the following services:

- ❑ **Applied Behavior Analysis (ABA)** – A specialized therapy used in the treatment of autism spectrum disorders that focuses on improving appropriate behaviors and minimizing negative behaviors.
- ❑ **Psychiatric services** – Services that focus on treating behaviors that pose a danger to self, others and/or property or that impair daily functioning, such as:
 - Diagnostic evaluations and assessment
 - Treatment planning
 - Referral services
 - Medication management
 - Inpatient/24-hour supervisory care
 - Partial hospitalization/day treatment
 - Intensive outpatient treatment
 - Services at an acute residential treatment facility
 - Individual, family, therapeutic group, and provider-based case management services
 - Psychotherapy, consultation, and training session for parents
 - Paraprofessional and resource support for the family
 - Crisis intervention
 - Transitional care

Emergency service programs

 **Important!** Always seek emergency care if you (or someone covered under your Plan) present a significant risk to yourself or others. In a life-threatening emergency, go to the closest emergency room (see pages 42-43 for benefits information). If you call Wellpoint seeking non-life threatening emergency care, Wellpoint will connect you with appropriate services within six hours.

Seek urgent care if you have a condition that may become an emergency if it is not treated quickly. Call Wellpoint at 800-442-9300 if you need help finding an available contracted provider. Wellpoint will help you schedule an appointment within 48 hours of your call.

In Massachusetts, **Emergency service programs (ESPs)** provide behavioral health crisis assessment, intervention and stabilization services on short notice. These programs are staffed by behavioral health providers who can evaluate a member in their home, office, or at some other community-based location, like a school. Evaluations can also be performed at a hospital emergency room, and many Massachusetts hospitals contact one of these programs if an ER patient needs behavioral health intervention.

| | With contracted providers | With non-contracted providers |
|--|---------------------------|-------------------------------|
| Emergency service programs in Massachusetts | No member costs | No member costs |

ESPs provide crisis assessment within one hour of being contacted. They will evaluate the member to determine what type of service is needed, and help access the service. For example, if a suicidal member calls an ESP, a provider will come to their location and perform an evaluation. If inpatient care is needed, the ESP will find a bed and get the necessary preapproval.

To contact an ESP, call 877-382-1609 and enter your Massachusetts ZIP code to get the toll-free number for the ESP in your area.

X Restrictions:

- If you're admitted to a non-contracted hospital from the emergency room and there are no contracted hospitals available, you won't owe any coinsurance.
- Wellpoint will pay up to the non-contracted allowed amount for services you get at a non-contracted inpatient facility. You may be responsible for paying charges over the allowed amount (that is, the facility may balance bill you).

📞 Notify Wellpoint if you're admitted to the hospital from the emergency room.

Your provider should notify Wellpoint within 24 hours of your admission.

Inpatient behavioral health care (hospital admissions)

Inpatient behavioral health care addresses behavioral health conditions with severe symptoms that are expected to improve with intensive, short-term treatment. These are services you get when staying overnight (that is, you've been admitted) at an acute care hospital, psychiatric hospital, substance use disorder facility, or residential facility. Most of these services are available for both adults and adolescents, unless otherwise noted.

| | With contracted providers | With non-contracted providers |
|---|---------------------------|-------------------------------|
| 📞 Inpatient behavioral health care | No member costs | 20% coinsurance |

Table 10 lists the services and programs covered under this benefit.

Table 10. Behavioral health inpatient services

| Inpatient service | Description |
|--|--|
| Acute residential treatment | Short-term, 24-hour programs that provide treatment within a protected and structured environment |
| Acute residential withdrawal management [ASAM level 3.7 detox] | Drug or alcohol withdrawal (detox) that is medically monitored, for members at risk of severe withdrawal |
| Clinical stabilization services for substance use disorder (CSS) [ASAM level 3.5] | Clinically-managed detox and recovery services provided in a non-medical setting |
| Community-based acute treatment (CBAT) | Treatment for children and adolescents with serious behavioral health disorders who need a protected and structured environment |
| Crisis stabilization units (CSU) | 24-hour observation and supervision when inpatient hospital care isn't needed |
| Dual diagnosis acute treatment (DDAT) [ASAM level 3.5] | Clinically-managed detox and recovery services for those with both a substance use and mental health condition who require a protected and structured environment |
| Inpatient psychiatric services | Admission to an acute care hospital or psychiatric hospital for treatment of a mental health condition |
| Inpatient substance use disorder services, medically managed [ASAM level 4 detox] | 24-hour medical care for substance withdrawal provided at an acute care hospital |
| Observation stays | A hospital stay that allows for extended assessment or observation when an inpatient admission may not be appropriate or needed. Observation stays typically last 24 hours or less, but can be for up to 72 hours. |
| Transitional care units (TCU) | Facilities that help children and adolescents transition from an acute care facility to home, a residential program, or foster care |

✕ Restrictions:

- If you're admitted to a non-contracted hospital from the emergency room and there are no contracted hospitals available, you won't owe any coinsurance.
- There's no coverage for non-acute residential treatment. Examples of such treatment include:
 - Clinically-managed, low-intensity residential services
 - Clinically-managed, population-specific, high-intensity residential services
 - Recovery residences
 - Sober homes

- There's no coverage for treatment performed in a non-conventional setting. Examples of non-conventional settings include:
 - Spas or resorts
 - Therapeutic or residential schools
 - Educational, vocational, or recreational locations
 - Day care or preschools
 - Outward Bound
 - Wilderness, camp or ranch programs


 **Behavioral health inpatient services may need preapproval if not covered by Medicare.** Your provider should notify Wellpoint when you get behavioral health inpatient services that aren't covered by Medicare. See the preapprovals list on pages 75-77.

Medication-assisted treatment (MAT)

The Plan covers **medication-assisted treatment (MAT)**, the long-term prescribing of medication as an alternative to the opioid on which a member was dependent. This treatment is usually dispensed through **opiate treatment programs (OTP)** that are licensed to distribute and administer these medications.

| | With contracted providers | With non-contracted providers |
|--|---------------------------|-------------------------------|
| Medication-assisted treatment from opiate treatment programs | No member costs | No member costs |

When you get this treatment through an OTP, both the drug and its administration are covered at no member cost. You can also get this treatment from a provider in an office setting, but in that case you will be responsible for the member costs associated with a provider visit.

 **Important!** You owe costs for an office visit when you get MAT from an individual provider. In addition, you'll need to fill a prescription for the medication at a pharmacy.

Medications covered under this benefit include methadone, buprenorphine (Suboxone), and naltrexone (Vivitrol).

Medication management (outpatient)

The Plan covers medication management visits, including medication management visits that include outpatient therapy. **Medication management** consists of visits with a behavioral health provider who can evaluate and prescribe medication, if needed. These services may be handled in person or through virtual care (telehealth).

| | With contracted providers | With non-contracted providers |
|-----------------------|---|---|
| Medication management | <ul style="list-style-type: none"> Visits 1-4: no member costs After 4: \$5 copay | <ul style="list-style-type: none"> Visits 1-15: 20% coinsurance After 15: 50% coinsurance |


Medication management also includes **ambulatory withdrawal management**, more commonly known as **outpatient detox**. Ambulatory withdrawal management is a drug or alcohol withdrawal process in which a member has daily visits with a provider throughout withdrawal.

X Restrictions:

- Therapy visits, office services and medication management visits all count toward the 4-visit limit (contracted) or the 15-visit limit (non-contracted), whichever applies.

Outpatient – office services

The Plan covers medically necessary office services to treat mental health and substance use disorder conditions. These services must be provided in an appropriate setting such as a medical office, home, hospital, other medical facility, or through virtual care (telehealth).

| | With contracted providers | With non-contracted providers |
|---|--|---|
|  Office services | <ul style="list-style-type: none"> Visits 1-4: no member costs After 4: \$10 copay | <ul style="list-style-type: none"> Visits 1-15: 20% coinsurance After 15: 50% coinsurance |

Covered office services include the services and programs listed in Table 11.


Table 11. Behavioral health outpatient office services

| Office service | Description |
|---|--|
| Acupuncture withdrawal management (detox) | The use of acupuncture to ease the symptoms of drug or alcohol withdrawal |
| Dialectical behavioral therapy (DBT) | A combination of therapies designed to help change unhealthy behaviors and treat people suffering from behavioral health disorders |
| Neuropsychological testing | Testing to find out if a problem with the brain is affecting one's ability to reason, concentrate, solve problems, or remember |
| Psychiatric visiting nurse (VNA) services | Short-term treatment delivered in the home or living environment to treat behavioral health disorders with medication |

| Office service | Description |
|---|--|
| Psychological testing | Standardized assessment tools to diagnose and assess overall psychological functioning |
| Transcranial magnetic stimulation (TMS) | A non-invasive method of brain stimulation used to treat major depression |


✕ Restrictions:

- Therapy visits, office services and medication management visits all count toward the 4-visit limit (contracted) or the 15-visit limit (non-contracted), whichever applies.
- If you have more than one office service from the same provider on the same day, you only owe one copay.

 **Behavioral health outpatient services may need preapproval if not covered by Medicare.** Your provider should contact Wellpoint if you will be having a behavioral health office service that isn't covered by Medicare. See the preapprovals list on pages 75-77.

Outpatient – other services

Outpatient services for behavioral health conditions don't require an inpatient hospital admission or overnight stay, but they do require more intensive support than other kinds of behavioral health care. Most of these services are available for both adults and adolescents, unless otherwise noted.

| | With contracted providers | With non-contracted providers |
|--|---------------------------|-------------------------------|
|  Outpatient services | No member costs | 20% coinsurance |

Covered outpatient services include the types of services and programs listed in Table 12.


Table 12. Behavioral health outpatient other services

| Outpatient service | Description |
|----------------------------------|--|
| Community support programs (CSP) | Programs to help members access and use behavioral health services |
| Day treatment | Behavioral health programs offering structured, goal-oriented treatment that focuses on improving one's ability to function in the community |
| Electroconvulsive therapy (ECT) | Psychiatric treatment in which seizures are electrically induced in patients to provide relief from mental disorders |

| Outpatient service | Description |
|--|---|
| Family stabilization team (FST) | Programs offering intensive services in the home to help children, adolescents and their families deal with complex life stressors |
| Intensive outpatient programs (IOP) <ul style="list-style-type: none"> ▪ For mental health ▪ For substance use disorder [ASAM level 2.1] | Programs that offer thorough, regularly-scheduled treatment in a structured environment. These programs offer at least three hours of therapy a day, up to seven days a week |
| Partial hospitalization programs (PHP) <ul style="list-style-type: none"> ▪ For mental health ▪ For substance use disorder [ASAM level 2.5] | Non-residential, structured outpatient psychiatric and substance use programs that are more intensive than one would get in a doctor's office, but that are an alternative to inpatient care. These programs offer at least five hours of therapy a day, up to seven days a week. |
| Structured outpatient addictions program (SOAP) | Non-residential, structured substance use disorder programs that are more intensive than one would get in a doctor's office, but that are an alternative to inpatient care. These programs offer at least three hours of therapy a day, up to seven days a week. |

Restrictions:

- There's no coverage for treatment performed in a non-conventional setting. Examples of non-conventional settings include:
 - Spas or resorts
 - Therapeutic or residential schools
 - Educational, vocational, or recreational locations
 - Day care or preschools
 - Outward Bound
 - Wilderness, camp or ranch programs

 **Behavioral health outpatient services may need preapproval if not covered by Medicare.** Your provider should contact Wellpoint if you will be having a behavioral health outpatient service that isn't covered by Medicare. See the preapprovals list on pages 75-77.

Substance use disorder assessment / referral

Substance use disorder assessment/referral is a comprehensive assessment of substance use to allow a provider to refer a member to appropriate care.

| | With contracted providers | With non-contracted providers |
|--|---------------------------|-------------------------------|
| Substance use disorder assessment / referral | No member costs | No member costs |

Therapy (outpatient)

The Plan covers medically necessary individual, family, and group therapy. Medication management performed in combination with therapy is also covered. These services must be provided in an appropriate setting such as a medical office, home, hospital, other medical facility, or through virtual care (telehealth).

| | With contracted providers | With non-contracted providers |
|--------------------|--|---|
| Individual therapy | <ul style="list-style-type: none"> Visits 1-4: no member costs After 4: \$10 copay | <ul style="list-style-type: none"> Visits 1-15: 20% coinsurance After 15: 50% coinsurance |
| Family therapy | <ul style="list-style-type: none"> Visits 1-4: no member costs After 4: \$10 copay | <ul style="list-style-type: none"> Visits 1-15: 20% coinsurance After 15: 50% coinsurance |
| Group therapy | <ul style="list-style-type: none"> Visits 1-4: no member costs After 4: \$5 copay | <ul style="list-style-type: none"> Visits 1-15: 20% coinsurance After 15: 50% coinsurance |

X Restrictions:

- If you have more than one type of therapy on the same day and from the same provider, you only owe one copay. If the copays that apply to the services differ, you owe the higher copay.
- Family and individual therapy must be conducted in a provider's office, a facility or, if appropriate, at a member's home.
- Group therapy sessions must be 50 minutes or less.
- Therapy visits, office services and medication management visits all count toward the 4-visit limit (contracted) or the 15-visit limit (non-contracted), whichever applies.

Part 4:

Using Your Plan

Plan and coverage details

For questions about any of the information in Part 4 of this handbook, please call Wellpoint Member Services at 800-442-9300.

Administered by



Chapter 10: Excluded and limited services

This chapter lists services and supplies that are not covered or have limited or restricted coverage under the Plan.

You should know ... Your Medicare Extension plan covers any service that Medicare covers, even if the service is listed in Table 13 as excluded, restricted, or limited.


 **Important!** Costs for services that the Plan doesn't cover don't count toward your member costs or your out-of-pocket maximums. Member costs and out-of-pocket maximums only apply to covered services.

Table 13. Excluded, restricted, and limited benefits

| Service | What is not covered or has limited coverage |
|-------------------------------|---|
| A | |
| Acne-related services | No coverage for the removal of acne cysts, injections to raise acne scars, cosmetic surgery, dermabrasion or similar services. Services to diagnose or treat the underlying condition causing the acne are covered. |
| Acupuncture | Covered only as a behavioral health service when acupuncture is used as part of drug withdrawal management |
| Allowed amounts | No coverage for charges over the Plan's allowed amounts |
| Alternative treatments | No coverage for alternative treatments that are used in place of conventional medicine, as defined by the National Center for Complementary and Integrative Health (NIH) |

| Service | What is not covered or has limited coverage |
|---|---|
| Ambulances | <ul style="list-style-type: none"> ▪ The following restrictions apply to emergency transportation: <ul style="list-style-type: none"> ▫ Based on the severity of your condition, no other form of transportation can safely transport you to the nearest facility. ▫ Air or water ambulance is covered only when your medical condition is such that your health would be endangered by the time needed for ground transportation. ▫ Emergency inter-facility transportation to the nearest appropriate facility may be necessary when your current facility is unable to treat your condition and the treatment is considered a medical emergency. ▪ All ambulance transportation must be medically necessary and must take you to the nearest appropriate hospital or facility. ▪ There is no coverage for transportation that is primarily for the convenience of the individual, individual's family, or physician. ▪ Transfers to a hospital that you prefer (e.g., to be closer to home) are not covered. ▪ Transportation in chair cars or vans is not covered. |
| Anesthesia for behavioral health services | Covered for electroconvulsive therapy (ECT) only |
| Animals | No coverage for expenses related to service animals, pet therapy, or hippotherapy (therapeutic or rehabilitative horseback riding) |
| Arch supports (e.g., Dr. Scholl's inserts) | Not covered |
| Assistant surgeons | <ul style="list-style-type: none"> ▪ An assistant surgeon must be a licensed provider (e.g., physician, physician assistant) acting within the scope of his or her license. ▪ Only one assistant surgeon per procedure is covered. Second and third assistants are not covered. ▪ Interns, residents, and fellows are not covered as assistant surgeons. |
| Athletic trainers | Not covered |

| Service | What is not covered or has limited coverage |
|---|--|
| B | |
| Beds / bedding | No coverage for non-hospital beds, orthopedic mattresses, or weighted blankets |
| Behavioral health services | <ul style="list-style-type: none"> ▪ Primary care visits associated with a behavioral health diagnosis are covered. Otherwise, there is no coverage for the diagnosis, treatment or management of mental health/substance use disorder conditions by medical (non-behavioral health) providers. ▪ No coverage of services for conditions that are not classified in the most current edition of the <i>Diagnostic and Statistical Manual of Mental Health Disorders</i> (DSM) ▪ Other non-covered behavioral health services include: <ul style="list-style-type: none"> ▫ Services not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance use disorder ▫ Services not consistent with prevailing national standards of clinical practice for the treatment of such conditions ▫ Services not consistent with prevailing professional research which would demonstrate that the service or supplies will have a measurable and beneficial health outcome ▫ Services that typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; or that are consistent with appropriate level-of-care clinical criteria, clinical practice guidelines or best practices as modified from time to time. |
| Biofeedback | Not covered to treat behavioral health conditions |
| Blood | The Plan does not pay for donated blood |
| Blood pressure cuffs (sphygmomanometers) | Not covered |
| C | |
| Cardiac rehab programs | Covered only when started within six months of a cardiac event |
| Chair cars / vans | No coverage for transportation in chair cars or vans |
| Chiropractic care | <ul style="list-style-type: none"> ▪ Group chiropractic care is not covered ▪ Services provided by a chiropractor are considered chiropractic care, not physical therapy |
| Chronic conditions | There is no coverage for physical therapy, occupational therapy or speech therapy to treat a chronic condition when that treatment is neither curative nor restorative |

| Service | What is not covered or has limited coverage |
|--|--|
| Clinical trials for treatments other than cancer | No coverage for any clinical research trial other than a qualified clinical trial for the treatment of cancer (pages 35-36) |
| Cognitive rehabilitation | Not covered, except as related to COVID-19 Cognitive rehabilitation is treatment to restore function or minimize effects of cognitive deficits including, but not limited to, those related to thinking, learning, and memory. |
| Colonoscopies for people under age 45 | Covered as a preventive service only under limited circumstances, based on clinical review of family and personal history |
| Computer-assisted communications devices | Not covered |
| Convenience items | No coverage for convenience items used during a hospital stay, such as telephones, television, computers, and beauty or barber services |
| Cosmetic services | No coverage for cosmetic procedures or services except for: <ul style="list-style-type: none"> ▪ Treatment for HIV-associated lipodystrophy ▪ The initial surgical procedure to correct appearance that has been damaged by an accidental injury Cosmetic services are not covered even if they are intended to improve a member's emotional outlook or treat a member's mental health condition. Cosmetic services are services done mainly to improve appearance. They don't restore bodily function or correct functional impairment. |
| Coverage under another plan or program | No coverage for services provided under another plan, or services that federal, state, or local law mandates must be provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation. |
| Custodial care | Not covered Custodial care is a level of care that is chiefly designed to assist with activities of daily living and that cannot reasonably be expected to greatly restore physical health or bodily function. |
| D | |
| Dialysis | No coverage for dialysis to treat a behavioral health condition |
| Dental care | The Plan does not provide benefits for dental care. Medical services that include treatment related to dental care are covered in certain situations (page 36) |

| Service | What is not covered or has limited coverage |
|---|--|
| Dentures, dental prosthetics, and related surgery | Not covered |
| Driving evaluations | Not covered |
| Drugs – off-label | <p>Not covered unless the off-label use meets the Plan's definition of medical necessity or the drug is specifically designated as covered by the Plan.</p> <p>Off-label use is the use of a drug for a purpose other than that approved by the FDA.</p> |
| Drugs – over-the-counter | <p>Not generally covered and never covered without a prescription. Some over-the-counter drugs, such as tobacco cessation products, are covered by the prescription drug plan when you have a prescription (Part 5 of this handbook).</p> |
| Duplicate (redundant) services | <p>No coverage for multiple charges for the same service or procedure, on the same date</p> <p>A service is considered duplicate (redundant) when the same service is being provided, at the same time, to treat the condition for which it is ordered.</p> |
| Durable medical equipment (DME) | <p>Only medically necessary equipment is covered. Types of equipment that are not covered include:</p> <ul style="list-style-type: none"> ▪ Equipment intended for athletic or recreational use (e.g., exercise equipment, wheelchairs for sports) ▪ Items intended for environmental control or a home modification (e.g., bathroom items, electronic door openers, air cleaners, dehumidifiers, elevators, ramps, stairway lifts) ▪ Added, non-standard features or accessories (e.g., hand controls for driving, transit systems that secure wheelchairs in moving vehicles, wheelchair customizations) ▪ Items specifically designed to be used outdoors (e.g., special wheelchairs for beach access, equipment for use on rough terrain) ▪ Items that serve as backup by duplicating other equipment (e.g., a manual wheelchair as backup for a powered wheelchair) ▪ Equipment upgrades or replacements for items that function properly or that can be repaired |

| Service | What is not covered or has limited coverage |
|---|---|
| E | |
| Ear molds | Not covered except when needed for hearing aids for members age 21 and under |
| Enteral/oral therapy | <p>Prescription and nonprescription enteral/oral formulas are covered only when ordered by a physician for the medically necessary treatment of malabsorption disorders caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.</p> <p>Enteral therapy is prescribed nutrition that is administered through a tube that has been inserted into the stomach or intestines. Oral therapy is administered by mouth.</p> |
| Equipment transportation and set-up | No coverage for costs associated with transporting and setting up equipment, such as portable X-ray equipment. |
| Exercise / recreational equipment | No coverage for equipment intended for athletic or recreational use (e.g., exercise equipment, wheelchairs for sports). |
| Experimental or investigational services or supplies | <p>No coverage for a service or supply that the Plan determines is experimental or investigational; that is, through the use of objective methods and study over a long enough period of time to be able to assess outcomes, the evidence is inadequate or lacking as to its effectiveness.</p> <p>The fact that a physician ordered it, or that this treatment is being tried after others have failed, does not make it medically necessary.</p> |
| Eyeglasses and contact lenses | <ul style="list-style-type: none"> ▪ Only covered within six months after an eye injury or cataract surgery ▪ Coverage applies to the initial lenses only ▪ No coverage for deluxe frames or specialty lenses such as progressive or transitional lenses, tinted lenses, anti-reflective coating or polycarbonate lenses |
| F | |
| Facility fees | Not covered for office visits or behavioral health office services |
| Family members | No coverage for services received from someone who is in your immediate family. Your immediate family consists of you, your spouse and your children, as well as the brothers, sisters and parents of both you and your spouse. This includes any services that providers perform on themselves. |

| Service | What is not covered or has limited coverage |
|---|--|
| Fees for non-medical services | <p>Fees for non-medical services are not covered. Some examples of these types of fees include:</p> <ul style="list-style-type: none"> ▪ Day care services ▪ Food services (e.g., diet programs) ▪ Lab handling fees ▪ Membership and joining fees (e.g., Weight Watchers), with the exception of the fitness reimbursement ▪ Record processing fees, unless required by law ▪ Shipping costs (e.g., the cost of shipping eggs or sperm between fertility clinics) ▪ Storage fees ▪ Transportation and set-up costs (e.g., portable X-ray equipment) |
| Fitness reimbursement | <ul style="list-style-type: none"> ▪ Any family members may have fitness memberships but the reimbursement is paid to the plan enrollee only. ▪ You must participate in physical activity an average of four times or more per month. ▪ Ineligible costs include beach or country club memberships or dues; fees for one-day events; annual or day passes (such as for skiing); spas or spa services; personal or home fitness equipment. |
| Free or no-cost services | <ul style="list-style-type: none"> ▪ No coverage for any medical service or supply that wouldn't have cost anything if there was no medical insurance ▪ No coverage for services that you have no legal responsibility to pay |
| G | |
| Genetic testing for behavioral prescribing | Not covered |
| Government programs | <p>No coverage for any service or supply furnished by, or covered as a benefit under, a program of any government (or its subdivisions or agencies) except for the following:</p> <ul style="list-style-type: none"> ▪ A program established for its civilian employees ▪ Medicare (Title XVIII of the Social Security Act) ▪ Medicaid (any state medical assistance program under Title XIX of the Social Security Act) ▪ A program of hospice care |
| Group therapies | <p>There is no coverage for:</p> <ul style="list-style-type: none"> ▪ Group chiropractic care ▪ Group occupational therapy ▪ Group physical therapy |

| Service | What is not covered or has limited coverage |
|--|---|
| H | |
| Hearing aids | <ul style="list-style-type: none"> Over-the-counter (OTC) hearing aids are not covered Hearing aid batteries are not covered |
| Herbal medicine | Not covered |
| Home modifications or environmental controls | No coverage for items intended for environmental control or home modification such as bathroom items, electronic door openers, air cleaners, dehumidifiers, elevators, ramps, and stairway lifts |
| Homemaking services | Not covered |
| Homeopathic / holistic / naturopathic care | Not covered |
| Household residents | No coverage for services received from anyone who shares your legal residence |
| Hypnotherapy | Not covered |
| I | |
| Immunization titers | <p>Covered for pregnant women only</p> <p>Immunization titers are lab tests performed to determine if a person has had a vaccination.</p> |
| Incontinence supplies | Not covered |
| Infertility treatment | <ul style="list-style-type: none"> Experimental infertility procedures are not covered. The Plan does not pay people to donate their eggs or sperm. Reversal of voluntary sterilization is not covered. Shipping costs, such as the cost of shipping eggs or sperm between clinics, are not covered. Procurement and processing of sperm, eggs, and/or inseminated eggs are covered only for the treatment of infertility. Storage fees for storing or banking sperm, eggs, and/or inseminated eggs are limited to a maximum of 12 months in storage. The Plan does not pay people to be surrogates (gestational carriers) for Wellpoint plan members, and there is no coverage for medical services, including in vitro fertilization, for a surrogate who is not a Wellpoint member. |

| Service | What is not covered or has limited coverage |
|---|---|
| Intraocular lenses (IOLs) | Monofocal intraocular lenses (IOLs) are covered when implanted in the eye after the removal of cataracts. Presbyopia-correcting IOLs, which restore vision in a range of distances, are not covered. Multifocal IOLs and accommodating IOLs are presbyopia-correcting IOLs and are also not covered. |
| L | |
| Lift / riser chairs | Not covered |
| Light boxes | Covered only for treatment of skin conditions |
| Long-term maintenance care and long-term therapy | Not covered |
| M | |
| Massage therapy | No coverage for massage therapy or any other services from a massage therapist or neuromuscular therapist |
| Medical necessity | There is no coverage for any treatment that is not medically necessary. The only exceptions to this requirement are: <ul style="list-style-type: none"> ▪ Routine care of a newborn child provided by a hospital during a hospital stay that starts with birth and while the child's mother is confined in the same hospital ▪ Covered preventive care provided by a hospital or doctor (Chapter 6) ▪ A service or supply that qualifies as covered hospice care (pages 50-51) |
| Medical orders | There is no coverage for any service or supply that has not been recommended and approved by a physician. All covered services and supplies need a medical order from a physician. |
| Military service or wartime injuries | No coverage for services to treat a condition that was the result of war (declared or undeclared), or service in the armed forces of any country if you are legally entitled to other benefits (such as through the Veterans Administration) |
| Missed appointments | Not covered |
| N | |
| Narconon treatment and facilities | Not covered |

| Service | What is not covered or has limited coverage |
|--|---|
| Non-conventional behavioral health treatments | <p>No coverage for non-conventional behavioral health treatments. Examples of non-conventional treatments include:</p> <ul style="list-style-type: none"> ▪ Aversive or counter-conditioning ▪ Brain imaging or mapping to diagnose behavioral health disorders ▪ Hemodialysis ▪ Olfactory/gustatory release ▪ Primal therapy ▪ Prometa (GABASYNC) treatment protocol ▪ Rolfing ▪ Structural Integration |
| Non-conventional treatment settings | <p>No coverage for treatment performed in a non-conventional setting. Examples of non-conventional settings include:</p> <ul style="list-style-type: none"> ▪ Spas or resorts ▪ Therapeutic or residential schools ▪ Educational, vocational, or recreational locations ▪ Day care or preschools ▪ Outward Bound ▪ Wilderness, camp or ranch programs |
| Non-covered services and associated services | <p>Non-covered services include those for which there is no benefit and those that the Plan has determined to be not medically necessary.</p> <p>If a service is not covered by the Plan, any associated services are also not covered. For example, anesthesia and facility fees associated with a non-covered surgery are not covered.</p> |
| Nutritional counseling | <p>Services or counseling (therapy) must be performed by a registered dietician and are limited to three visits in a plan year. There is no visit limit when the counseling is for:</p> <ul style="list-style-type: none"> ▪ Adults who are overweight or obese and who are at high risk for cardiovascular disease (Chapter 6) ▪ Children who are overweight or obese (Chapter 6) ▪ Children under 18 with cleft lip/palate (page 34) ▪ Members with certain eating disorders ▪ Members with diabetes (page 37) |
| Nutritional supplements (oral) | <p>No coverage for nutritional supplements administered by mouth, including:</p> <ul style="list-style-type: none"> ▪ Dietary and food supplements that are administered orally, and related supplies ▪ Nutritional supplements to boost caloric or protein intake, including sport shakes, puddings and electrolyte supplements |

| Service | What is not covered or has limited coverage |
|---------------------------------|--|
| O | |
| Occupational therapy | No coverage for group occupational therapy |
| Orthodontic treatment | Not covered |
| Orthopedic mattresses | Not covered |
| Orthotics | No coverage for temporary or trial orthotics, video tape gait analysis, diagnostic scanning, or arch supports |
| Oxygen equipment for travel | No coverage for oxygen equipment required for use on an airplane or other means of travel |
| P | |
| Park admissions | No coverage for admissions fees to national parks or preserves |
| Pastoral counselors | Covered for bereavement counseling, or when required by law |
| Personal items | No coverage for personal items that could be purchased without a prescription (e.g., air conditioners, arch supports, bed pans, bathroom items, blood pressure cuffs, commodes, computer-assisted communications devices, corrective shoes, heating pads, hot water bottles, incontinence supplies, lift or riser chairs, non-hospital beds, orthopedic mattresses, shower chairs, telephones, televisions, thermal therapy devices, whirlpools) |
| Physical therapy | <ul style="list-style-type: none"> ▪ No coverage for certain therapy services including, but not limited to: acupuncture, aerobic exercise, craniosacral therapy, diathermy, infrared therapy, kinetic therapy, microwave therapy, paraffin treatment, Rolfing therapy, Shiatsu, sports conditioning, ultraviolet therapy, and weight training. ▪ No coverage for group physical therapy |
| Private duty nursing | Not covered |
| Programs with multiple services | No coverage for programs that provide multiple services but that bill at a single, non-itemized rate (for example, a daily fee for a full-day rehab program). Itemized bills are always required. |
| Providers | <ul style="list-style-type: none"> ▪ No coverage for services from providers who have been sanctioned ▪ No coverage for services from unlicensed providers ▪ No coverage for services outside the scope of a provider's license |

| Service | What is not covered or has limited coverage |
|---|---|
| R | |
| Reiki therapy | Not covered Reiki is a hands-on energy-based therapy. |
| Religious facilities | No coverage for services received at non-medical religious facilities |
| Residential treatment for behavioral health services | No coverage for non-acute residential treatment. Examples of such treatment include: <ul style="list-style-type: none"> ▪ Clinically-managed, low-intensity residential services ▪ Clinically-managed, population-specific, high-intensity residential services ▪ Recovery residences ▪ Sober homes |
| Respite care | Limited to a total of five days each calendar year. Respite care is covered in a hospital, a skilled nursing facility, a nursing home or in the home. |
| Routine screenings | No coverage except according to the preventive care schedule (Chapter 6) |
| S | |
| School services | No coverage for services provided through schools |
| Sensory integration therapy | Not covered |
| Shipping costs | No coverage for shipping costs, such as the cost of shipping eggs or sperm between fertility clinics |
| Shoes | No coverage for shoes, including special shoes purchased to accommodate orthotics or to wear after foot surgery, except for: <ul style="list-style-type: none"> ▪ Therapeutic shoes for the prevention of complications associated with diabetes (limited to one pair each year) ▪ Orthopedic shoes that attach directly to a brace |
| Stairway lifts and stair ramps | Not covered |
| Stimulators / stimulation treatments | Transcranial magnetic stimulation is covered under your behavioral health benefit. Otherwise, there is no coverage for stimulators or stimulation treatments, including: <ul style="list-style-type: none"> ▪ Alpha-Stim cranial electrotherapy stimulator ▪ Fischer Wallace neurostimulators ▪ Vagus nerve stimulation |

| Service | What is not covered or has limited coverage |
|--|--|
| Storage for blood / bodily fluids | No coverage for the storage of autologous blood donations or other bodily fluids or specimens, except when done in conjunction with a scheduled covered procedure |
| Surface electromyography (SEMG) | Not covered |
| T | |
| Therapy (behavioral health) | <ul style="list-style-type: none"> Group therapy sessions must be 50 minutes or less Family and individual therapy must be conducted in a provider's office, a facility or, if appropriate, at a member's home |
| Thermal therapy | No coverage for any type of thermal therapy, including the application or purchasing of hot packs, cold packs or continuous thermal therapy devices |
| Third parties | No coverage for any medical supply or service (such as a court-ordered test or an insurance physical) that is required by a third party but is not otherwise medically necessary. Other examples of a third party are an employer, an insurance company, a school, a court or a sober living facility. |
| TMJ (temporomandibular joint) disorder | <p>Treatment of TMJ disorder is limited to the initial diagnostic examination, initial testing and medically necessary surgery.</p> <p>TMJ disorder is a syndrome or dysfunction of the joint between the jawbone and skull and the muscles, nerves and other tissues related to that joint.</p> |
| Tobacco cessation counseling | Limited to 300 minutes each calendar year |
| Transportation to/from appointments | Transportation to the place where you will be receiving hospice services is covered. There is no coverage for any other transportation to or from scheduled appointments. |
| Travel time | No coverage for travel time to or from medical appointments |
| V | |
| Vision correction | No coverage for surgery to correct refractive errors (visual acuity problems). Non-covered services include orthoptics for vision correction, radial keratotomy, and other laser surgeries. Refractive errors include astigmatism, myopia (near-sightedness), hyperopia (far-sightedness), and presbyopia (aging-related blurry vision). |

| Service | What is not covered or has limited coverage |
|-----------------------------------|--|
| W | |
| Weight loss | <ul style="list-style-type: none"> Physician services for weight loss treatment are limited to members whose body mass index (BMI) is 40 or more while under the care of a physician. Any such treatment is subject to periodic review. No coverage for residential inpatient weight loss programs No coverage for membership fees and food items used to participate in a commercial weight loss program |
| Wheelchair transit systems | No coverage for transit systems used to secure wheelchairs in moving vehicles. |
| Wigs | Not covered for any purpose other than the replacement of hair loss resulting from treatment of any form of cancer or leukemia |
| Worker's compensation | <p>No coverage for any service or supply furnished for an occupational injury or disease for which a person is entitled to benefits under a workers' compensation law or similar law.</p> <p>Occupational injury or disease is an injury or disease that arises out of and in the course of employment for wage or profit.</p> |
| Worksite evaluations | No coverage for exams performed by a physical therapist to evaluate a member's ability to return to work |
| X | |
| X-ray equipment (portable) | No coverage for costs associated with transporting and setting up portable X-ray equipment. |

Chapter 11: About your plan and coverage

Types of healthcare providers

What is a healthcare provider? A healthcare provider is a person, place, or organization that delivers healthcare services or supplies. A provider can be a **person** (like a doctor), a **place** (like a hospital), or an **organization** (like a hospice).

This handbook talks about many different providers of medical care and services. Here's a brief look at what to know about the different kinds of providers.

Primary care providers (PCPs)

We strongly encourage all Wellpoint members to choose a **primary care provider**, or **PCP**. Having a PCP means working with a doctor who is familiar with you and your healthcare needs. Your PCP can help you understand and coordinate care you get from other providers, such as specialists, who may not know you as well.

A PCP can be a nurse practitioner, physician assistant or physician whose specialty is family medicine, general medicine, pediatrics, geriatrics or internal medicine.

Specialists

Specialists, also called **specialty care providers**, are physicians, nurse practitioners and physician assistants who focus on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

As a Wellpoint member, you don't need a referral to see a specialist.

Behavioral health providers

Behavioral health providers are providers that treat mental health and substance use disorders. These providers include many types of doctors and therapists, as well as hospitals and other facilities that offer behavioral health treatment.

Behavioral health providers who are contracted with Carelon Behavioral Health are covered at a higher benefit level than providers who are not contracted. For more information about contracted and non-contracted behavioral health providers, see page 74.

Hospitals and other inpatient facilities

The Plan covers hospital services when you are admitted to an inpatient facility. Your benefits for these services depends on what type of inpatient facility you go to and the type of care you get. See pages 53-55 for coverage details.

Table 14. Types of inpatient facilities

| Inpatient facility | What this type of facility provides |
|--|---|
| Acute care hospitals | Medical centers and community hospitals that provide treatment for severe illness, conditions caused by disease or trauma, and recovery from surgery. These hospitals deliver intensive, 24-hour medical and nursing care. |
| Rehabilitation (rehab) facilities | Specialized hospitals that provide rehab services to restore basic functioning (such as walking or sitting upright) that was lost due to illness or injury. Patients in these facilities have a good potential for recovery and are able to participate in a rehab program that includes therapy services for three to five hours a day. |
| Long-term care facilities | Specialized hospitals that treat patients who need further care for complex medical conditions but that no longer require the services of a traditional hospital. These patients' needs are mostly medical and their ability to participate in rehab is limited. |
| Skilled nursing facilities | Provide lower intensity rehab and medical services. Patients in these facilities have continuing medical needs that require skilled nursing care, but do not need daily physician care. Some of these patients may or may not require rehab, while others may need long-term custodial care. The Plan does not cover custodial care. |

Walk-in clinics



Important! A facility's name isn't always a guide to how it bills or what your member costs are. For example, a walk-in clinic that calls itself an urgent care center may bill as a hospital emergency room or a medical practice, instead of as an urgent care center. Before you use a walk-in clinic, you may want to ask how your visit will be billed. How your visit is billed determines how much you owe. See pages 42-43 for coverage details.

Walk-in clinics are sites that offer medical care on a walk-in basis, so no appointment is needed. Although walk-in clinics have a variety of different names, they fall into four general categories. These four categories differ based on the services they offer and how they bill for their services.

Table 15. Types of walk-in clinics

| Walk-in clinic | What this type of clinic provides |
|-----------------------|--|
| Medical practices | Some doctors’ offices offer services to walk-in patients. They offer the services you’d expect to get at a primary care practice. |
| Retail health clinics | Located in retail stores or pharmacies. They offer basic services like vaccinations and treatment for colds or mild sinus infections. |
| Urgent care centers | Independent, freestanding locations that treat conditions that should be handled quickly but that aren’t life-threatening. They often do X-rays, lab tests and stitches. |
| Hospitals | Some hospitals have walk-in clinics within or associated with their emergency departments. |

Medicare participating providers

Participating providers are healthcare providers who have signed an agreement with Medicare to accept Medicare assignment; that is, they agree to accept Medicare’s payment as payment in full for covered services. No matter where you live, participating providers will not balance bill you for charges over the allowed amount. See “How the providers you use can affect your costs” on page 23 to find out more.

 Look for Medicare participating providers at [medicare.gov](https://www.medicare.gov).


Wellpoint contracted suppliers

If there aren’t any Medicare suppliers for the equipment or supply you need, there may be a Wellpoint contracted supplier you can use. Wellpoint **contracted suppliers** have contracted with Wellpoint to accept the Plan’s allowed amounts. This means that you won’t be balance billed as long as you use contracted suppliers for the following services:

- ☐ Durable medical equipment (DME)
- ☐ Medical/diabetic supplies
- ☐ Home health care
- ☐ Home infusion therapy (including enteral/oral therapy)

Services from contracted suppliers are covered at 100% of the allowed amount. **Non-contracted suppliers** are covered at 80%, so you’ll owe 20% coinsurance. Outside of Massachusetts, non-contracted suppliers can balance bill you for charges over the allowed amount. Since the Plan doesn’t cover balance bills, payment is your responsibility.

In this handbook, the **checkmark** ✓ identifies services with a contracted supplier benefit.

 Find Wellpoint contracted suppliers at [wellpointmass.com](https://www.wellpointmass.com).



Important! Non-contracted suppliers are covered at 80%, even if you are using the non-contracted supplier because the item isn't available from a contracted supplier.

How to find providers



To find Medicare participating providers and suppliers, go to [medicare.gov](https://www.medicare.gov).



From the [wellpointmass.com](https://www.wellpointmass.com) website, you can look for:

- ☐ Contracted behavioral health providers
- ☐ Wellpoint contracted suppliers
- ☐ Other kinds of facilities in Massachusetts, like urgent care centers and ambulatory surgery centers

How Wellpoint reimburses providers

Wellpoint reimburses providers on a fee-for-service basis. Wellpoint does not withhold portions of benefit payments from providers or offer providers incentive payments to control the use of services. Explanations of provider payments are detailed in your *Explanations of Benefits* (EOB). In this Plan, providers may discuss the nature of the way they are compensated with you.

How claims are processed

Before Wellpoint can process your claims, your claims must first be submitted to Medicare for consideration. Most hospitals, physicians or other healthcare providers will submit claims to Medicare for you. Medicare will send you an *Explanation of Medicare Benefits* (EOMB) that explains what Medicare paid and if any balance remains.

Once Medicare processes your claims, any remaining balance is automatically sent to Wellpoint Member Services, where benefits under the Medicare Extension plan are determined. This process is called **Medicare crossover**. You are not responsible for paying any balances until the Medicare crossover process is completed. At that time, you will receive an *Explanation of Benefits* (EOB) from Wellpoint.

How to submit a claim

If you need to submit a claim, you must first submit your claim to Medicare. You must then submit written proof of the claim to Wellpoint, with the information listed below.

You must provide this information when you submit a claim:

- | | |
|--------------------------------------|--|
| ▪ Medicare EOMB | ▪ Name of enrollee |
| ▪ Diagnosis | ▪ Enrollee's ID number |
| ▪ Date of service | ▪ Name of patient |
| ▪ Amount of charge | ▪ Description of each service or purchase |
| ▪ Name, address and type of provider | ▪ Other insurance information, if applicable |
| ▪ Provider tax ID number, if known | ▪ Accident information, if applicable |
| | ▪ Proof of payment, if applicable |

If the proof of payment you get from a provider contains information in a foreign language, please provide Wellpoint with a translation, if possible.

Wellpoint's claim form may be used to submit written proof of a claim. Original bills or paid receipts from providers will also be accepted as long as the information described above is included.



Download claim forms and other materials from [wellpointmass.com](https://www.wellpointmass.com).

Claims for prescription drug services – These claims must be submitted directly to the administrator of those services. See Part 5 of this handbook (pages 137-144).

Deadlines for filing claims

Written proof of a claim must be submitted to Wellpoint within two years of the date of service. Claims submitted after two years will be accepted for review only if you show that the person submitting the claim was mentally or physically incapable of providing written proof of the claim in the required amount of time.

Recovery of overpaid claims

If the Plan issues an overpayment for a claim, the Plan has the right to recover the overpayment from one or more of the following:

- ☐ The individual that received the payment or for whom the payment was made
- ☐ Other insurance companies
- ☐ Other organizations

About claim reviews

Wellpoint routinely reviews submitted claims to evaluate the accuracy of billing information. We may request written documentation such as operative notes, procedure notes, office notes, pathology reports and X-ray reports from your doctor.

In cases of suspected claim abuse or fraud, Wellpoint may require that the person whose disease, injury or pregnancy is the basis of the claim be examined by a physician selected by the Plan. This examination will be performed at no cost to you.

Deadlines on bringing legal action

You cannot bring suit or legal action to recover benefits for charges incurred while covered under the Plan any earlier than 60 days, or any later than three years, after Wellpoint receives complete written proof of the claim. However, if the state where you lived at the time of the alleged loss has a longer time limit, the limit is extended to be consistent with that state's law.

Right of reimbursement (payment from a third party)

If you or your dependents get payments from a third party for an injury or disease that Wellpoint previously paid claims for, Wellpoint will have a lien on any money you receive. This lien applies to any money you or your covered dependents get from, among others, the person or entity responsible for the injury or disease, his or her insurers, or your own auto insurance carrier, including uninsured or underinsured motorist coverage.

You and your dependents will not have to reimburse Wellpoint for any more than the amount Wellpoint paid in benefits.

You or your dependents must execute and deliver any documents required by Wellpoint or its designee, and do whatever is necessary to help Wellpoint attempt to recover benefits it paid on behalf of you or your dependents.

For additional information about the right of reimbursement, also called subrogation, see page 161.

About your privacy rights

The GIC's *Notice of Privacy Practices* appears in Appendix A. This notice describes how medical information about you may be used and disclosed, as well as how you can get access to this information. The notice also explains your rights as well as the GIC's legal duties and privacy practices.

About the review process

Wellpoint reviews certain services to make sure they are eligible for benefits. These **preapproval reviews** – sometimes called **pre-service reviews** or **preauthorizations** – are a standard practice for most health plans. These reviews help ensure that benefits are paid for services that meet the Plan's definition of medical necessity.

Note: The clinical criteria used for these reviews are developed with input from actively practicing physicians, and in accordance with the standards adopted by the national accreditation organizations. The criteria are regularly updated as new treatments, applications and technologies become generally-accepted professional medical practice.

In most cases, your provider will contact Wellpoint when a service requires review. Callers can leave a message if calling after business hours; Member Services will return the call on the next business day. When calling, Wellpoint staff will identify themselves by name, title and organization.

Associates, consultants, and other providers are not rewarded or offered money or incentives for denying care or a service, or for supporting decisions that result in using fewer services. Wellpoint doesn't make decisions about hiring, promoting or firing these individuals based on the idea they will deny benefits. Decisions are based only on appropriateness of care and service and existence of coverage.

When a preapproval is first requested

When Wellpoint is notified that you've been admitted to the hospital or are scheduled for a service that needs to be reviewed:

- ☐ Your request goes to a Wellpoint nurse reviewer, along with any clinical information provided by your doctor or other providers.
- ☐ The nurse reviewer goes over the information to determine if it meets Wellpoint's medical policies and guidelines and is eligible for benefits.
- ☐ If the nurse reviewer is able to certify that the service is eligible for benefits, the service will be approved.
- ☐ If the nurse reviewer cannot certify the service, he or she will forward your request to a Wellpoint physician advisor who will determine if the service is eligible for benefits and can be approved.

If the service is approved

When a service is approved, Wellpoint will notify your doctor and any other providers (such as a hospital) who need to know.

If the service is not approved

When Wellpoint determines that a service is not eligible for benefits, it's called an **adverse benefit determination**. Wellpoint will notify you, your doctor, and any other providers who need to know.

Your doctor can ask to speak with a physician advisor or submit more supporting information to be reviewed by a physician advisor. A request for reconsideration must occur within three business days of receiving notice of an adverse benefit determination.

When you need additional approval

Some medical services may be ongoing and need to be reviewed again at a later time. For example, if you are in the hospital, your doctor may recommend that you stay in the hospital beyond the number of days that the Plan first approved. When this happens, Wellpoint reviews the additional services just as it did when you were first approved.

About your appeal rights

You have the right to appeal an adverse benefit determination within 180 days of being notified of the determination. Your appeal should state why you believe the final determination was in conflict with the Plan provisions. You should also include all supporting documentation that you or your healthcare provider believes supports your position.

Wellpoint will review the documentation that you submit, and will make a decision within 30 days after receiving your appeal request. This decision will be sent to you in writing and will include the specific reasons for the decision. The decision notice will also give you instructions for additional appeal procedures, if they are available.

All appeals should be directed to:

Wellpoint
Appeals Review
P.O. Box 4077
Woburn, MA 01888

Chapter 12: About enrollment and membership

This chapter describes the enrollment process for you and your eligible dependents; when coverage starts and ends; and continuing coverage when eligibility status changes.

Free or low-cost health coverage for children and families

If you are eligible for health coverage from your employer but are unable to afford the premiums, your state may have a premium assistance program to help pay for coverage. For more information, see Appendix B, “Mandates and required member notices.”

Application for coverage

Eligibility of members and dependents, as well as coverage effective dates, are determined by the GIC. You or your dependents must be enrolled in Medicare Parts A and B to be eligible to join the Medicare Extension plan. If you have a dependent who is not covered by Medicare, he or she may enroll in one of the GIC’s non-Medicare plans.

You must apply to the GIC for enrollment in the Plan.

You must enroll dependents when they become eligible, generally within 60 days of the qualifying event (e.g., marriage, birth, adoption). You must complete an enrollment form to enroll or add dependents and supply any required documentation required by the GIC.

Visit www.mass.gov/mygiclink-member-benefits-portal for enrollment instructions. Questions? Retirees can contact the GIC at www.mass.gov/forms/contact-the-gic or by calling 617-727-2310.

When coverage begins

Coverage under the Plan starts as follows:

For persons applying during an annual enrollment period

Coverage begins each year on July 1.

For spouses and dependents

Coverage begins on the later of:

1. The date your own coverage begins, or
2. The date that the GIC has determined your spouse or dependent is eligible

For new retirees/Medicare enrollees and surviving spouses

Upon application, you will be notified by the GIC of the date your coverage begins.

When coverage ends for enrollees

Your coverage ends on the earliest of:

1. The end of the month covered by your last contribution toward the cost of coverage
2. The end of the month in which you cease to be eligible for coverage
3. The date of death
4. The date the surviving spouse remarries, or
5. The date the Plan terminates

When coverage ends for dependents

A dependent's coverage ends on the earliest of:

1. The date your coverage under the Plan ends
2. The end of the month covered by your last contribution toward the cost of coverage
3. The date you become ineligible to have a spouse or dependents covered
4. The end of the month in which the dependent ceases to qualify as a dependent
5. The date the dependent child, who was permanently and totally impaired by age 19, marries
6. The date the covered divorced spouse remarries (or the date the enrollee remarries)
7. The date of the spouse or dependent's death, or
8. The date the Plan terminates

Duplicate coverage

No person can be covered (1) as both an employee, retiree or surviving spouse, and a dependent, or (2) as a dependent of more than one covered person (employee, retiree, spouse or surviving spouse).

Special enrollment condition

If you declined to enroll your spouse or dependent(s) as a new hire, your spouse or dependent(s) may only be enrolled within 60 days of a qualifying event or during the GIC's spring annual enrollment. Visit www.mass.gov/mygiclink-member-benefits-portal for enrollment instructions and www.mass.gov/service-details/gic-qualifying-events to learn more about qualifying events. Questions? Retirees can contact the GIC at www.mass.gov/forms/contact-the-gic or by calling 617-727-2310.

Continuing coverage upon termination of employment

Coverage may be continued if eligibility status changes due to termination of employment, involuntary layoff, reduction of work hours, or retirement. For information on options for continuation of coverage, visit the GIC's website at www.mass.gov/GIC.

Continuing health coverage for survivors

Surviving spouses of covered retirees and/or their eligible dependent children may be able to continue coverage. Surviving spouse coverage ends upon remarriage. Orphan coverage is also available for some surviving dependents. For more information on eligibility for survivors and orphans, contact the GIC.

To continue coverage, you must submit an enrollment form to the GIC to continue coverage within 30 days of the covered employee or retiree's death. You must also make the required contribution toward the cost of the coverage.

Coverage will end on the earliest of:

1. The end of the month in which the survivor dies
2. The end of the month covered by your last contribution payment for coverage
3. The date the coverage ends
4. The date the Plan terminates
5. For dependents: the end of the month in which the dependent would otherwise cease to qualify as a dependent, or
6. The date the survivor remarries

Option to continue coverage after a change in marital status

Your former spouse will not cease to qualify as a dependent under the Plan solely because a judgment of divorce or separate support is granted. (For the purposes of this provision, “judgment” means only a judgment of absolute divorce or of separate support.) Massachusetts law presumes that he or she continues to qualify as a dependent, unless the divorce judgment states otherwise.

If you get divorced, you must notify the GIC within 60 days and send the GIC a copy of the following sections of your divorce decree: Divorce Absolute Date, Signature Page, and Health Insurance Provisions. If you or your former spouse remarries, you must also notify the GIC. If you fail to report a divorce or remarriage, the Plan and the GIC have the right to seek recovery of health claims paid or premiums owed for your former spouse.

Under M.G.L. Ch. 32A as amended and the GIC’s regulations, your former spouse will no longer qualify as a dependent after the earliest of these dates:

1. The end of the period in which the judgment states he or she must remain eligible for coverage
2. The end of the month covered by the last contribution toward the cost of the coverage
3. The date he or she remarries
4. The date you remarry. If your former spouse is covered as a dependent on your remarriage date, and the divorce judgment gives him or her the right to continue coverage, coverage will be available at full premium cost (as determined by the GIC) under a divorced spouse rider. Alternatively, your former spouse may enroll in COBRA coverage.

Notice of COBRA continuation coverage rights

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage (health plan coverage, dental coverage, vision coverage all may be considered "group health coverage") would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage.

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- ☐ Your hours of employment are reduced, or
- ☐ Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- ☐ Your spouse dies;
- ☐ Your spouse's hours of employment are reduced;
- ☐ Your spouse's employment ends for any reason other than his or her gross misconduct;
- ☐ Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- ☐ You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- ☐ The parent-employee dies;
- ☐ The parent-employee's hours of employment are reduced;
- ☐ The parent-employee's employment ends for any reason other than his or her gross misconduct;
- ☐ The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- ☐ The parents become divorced or legally separated; or
- ☐ The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- ☐ The end of employment or reduction of hours of employment;
- ☐ Death of the employee; or
- ☐ The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Group Insurance Commission (GIC) and you are encouraged to make such notifications through the member portal (mygiclink.my.site.com). You may also submit notice by mailing it to: Group Insurance Commission, P.O. Box 556, Randolph, MA 02368. If you are notifying the GIC of a legal separation or divorce, we require you to submit a copy of your divorce decree and the parts of your divorce or separation agreement that are pertinent to GIC benefits (health, dental, vision insurance, etc.). The GIC reserves the right to require any additional information or documentation that it deems necessary.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion (within 60 days of the event), you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must submit documents demonstrating that the Social Security Administration determined that you are disabled. You must submit notice within 60 days of this event; however, you have until the end of your initial COBRA period of 18 months to submit the SSA determination. If you do not submit the required notice or documentation on or before the deadlines, you will lose any right to COBRA extension. **You must provide this notice to the Group Insurance Commission (GIC) and you are encouraged to make such notifications through the member portal (mygiclink.my.site.com).** You may also submit notice by mailing it to: Group Insurance Commission, P.O. Box 556, Randolph, MA 02368.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, [Children's Health Insurance Program \(CHIP\)](#), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- ❑ The month after your employment ends; or
- ❑ The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your COBRA rights, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Group Insurance Commission
Public Information Unit
P.O. Box 556
Randolph, MA 02368

You may also contact the GIC via the member portal (mygiclink.my.site.com), via online contact form (mass.gov/forms/contact-the-gic), or call 617-727-2310.

Coordinating benefits with other health plans (COB)

It is common for family members to be covered by more than one healthcare plan. This happens, for example, when spouses or partners have family coverage through both of their employers or former employers. When you or your dependents are covered by more than one health plan, one plan is identified as the primary plan for coordination of benefits (COB). Any other plan is then the secondary plan. The goal of COB is to determine how much each plan should pay when you have a claim, and to make sure that the combined payments of all plans do not add up to more than your covered healthcare expenses.

Definition of plan

For the purposes of COB, the term **plan** is defined as any plan that provides medical or dental care coverage. Examples include, but are not limited to, group or blanket coverage; group practice or other group prepayment coverage, including hospital or medical services coverage; labor-management trustee plans; union welfare plans; employer organization plans; employee benefit organization plans; automobile no-fault coverage; and coverage under a governmental plan, or coverage required or provided by law, including any legally required, no-fault motor vehicle liability insurance. (This does not include a state plan under Medicaid or any plan when, by law, its benefits are in excess of those of any private insurance program or other non-governmental program.)

The term **plan** does not include school-accident type plans or coverage that you purchased on a non-group basis.

Determining the order of coverage: Medicare and Medicare Extension

The benefits for an enrollee and his or her dependents simultaneously covered by Wellpoint Medicare Extension and Medicare Part A and/or Part B will be determined as follows:

1. Expenses payable under Medicare will be considered for payment only to the extent that they are covered under the Plan and/or Medicare.
2. In calculating benefits for expenses incurred, the total amount of those expenses will first be reduced by the amount of the actual Medicare benefits paid for those expenses, if any.
3. Wellpoint plan benefits will then be applied to any remaining balance of those expenses.

Note that some providers choose not to participate in the Medicare program. If members use these providers for services that Medicare normally covers, Wellpoint will only consider for payment the amount that would have been allowed if Medicare had processed the claim as the primary carrier.

Example – Some providers choose not to participate in the Medicare program (that is, they are private contract providers). If you use a private contract provider for services that Medicare normally covers, and the charge is \$100, Wellpoint subtracts the primary plan's benefit before it pays its portion of the bill. In this case, the Plan assumes that Medicare would have paid \$80, leaving \$20 in coinsurance. The Plan will apply its benefit to the \$20, and you may be responsible for the remainder.

Determining the order of coverage: non-Medicare plans

If Wellpoint Medicare Extension is the primary plan, benefit payments will be made as if the secondary plan or plans did not exist. A secondary plan may reduce its benefits if payments were made by Wellpoint.

If another plan is primary, benefit payments under Wellpoint Medicare Extension are determined in the following manner:

- a) The Plan determines its **covered expenses** – that is, what the Plan would pay in the absence of other insurance; then
- b) The Plan subtracts the **primary plan's benefits** – benefits paid by the other plan, or the reasonable cash value of any benefits in the form of services – from the covered expenses in (a) above; and then
- c) The Plan pays the difference, if any, between (a) and (b).

The following are the rules used by Wellpoint Medicare Extension (and most other plans) to determine which plan is the primary plan and which plan is the secondary plan:

1. The plan without a COB provision is primary.
2. The plan that covers the person as an employee, member, or retiree (that is, other than as a dependent) is primary, and the plan that covers the person as a dependent is secondary.
3. The order of coverage for a dependent child who is covered under both parents' plans is determined by the **birthday rule**, as follows:
 - a) The primary plan is the plan of the parent whose birthday falls first in the calendar year, or
 - b) If both parents have the same birthday (month and day only), the primary plan is the plan that has covered a parent for the longest period of time

However, if the other plan has a rule based on the gender of the parent, and if the plans do not agree on the order of coverage, the rules of the other plan will determine the order.

4. The order of coverage for dependent children who are covered under more than one plan, and whose parents are divorced or separated, follows any applicable court decree.

If there is no such decree determining which parent is financially responsible for the child's healthcare expenses, coverage is determined as follows:

- a) First, the plan covering the parent with custody of the child (the custodial parent)
 - b) Second, the plan covering the custodial parent's spouse, if applicable
 - c) Third, the plan covering the non-custodial parent
 - d) Fourth, the plan covering the non-custodial parent's spouse, if applicable
5. According to the **active before retiree rule**, the plan that covers a person as an active employee is primary, and the plan that covers that same person as a retiree is secondary. This applies both to that person and his or her dependents.

However, if the other plan's rule is based on length of coverage, and if the plans do not agree on the order of coverage, the rules of the other plan will determine the order.

If none of the above rules can be applied, the plan that has covered the person for a longer period of time is primary, and the plan that has covered that same person for the shorter period of time is secondary.

Right to receive and release information

In order to fulfill the terms of this COB provision or any similar provision:

- ☐ A claimant must provide the Plan with all necessary information
- ☐ The Plan may obtain from or release information to any other person or entity as necessary

Facility of payment

A payment made under another plan may include an amount that should have been paid by Wellpoint Medicare Extension. If it does, the Plan may pay that amount to the organization that made the payment, and treat it as a benefit payable under Wellpoint Medicare Extension. Wellpoint Medicare Extension will not have to pay that amount again.

Right of recovery

If Wellpoint Medicare Extension pays more than it should have under the COB provision, the Plan may recover the excess from one or more of the following:

- ☐ The persons it has paid or for whom it has paid
- ☐ The other insurance company or companies
- ☐ Other organizations

Chapter 13: Other plan resources

Getting help from Wellpoint Member Services

To reach Wellpoint Member Services, call 800-442-9300 (toll free). Representatives are available Monday through Thursday from 7:30 a.m. to 6:00 p.m. and Friday from 7:30 a.m. to 5:00 p.m. (Eastern time) to answer questions you or your family may have about your medical coverage.

You can use our automated phone line (800-442-9300) to get information about your claims at any time. You can also set up a user account that will let you access your claims online (page 125).

Member service representatives are benefits specialists who can answer questions about:

- ☐ Claim status
- ☐ Preapproval reviews
- ☐ Covered services
- ☐ Wellpoint contracted suppliers and Medicare suppliers
- ☐ Plan benefits
- ☐ Resources on the [wellpointmass.com](https://www.wellpointmass.com) website

Clinical services include registered nurses and other healthcare professionals who can provide assistance with complex medical issues. Clinical services can help you:

- ☐ Review your ongoing needs
- ☐ Find out about other services that may be useful
- ☐ Get information about your Medicare benefits
- ☐ Guide you on home care plans, as appropriate

How to reach Wellpoint Member Services


| | Contact | Hours (Eastern time) |
|---------------------------|---|---|
| By phone | 800-442-9300 TTY: 711 (toll free) | 7:30 a.m. to 6:00 p.m. (M-Th) 7:30 a.m. to 5:00 p.m. (F) |
| Through the member portal | Use Live Chat or send a message from your Wellpoint account | Anytime |

About the Sydney Health app

The **Sydney Health** app gives you electronic access to plan information and member services from your mobile device. Download Sydney Health to your mobile device from the App Store® or Google Play®. Once you've registered as a Wellpoint member, Sydney Health has tools that let you track not just your claims but your overall health and medical situation.

Use the Sydney Health app to...

- Get information about your plan benefits
- Check on the status of your claims
- Look for healthcare providers
- Keep track of your member costs
- Get your electronic member ID card
- Get suggestions and tips for managing health conditions like diabetes or asthma
- Sync with a FitBit or other fitness tracker
- Get digital reminders about scheduling checkups and important tests

In this handbook, the smartphone  symbol lets you know about information you can find, tasks you can perform, and resources that are available through Sydney Health.




You can also access Sydney Health online by logging in at wellpointmass.com. See below for instructions on how to register for your Wellpoint account, if you haven't already done so.

About wellpointmass.com

You can find additional information and resources at the wellpointmass.com website. From the website, you can:

- ❑ **Check on your claims and other account information** – You'll need to register as a Wellpoint member (if you haven't already registered through the Sydney Health app). Once you're registered, you can check your account anytime.
Register by creating a user ID and password to protect the privacy of your information. Dependents age 18 or older can access their individual claims information by establishing their own user IDs and passwords.
- ❑ **Download forms, fliers, and other materials, including this handbook** – We recommend using your handbook as a PDF because it is almost always easier and faster to find information by searching in a PDF.
- ❑ **Look for healthcare providers such as:**
 - Contracted behavioral health providers
 - Wellpoint contracted suppliers
 - Other kinds of facilities in Massachusetts, like urgent care centers and ambulatory surgery centers

Throughout this handbook, the computer  lets you know about information you can find, tasks you can perform, and resources that are available through wellpointmass.com.

Calling the 24-Hour Nurse Line

The **24-Hour Nurse Line** provides toll-free access to extensive health information at any time. The Nurse Line is an educational resource. If you have specific issues about your health or your treatment, you should always consult your doctor.

When you call the 24-Hour Nurse Line, you'll speak with registered nurses who can discuss your concerns, address your questions about procedures or symptoms, and help you prepare for a doctor's visit. They can also discuss your medications and any potential side effects. The Nurse Line can also refer you to local, state and national self-help agencies.

To speak with a nurse, call the Nurse Line toll free at 800-424-8814 and, when prompted, be sure to choose the Nurse Line option.

How to ask for a claim review

If you have questions about a claim, you can ask Wellpoint to review the claim. Contact us in any of the ways listed below. Be sure to provide us with any additional information about your claim, if any. We will notify you of the result of the investigation and the final determination.

- ☐ **Call** Wellpoint Member Services at 800-442-9300
- ☐ **Log into your Wellpoint account** to send a message or use Live Chat
- ☐ **Mail** your written request to:
Wellpoint
Claims Department
P.O. Box 4095
Woburn, MA 01888

How to ask to have medical information released

We will release your medical information if we get a written request from you to do so.

If you want your medical information sent to another person or company, you must fill out a *Member Authorization Form* that specifies who may see your information.



Download the *Member Authorization Form* from [wellpointmass.com](https://www.wellpointmass.com).

The GIC's policies for releasing and requesting medical information to a third party comply with the Health Insurance Portability and Accountability Act (HIPAA). For more details, see the GIC's *Notice of Privacy Practices* in Appendix A.

Chapter 14: Plan definitions

| Term | What it means... |
|--|---|
| A | |
| Acupuncture withdrawal management (detox) | The use of acupuncture to ease the symptoms of drug or alcohol withdrawal. |
| Acute residential treatment | Short-term, 24-hour programs that provide behavioral health treatment within a protected and structured environment. |
| Acute residential withdrawal management | Drug or alcohol withdrawal (detox) that is medically monitored, for members at risk of severe withdrawal. |
| Adverse benefit determination (page 111) | <p>A determination to deny, reduce or terminate, or fail to provide or make a payment (in whole or in part) for a benefit based on any of the following:</p> <ul style="list-style-type: none"> ▪ The case does not meet the Plan's requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness ▪ The services were determined to be experimental or investigational ▪ The services were not covered based on any plan exclusion or limitation ▪ The person was not eligible to participate in the Plan ▪ The imposition of source of injury exclusion, network exclusion, or other limitation of an otherwise covered benefit ▪ Any instance where the Plan pays less than the total amount of expenses submitted with regard to a claim, including coinsurance and copays ▪ A rescission of coverage (a retroactive cancellation), except if it results from failure to pay premiums |
| Allowed amount (page 21) | The maximum amount on which payment is based for covered healthcare services. For services covered by Medicare, the allowed amount is the same as the Medicare-approved amount. For services not covered by Medicare, the allowed amount is the amount Wellpoint determines to be within the range of payments most often made to similar providers for the same service or supply. This allowed amount may not be the same as the provider's actual charge. |

| Term | What it means... |
|--|---|
| Ambulatory surgery center | An independent, freestanding facility licensed to provide same-day medical services that require dedicated operating rooms and post-operative recovery rooms. These facilities are independent centers, not hospital-run facilities located in a hospital or elsewhere. The presence of a hospital name indicates that the site is a hospital facility, not an ambulatory surgery center. |
| Ambulatory withdrawal management | Drug or alcohol withdrawal process in which a member has daily visits with a provider throughout withdrawal. More commonly called outpatient detox . |
| Appeal (page 111) | A request that Wellpoint review an adverse benefit determination or a grievance. |
| Applied Behavior Analysis (ABA) | Specialized therapy used to treat autism spectrum disorders that focuses on improving appropriate behaviors and minimizing negative behaviors. |
| B | |
| Balance billing (page 22) | When a provider bills you for the difference between what the provider billed and the amount paid by the Plan (the allowed amount). For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may balance bill you for the remaining \$30. |
| Behavioral health services (pages 73-88) | Services to treat mental health and substance use disorder conditions. The benefits for these services are described in Part 3 of this handbook. |
| C | |
| Clinical stabilization services (CSS) | Clinically managed detox and recovery services provided in a non-medical setting. |
| Coinsurance (page 20) | Your share of the costs of a covered healthcare service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance <i>plus</i> any copays that may apply. |
| Coinsurance limit | See Out-of-pocket (OOP) maximums |
| Community-based acute treatment (CBAT) | Treatment for children and adolescents with serious behavioral health disorders who need a protected and structured environment. |
| Community support programs (CSP) | Programs to help members access and use behavioral health services. |

| Term | What it means... |
|--|--|
| Contracted suppliers (page 24) | <p>Medicare suppliers or Wellpoint-contracted suppliers who deliver certain services or equipment including, but not limited to, durable medical equipment (DME), medical supplies, and home health care. You get these services at a higher benefit level when you use contracted suppliers.</p> <p>When available, always use Medicare suppliers. For services that aren't available from Medicare suppliers – including services that Medicare doesn't cover but are covered by the Plan – the contracted suppliers are providers that contract with Wellpoint.</p> |
| Copay (copayment) (page 20) | A fixed amount you pay for a covered healthcare service, usually when you get the service. The dollar amount of the copay depends on the service it applies to. Not all services have copays. |
| Cosmetic services (page 93) | Services performed mainly to improve appearance. These services do not restore bodily function or correct functional impairment. Cosmetic services are not covered. |
| Cost sharing (Chapter 2) | Your share of the cost for a covered service that you must pay out of your own pocket. Your share can be a copay and/or coinsurance. |
| Crisis stabilization unit (CSU) | 24-hour observation and supervision for behavioral health conditions when inpatient care isn't needed. |
| Custodial care (page 93) | A level of care that is chiefly designed to assist with activities of daily living and cannot reasonably be expected to greatly restore health or bodily function. |
| D | |
| Day treatment | Behavioral health programs offering structured, goal-oriented treatment that focuses on improving one's ability to function in the community. |
| Dependent (Chapter 12) | <ol style="list-style-type: none"> 1. The employee's or retiree's spouse or a divorced spouse who is eligible for dependent coverage pursuant to Massachusetts General Laws Chapter 32A as amended 2. A GIC-eligible child, stepchild, adoptive child or eligible foster child of the member, or of the member's spouse, until the end of the month following the dependent's 26th birthday 3. A GIC-eligible unmarried child who upon becoming 19 years of age is mentally or physically incapable of earning his or her own living, proof of which must be on file with the GIC 4. A dependent of a dependent, if the primary dependent is either a full-time student or an IRS dependent, or has been an IRS dependent within the past two years <p>If you have questions about coverage for someone whose relationship to you is not listed above, contact the GIC.</p> |

| Term | What it means... |
|--|--|
| Dialectical behavioral therapy (DBT) | A combination of behavioral, cognitive and supportive therapies designed to help change unhealthy behaviors and treat people suffering from behavioral health disorders. |
| DME (durable medical equipment) | Equipment and supplies ordered by a healthcare provider for everyday or extended use. Oxygen equipment, wheelchairs, and crutches are all examples of DME. |
| DPH-licensed providers | The Massachusetts Department of Public Health (DPH) issues licenses to Massachusetts facilities that provide healthcare services. To be licensed, facilities must meet specific quality and safety standards. |
| Dual diagnosis acute treatment (DDAT) | Clinically-managed detox and recovery services for those with both a substance use and mental health condition who require a protected and structured environment. |
| E | |
| Elective | A medical service or procedure is elective if you can schedule it in advance, choose where to have it done, or both. |
| Electroconvulsive therapy (ECT) | Psychiatric treatment in which seizures are electrically induced to provide relief from mental disorders. |
| Emergency | An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: <ul style="list-style-type: none"> ▪ Your health would be put in serious danger, or ▪ You would have serious problems with your bodily functions, or ▪ You would have serious damage to any part or organ of your body. |
| Emergency service program (ESP) | Programs that provide behavioral health crisis assessment, intervention and stabilization services on short notice. |
| Enrollee | An employee, retiree or survivor who is covered by the GIC's health benefits program and enrolled in a Wellpoint health plan. (Enrollees are the same as subscribers.) |
| Excluded services | Healthcare services that the Plan doesn't pay for or cover. |
| Experimental or investigational procedure | A service that is determined by the Plan to be experimental or investigational; that is, inadequate or lacking in evidence as to its effectiveness, through the use of objective methods and study over a long enough period of time to be able to assess outcomes. The fact that a physician ordered it or that this treatment has been tried after others have failed does not make it medically necessary. |

| Term | What it means... |
|--|---|
| F | |
| Family stabilization team (FST) | Programs offering intensive services in the home to help children, adolescents and their families deal with complex life stressors. |
| H | |
| Healthcare provider | A person, place, or organization that delivers healthcare services or supplies. A provider can be a person (like a doctor), a place (like a hospital), or an organization (like hospice). |
| Healthcare services | In this handbook, we use “healthcare services” when we’re talking about both medical and behavioral health services. |
| High-tech imaging | Tests such as MRIs, CT scans, and PET scans that give a more comprehensive view of the human body than plain film X-rays. Many of these tests also subject members to significantly higher levels of radiation compared to plain film X-rays and are also much more expensive. |
| Home state | The state where you live and get your routine health care. |
| Hospital / acute care hospital (pages 53-55) | <p>A medical center or community hospital that provides treatment for severe illness, conditions caused by disease or trauma, and recovery from surgery. Acute care hospitals deliver intensive, 24-hour medical and nursing care and meet all of the following conditions:</p> <ul style="list-style-type: none"> ▪ Operate pursuant to law for the provision of medical care ▪ Provide continuous 24-hour-a-day nursing care ▪ Have facilities for diagnosis and major surgery ▪ Provide acute medical/surgical care or acute rehabilitation care ▪ Are licensed as an acute hospital ▪ Have an average length of stay of less than 25 days |
| I | |
| Injury | Accidental bodily harm caused by something external (outside of your body). |
| Inpatient behavioral health services (pages 82-84) | Treatment for behavioral health conditions that have severe symptoms but that are expected to improve with intensive, short-term treatment. |
| Inpatient medical care (pages 53-55) | Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Inpatient hospital services may also be referred to as hospitalization . |
| Intensive outpatient program (IOP) | Programs that offer thorough, regularly-scheduled behavioral health treatment in a structured environment. These programs offer at least three hours of therapy a day, up to seven days a week. |

| Term | What it means... |
|---|---|
| L | |
| Long-term care facilities (pages 53-55) | Specialized hospitals that treat patients who need further care for complex medical conditions but no longer require the services of a traditional hospital. |
| M | |
| Maintenance care | A treatment plan or therapy performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the nature of the treatment becomes supportive rather than corrective. |
| Medical services | In this handbook, medical services are services to treat medical (physical) conditions – in contrast to Behavioral health services . |
| Medical necessity | <p>With respect to care under the Plan, medical necessity means that treatment will meet at least the following standards:</p> <ol style="list-style-type: none"> 1. Is adequate and essential for evaluation or treatment consistent with the symptoms, proper diagnosis and treatment appropriate for your illness, disease or condition as defined by standard diagnostic nomenclatures (DSM-V or its equivalent ICD-10CM) 2. Is reasonably expected to improve or palliate your illness, condition or level of functioning 3. Is safe and effective according to nationally-accepted standard clinical evidence that is generally recognized by medical professionals and peer-reviewed publications 4. Is the most appropriate and cost-effective level of care that can safely be provided for your diagnosed condition 5. Is based on scientific evidence for services and interventions that are not in widespread use <p>Important! The fact that a doctor may prescribe, order, recommend or approve a procedure, treatment, facility, supply, device, or drug does not, in and of itself, make it medically necessary or make the charge a covered expense under the Plan, even if it has not been listed as an exclusion.</p> |
| Medical supplies or equipment | Disposable items that physicians prescribe as medically necessary to treat a disease or injury. Such items include surgical dressings, splints and braces. |
| Medication-assisted treatment (MAT) (page 84) | Long-term prescribing of medication as an alternative to the opioid on which a member was dependent. Typically, a member goes to a clinic daily to get the medication. |
| Medication management | Visits with a behavioral health provider who can evaluate and prescribe medication, if needed. |
| Member | An enrollee or his/her dependent who is covered by the Plan. |

| Term | What it means... |
|--|---|
| Member costs (Chapter 2) | Costs that you pay yourself toward your medical bills: copays and coinsurance. Member costs are also known as out-of-pocket costs . |
| N | |
| Network | The facilities, providers and suppliers that the Plan has contracted with to provide healthcare services. |
| Neuropsychological (neuropsych) testing | Testing to find out if a problem with the brain is affecting one's ability to reason, concentrate, solve problems, or remember. |
| Non-contracted supplier (page 24) | A supplier who is neither Medicare nor Wellpoint-contracted to provide certain services or equipment including, but not limited to, durable medical equipment and medical supplies. In some cases, you will have no coverage when you use a non-contracted supplier. |
| Non-hospital-owned facility | Facilities that perform outpatient medical services but that are not owned by or operated by a hospital. Non-hospital-owned facilities include many ambulatory surgery centers and urgent care centers. |
| O | |
| Observation care | A well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made about whether a patient will need inpatient hospital treatment or if he or she can be discharged from the hospital. Observation care is considered outpatient and is usually provided in medical centers and community hospitals. |
| Office services (pages 85-86) | Behavioral health services that can be provided in an office or office-like setting |
| Opiate treatment programs (OTP) | Programs licensed to distribute and administer medications as an alternative to an opioid on which a member was dependent. |
| Out-of-pocket costs | See Member costs |
| Out-of-pocket (OOP) maximums (page 19) | <p>The most you could pay during a calendar year for member costs (copays and coinsurance) for covered services. Once you reach an out-of-pocket maximum, the Plan starts to pay 100% of the allowed amount. There are three separate out-of-pocket maximums, each of which applies to different services:</p> <ul style="list-style-type: none"> ▪ Coinsurance limit ▪ Out-of-pocket maximum for behavioral health costs with contracted providers ▪ Out-of-pocket maximum for behavioral health costs with non-contracted providers <p>Out-of-pocket maximums don't include prescription drug costs, premiums, balance bills, or costs for services that the Plan doesn't cover.</p> |

| Term | What it means... |
|---|--|
| Outpatient behavioral health services (pages 86-87) | Services that don't require an inpatient hospital admission or overnight stay. Outpatient services include office services as well as more intensive types of behavioral health treatment. |
| Outpatient hospital services | Care at a hospital that doesn't require being admitted to the hospital. Outpatient care usually doesn't include an overnight stay. Outpatient services sometimes means health care provided at any non-hospital facility, such as a doctor's office or walk-in clinic. |
| P | |
| Palliative care | Medical care that focuses on treating symptoms – like severe pain, or plan difficulty breathing – to make you more comfortable. Palliative care is not intended to cure underlying conditions. |
| Partial hospitalization programs (PHP) | Non-residential, structured outpatient psychiatric and substance use programs that are more intensive than one would get in a doctor's office, but that are an alternative to inpatient care. These programs offer at least five hours of therapy a day, up to seven days a week. |
| Physician | Includes the following healthcare providers acting within the scope of their licenses or certifications: <ul style="list-style-type: none"> ▪ Certified nurse midwife ▪ Chiropractor ▪ Dentist ▪ Nurse practitioner ▪ Optometrist ▪ Physician ▪ Physician assistant ▪ Podiatrist See page 74 for a list of types of behavioral health providers. |
| Preapproval | Review process to confirm that a service you're going to have is eligible for benefits. Preapproval review lets you make sure that services you'll be getting are covered under the Plan. |
| Preferred vendors | See Contracted suppliers |
| Provider | See Healthcare provider |
| Psychiatric visiting nurse (VNA) services | Short-term treatment delivered in the home or living environment to treat a behavioral health disorder with medication. |
| Psychological (psych) testing | Standardized assessment tools to diagnose and assess overall psychological functioning. |

| Term | What it means... |
|---|---|
| R | |
| Rehabilitation (rehab) facilities (pages 53-55) | Specialized hospitals that provide rehab services to restore basic functioning (such as walking or sitting upright) that was lost due to illness or injury. |
| Rehabilitation (rehab) services | Healthcare services that help a person keep, get back or improve skills and functioning for daily living that were lost or impaired due to illness, injury or disability. These services may include physical therapy, occupational therapy, and speech-language pathology in a variety of inpatient and/or outpatient settings. |
| Respite care | Services given to an ill patient to relieve the family or primary care person from caregiving functions. |
| Retail health clinic (pages 105-106) | Walk-in clinics located in retail stores or pharmacies. They offer basic services like vaccinations and treatment for colds or mild sinus infections. |
| S | |
| Skilled care | Medical services that can only be provided by a registered or certified professional healthcare provider. |
| Skilled nursing facility (pages 53-55) | <p>An institution that provides lower intensity rehab and medical services. Skilled nursing facilities must meet all of the following conditions:</p> <ul style="list-style-type: none"> ▪ Operates according to law ▪ Is approved as a skilled nursing facility for payment of Medicare benefits, or is qualified to receive such approval, if requested ▪ Is licensed or accredited as a skilled nursing facility (if applicable) ▪ Primarily engages in providing room and board and skilled care under the supervision of a physician ▪ Provides continuous 24-hour-a-day skilled care by or under the supervision of a registered nurse (RN) ▪ Maintains a daily medical record for each patient <p>A facility does not qualify as a skilled nursing facility if it is used primarily for:</p> <ul style="list-style-type: none"> ▪ Rest ▪ Mental health or substance use disorder treatment ▪ Educational care ▪ Custodial care (such as in a nursing home) |
| Spouse | The legal spouse of the covered employee or retiree. |

| Term | What it means... |
|---|--|
| Structured outpatient addictions programs (SOAP) | Non-residential, structured substance use disorder programs that are more intensive than one would get in a doctor's office, but that are an alternative to inpatient care. These programs offer at least three hours of therapy a day, up to seven days a week. |
| Substance use disorder assessment / referral | A comprehensive assessment of substance use to allow a provider to refer a member to appropriate care. |
| T | |
| Transcranial magnetic stimulation (TMS) | A non-invasive method of brain stimulation used to treat major depression. |
| Transitional care unit (TCU) | Facilities that help children and adolescents transition from an acute care facility to home, a residential program, or foster care. |
| U | |
| Urgent care (pages 42-43) | Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care. |
| Urgent care center (pages 105-106) | An independent, freestanding facility that treats conditions that should be handled quickly but that aren't life-threatening. Urgent care centers often do X-rays, lab tests and stitches. |
| V | |
| Visiting nurse association | An agency certified by Medicare that provides part-time, intermittent skilled care and other home care services in a person's place of residence and is licensed in any jurisdiction requiring such licensing. |
| W | |
| Walk-in clinics (pages 105-106) | Sites that offer medical care on a walk-in basis, so no appointment is needed. Urgent care centers and retail health clinics are two examples of walk-in clinics. |

Part 5:

Your Prescription Drug Plan

Description of benefits for prescription drugs

SilverScript Employer PDP sponsored by the Group Insurance Commission

**A Medicare Prescription Drug Plan (PDP) offered by SilverScript®
Insurance Company with a Medicare contract**

**For questions about any of the information in Part 5 of this handbook,
please call SilverScript at 877-876-7214 (TTY: 711).**

Administered by
SilverScript®

Chapter 15: Your prescription drug plan

Important! Prescription drug benefits are subject to change. To review the most recent Plan Benefits document, please visit gic.silverscript.com.

About SilverScript

SilverScript Employer PDP sponsored by the Group Insurance Commission (GIC) is a Medicare-approved Part D prescription drug plan with additional coverage provided by the GIC to expand the Part D benefits. “Employer PDP” means that the plan is an employer-provided prescription drug plan. The plan is offered by SilverScript® Insurance Company, which is affiliated with CVS Caremark®, the GIC’s pharmacy benefit manager.

You are automatically enrolled in SilverScript coverage when you enroll in one of the GIC’s Medicare products. Do not enroll in any other Part D (prescription drug) plan. Doing so will immediately terminate your GIC health and prescription drug coverage.

Plan costs

This section includes information about your monthly premium, annual deductible (if any), and cost-sharing amounts during the Initial Coverage Stage for SilverScript. Although most members do not reach the Coverage Gap Stage (Stage 3) or the Catastrophic Coverage Stage (Stage 4) during the plan year, a summary of your costs in those stages is also included.

Monthly Premium

There is no separate prescription drug premium. This benefit is provided as part of your GIC health plan coverage.

Please note: If your modified adjusted gross income is above a certain amount, you may pay a Part D income-related monthly adjustment amount (Part D IRMAA). Medicare uses the modified adjusted gross income reported on your IRS tax return from two years ago (the most recent tax return information provided to Social Security by the IRS).

If Social Security notifies you about paying a higher amount for your Part D coverage, you’re required by law to pay the Part D income-related monthly adjustment amount (Part D IRMAA). **You pay your Part D IRMAA directly to Medicare, not to your plan or employer.**

You’re required to pay the Part D IRMAA even if your employer or a third party (like a teacher’s union or a retirement system) pays for your Part D plan premiums. If you don’t pay the Part D IRMAA and get disenrolled, you may also lose your retirement coverage and you may not be able to get it back.

For more information about Part D premiums based on income, call Medicare at 800-MEDICARE (800-633-4227).

Medicare Part D Drug Payment Stages

All Medicare Part D prescription drug plans have drug payment stages where drug costs may vary. You move through each stage based on the amount either you or the plan spend on prescription drugs. See the following section for information on the Medicare Part D drug payment stages. The Part D *Explanation of Benefits (EOB)* and other plan materials include additional information on the four drug payment stages.

Stage 1: Deductible Stage

Because you have no deductible, this payment stage does not apply to you.

Stage 2: Initial Coverage State Cost Sharing

During the Initial Coverage Stage, you pay a portion of your drug costs, and the plan pays its portion. The following tables show what you pay until your total yearly drug costs reach \$4,660. Total yearly drug costs are the total drug costs paid by both you and SilverScript. You may get your drugs at network retail pharmacies or through the mail-order pharmacy.

Table 16. Summary of Prescription Drug Benefits

| 2023 SilverScript Summary of Prescription Drug Benefits for the Group Insurance Commission | | | |
|--|---|--|--|
| Monthly Premium | | There is no separate prescription drug premium. This benefit is provided as part of your GIC health plan coverage. | |
| Deductible | | This plan does not have a deductible. | |
| Your share of the cost when you get a 30-day supply of a covered Part D prescription drug | | | |
| | Network Retail Pharmacy (Up to a 30-day supply available at <u>any</u> network pharmacy) | Mail-Order Pharmacy (Up to a 30-day supply) | Long-Term Care (LTC) Pharmacy (Up to a 31-day supply) |
| Tier 1: Generic | \$10 | \$25 | \$10 |
| Tier 2: Preferred Brand | \$30 | \$75 | \$30 |
| Tier 3: Non-Preferred Brand | \$65 | \$165 | \$65 |

Your share of the cost when you get a *long-term* supply (up to 90 days) of a covered Part D prescription drug

| | Preferred Network Retail Pharmacy (Up to a 90-day supply) | Standard Network Retail Pharmacy (Up to a 90-day supply) | Mail-Order Pharmacy (Up to a 90-day supply) |
|--|--|---|--|
| Tier 1: Generic | \$25 | \$30 | \$25 |
| Tier 2: Preferred Brand | \$75 | \$90 | \$75 |
| Tier 3: Non-Preferred Brand | \$165 | \$195 | \$165 |

Note: You pay the same share of the cost for your drug filled through the Mail-Order Pharmacy, whether you get a one-month supply or a long-term supply. This means that the copay or coinsurance listed in the previous table is applicable for any order, regardless of the day supply.

Please note: If you go to an out-of-network pharmacy, you will be reimbursed the cost of the drug less your cost share.

Stage 3: Coverage Gap Stage Cost Sharing

The coverage gap begins after the total yearly drug costs (including what the plan has paid and what you have paid) reaches \$4,660.

Due to the additional coverage provided by the GIC, you have the same copays or coinsurance that you had during the Initial Coverage Stage. Therefore, you may see no change in your copay and/or coinsurance until you qualify for catastrophic coverage.

Stage 4: Catastrophic Coverage State Cost Sharing

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$7,400 you pay 5% of the cost for a covered drug, but not greater than the cost share amounts listed in the Initial Coverage Stage section above.

Who can join?

To join SilverScript, you must be eligible for coverage provided by the GIC, be entitled to Medicare Part A and/or be enrolled in Medicare Part B, be a United States citizen or be lawfully present in the United States, and live in our service area. SilverScript is available in the United States and its territories.

Which drugs are covered?

To find out if your drug is on the formulary (list of Part D prescription drugs) or about any restrictions, call SilverScript Customer Care at 877-876-7214 (TTY: 711). You may also request a copy of the complete plan formulary.

Please note: The GIC provides additional coverage that may cover prescription drugs not included in your Medicare Part D benefit, such as:

- ☐ Prescription drugs for anorexia, weight loss, or weight gain
- ☐ Prescription drugs for the symptomatic relief of cough or cold
- ☐ Prescription vitamins and mineral products not covered by Part D
- ☐ Prescription drugs for treatment of sexual or erectile dysfunction
- ☐ Certain diabetic drugs and supplies not covered by Part D
- ☐ Prescription drugs for tobacco cessation
- ☐ Part B products, such as oral chemotherapy agents

For more information about your share of the cost or which prescription drugs may or may not be covered, please call SilverScript Customer Care at 877-876-7214 (TTY: 711). The SilverScript formularies do not include any drugs that may be available to you through the additional coverage provided by the GIC.

How will I determine my drug costs?

SilverScript groups each medication into one of three tiers. Use your formulary to find out the tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and whether you are in the Deductible (if any), Initial Coverage, Coverage Gap, or Catastrophic Coverage Stage. As you move from stage to stage, the amount you and the plan pay for your drugs may change. If the actual cost of a drug is less than the normal copay or coinsurance for that drug, you will pay the actual cost, not the higher copay or coinsurance.

Which pharmacies can I use?

More than 66,000 pharmacies nationwide make up the pharmacy network. These include retail, mail-order, long-term care and home infusion pharmacies. To find a network pharmacy near your home or where you are traveling in the United States or its territories, call SilverScript Customer Care at 877-876-7214 (TTY: 711) or use our online pharmacy locator tool on gic.silverscript.com.

You generally must use a network pharmacy in order to receive full benefit coverage on your prescriptions. You may get drugs from an out-of-network pharmacy in an emergency, but you may have to pay the full cost (rather than your normal share of the cost) at the time you fill your prescription. If you use an out-of-network pharmacy, we will reimburse you your total cost minus your copay amount for the drug. You must submit a paper claim in order to be reimbursed.

If you need to get your prescription filled while you are traveling outside the country, contact SilverScript Customer Care **before** you leave the U.S. You can request a vacation override for up to a 90-day supply of your medication. If you are traveling outside of the country and have an emergency drug expense, submit your itemized receipt with the completed SilverScript claim form to the GIC at P.O. Box 556, Randolph, MA 02368.

Please note: Veterans Affairs (VA) pharmacies are not permitted to be included in Medicare Part D pharmacy networks. The federal government does not allow you to receive benefits from more than one government program at the same time.

If you are eligible for VA benefits, you may still use VA pharmacies under your VA benefits. However, the cost of those medications and what you pay out-of-pocket will not count toward your Medicare out-of-pocket costs or Medicare total drug costs. Each time you get a prescription filled, you can compare your GIC benefit through SilverScript to your VA benefit to determine the best option for you.

Through the additional coverage provided by the GIC, you may be able to save on your maintenance prescription drugs by changing your 30-day supply to a 90-day supply at any CVS Pharmacy®, Longs Drugs (operated by CVS Pharmacy), or Navarro Discount Pharmacy location. These pharmacies are called “preferred network retail pharmacies.”

If you’re currently taking any long-term prescription drugs, you can continue to fill your 30-day supplies. However, you may save by changing your 30-day supply to a lower-cost 90-day supply. Filling one 90-day supply may cost you less than three 30-day supplies of the same prescription drug.

You can choose from two 90-day supply options for the same low price:

- ☐ **Option 1:** Refill at any CVS Pharmacy, Longs Drugs (operated by CVS Pharmacy), or Navarro Discount Pharmacy location, and pick up your prescription drugs at your convenience.
- ☐ **Option 2:** Refill with CVS Caremark Mail Service Pharmacy and have a 90-day supply of your long-term prescription drugs shipped to your home.

For questions about maintenance drugs with additional coverage provided by the GIC, including the cost to fill these drugs, please contact SilverScript Customer Care at 877-876-7214 (TTY: 711).

This document provides a summary of what SilverScript covers and what you will pay. To get a complete list of our benefits, please call SilverScript Customer Care at 877-876-7214 (TTY: 711) and ask for the *Evidence of Coverage*.

If you want to know more about the coverage and costs of original Medicare, look in your current *Medicare & You* handbook. View it online at www.medicare.gov or get a copy by calling 800-MEDICARE (800-633-4227), 24 hours a day, 7 days a week. TTY users should call 877-486-2048.

See *Evidence of Coverage* for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of SilverScript. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

SilverScript's pharmacy network includes limited lower-cost, preferred pharmacies in Alaska; suburban and rural areas of Idaho, Puerto Rico, Washington, and Wyoming; and rural areas of Arkansas, Colorado, Iowa, Kansas, Kentucky, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Mexico, North Dakota, Oklahoma, Oregon, and Wisconsin. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call 877-876-7214 (TTY: 711), 24 hours a day, 7 days a week, or consult the online pharmacy directory at gic.silverscript.com.

Members who get "Extra Help" are not required to fill prescriptions at preferred network pharmacies in order to get Low Income Subsidy (LIS) copays.

The typical number of business days after the mail-order pharmacy receives an order to receive your shipment is up to 10 days. Enrollees have the option to sign up for automated mail-order delivery.

SilverScript Employer PDP is a Prescription Drug Plan. This plan is offered by SilverScript Insurance Company, which has a Medicare contract. Enrollment depends on contract renewal.

Important plan information

Información Importante Sobre el Plan

SilverScript Customer Care

Call 1-877-876-7214

Calls to this number are free, 24 hours a day, 7 days a week.

Customer Care also has free language interpreter services available for non-English speakers.

TTY 711

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Calls to this number are free, 24 hours a day, 7 days a week.

Fax 1-888-472-1129

Write SilverScript Insurance Company
P.O. Box 30016
Pittsburgh, PA 15222-0330

Part 6: Appendices

Notices and reference information

Appendix A: GIC notices

Notice of Group Insurance Commission Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Effective July 1, 2022

By law, the GIC must protect the privacy and security of your personal health information. The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as “protected health information” or “PHI”) includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at www.mass.gov/GIC.

Required and permitted uses and disclosures

We typically use or share your health information in the following ways.

Run our organization

- ☐ We can use and disclose your information to run our organization and contact you when necessary.
- ☐ To operate our programs that include evaluating the quality of health care services you receive and performing analyses to reduce health care costs and improve our health plans performance.
- ☐ Arrange for legal and auditing services including fraud and abuse protection

Pay for your health services

We can use and disclose your health information as we pay for your health services, administrative fees for health care and determining eligibility for health benefits.

Provide you with information on health-related programs or products

This might be information regarding alternative medical treatments or programs or about other health-related services and products.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- ☐ Preventing disease
- ☐ Helping with product recalls
- ☐ Reporting adverse reactions to medications
- ☐ Preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research.

Comply with the law

- ☐ We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law
- ☐ Address workers' compensation, law enforcement, and other government requests
- ☐ For law enforcement purposes or with a law enforcement official
- ☐ With health oversight agencies for activities authorized by law
- ☐ Respond to lawsuits and legal actions
- ☐ We can share health information about you in response to a court or administrative order, or in response to a subpoena

The GIC may also use and share your health information as follows:

- ☐ To resolve complaints or inquiries made by you or on your behalf (such as an appeal).
- ☐ To enable business associates that perform functions on our behalf or provide services if the information is necessary for such functions or service. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. Our business associates are also directly subject to federal privacy laws.
- ☐ For data breach notification purposes. We may use your contact information to provide legally-required notice of unauthorized acquisition, access, or disclosure of your health information.
- ☐ To verify agency and plan performance (such as audit).
- ☐ To communicate with you about your GIC-sponsored benefits (such as your annual benefits statement).
- ☐ To tell you about new or changed benefits and services or health care choices.

Organizations that assist us

In connection with payment and healthcare operations, we may share your PHI with our third party “Business Associates” that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI and also have direct responsibility to protect your PHI imposed by federal law.

When it comes to your health information, you have certain rights

This section explains your rights and some of our responsibilities to help you. You have the right to:

- ❑ **Get a copy of your health and claims records** – You can ask to see or get a copy of your health and claims records and other health information we have about you. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). We will provide a copy or a summary of your health and claims records. We may charge a reasonable, cost-based fee.
- ❑ **Ask us to correct our records** – You can ask us to correct your health and claims records if you think they are incorrect or incomplete. You must ask for this in writing along with a reason for your request. We may say “no” to your request, but we’ll tell you why in writing within 60 days. If we deny your request, you may file a written statement of disagreement to be included with your information for future disclosures.
- ❑ **Request confidential communications** – You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.
- ❑ **Ask us to limit what we use or share** – You can ask us not to use or share certain health information for payment or our operations, and disclosures to family members or friends. You must ask for this in writing. We are not required to agree to your request, and in some cases federal law does not permit a restriction.
- ❑ **Get a list of those with whom we’ve shared information** – You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make or was part of a limited data set for research).
- ❑ **Get a copy of this privacy notice** – You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. (An electronic version of this notice is on our website at www.mass.gov/gic)

- ❑ **Choose someone to act for you** – If you have given someone power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- ❑ **Receive notification of any breach or your unsecured PHI**
- ❑ **File a complaint if you feel your rights are violated** – You can complain if you feel we have violated your rights by writing to us at: GIC Privacy Officer, P.O. Box 566, Randolph, MA 02368. Filing a complaint or exercising your rights will not affect your GIC benefits. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call 617-727-2310 or TTY for the deaf and hard of hearing at 617-227-8583.

Important notice from the GIC about your prescription drug coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Wellpoint's Medicare Extension plan and your options under Medicare's prescription drug coverage. This information can help you decide whether or not to join a non-GIC Medicare drug plan. If you are considering joining a non-GIC plan, you should compare your current coverage – particularly which drugs are covered, and at what cost – with that of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage can be found at the end of this notice.

For most people, the drug coverage that you currently have through your GIC health plan is a better value than the Medicare drug plans.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available to everyone with Medicare in 2006. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The GIC has determined that the prescription drug coverage offered by your plan is, on average for all participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Part D drug plan.

When can you join a Medicare Part D drug plan?

You can join a non-GIC Medicare drug plan when you first become eligible for Medicare and each subsequent year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two month Special Enrollment Period to join a non-GIC Medicare drug plan.

What happens to your current coverage if you decide to join a non-GIC Medicare drug plan?

- ❑ If you enroll in another Medicare prescription drug plan or a Medicare Advantage plan with or without prescription drug coverage, you will be disenrolled from the GIC-sponsored CVS Caremark plan. If you are disenrolled from CVS Caremark, you will lose your GIC medical, prescription drug, and behavioral health coverage.
- ❑ If you are the insured and decide to join a non-GIC Medicare drug plan, both you and your covered spouse/dependents will lose your GIC medical, prescription drug, and behavioral health coverage.
- ❑ If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available online at www.socialsecurity.gov or by phone at 800-772-1213 (TTY: 800-325-0778).

When will you pay a higher premium (penalty) to join a Medicare drug plan?

You should also know that if you drop or lose your current coverage with a GIC plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For more information about this notice or your current prescription drug coverage ...

Contact the GIC at 617-727-2310, extension 1.

Note: You will receive this notice each year and if this coverage through the Group Insurance Commission changes. You may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage ...

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- ☐ Visit www.medicare.gov
- ☐ Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the *Medicare & You* handbook for the telephone number) for personalized help.
- ☐ Call 800-MEDICARE (800-633-4227); TTY users should call 877-486-2048.

If you have limited income and assets, extra help paying for Medicare prescription drug coverage is available. For information about the Extra Help program, visit Social Security online at www.socialsecurity.gov or call 800-772-1213 (TTY: 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System or members of the National Guard performing certain types of duty under state authority. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The GIC has more generous guidelines for benefit coverage that apply to persons subject to USERRA, as set forth below:

- ❑ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents while in the military.
- ❑ Service members who elect to continue their GIC health coverage are required to pay the employee's share for such coverage.
- ❑ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated to GIC health coverage when you are reemployed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **866-4-USA-DOL** or visit its website at <https://www.dol.gov/vets>.

An interactive online USERRA Advisor can be viewed at <https://webapps.dol.gov/elaws/vets/userra/>. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information about your GIC coverage, please contact the Group Insurance Commission at 617-727-2310.

Appendix B: Mandates and required member notices

Premium assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office, or dial **877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your state for further information on eligibility.

Premium assistance under Medicaid and CHIP

ALABAMA – Medicaid

Website: <http://myalhipp.com/>

Phone: 855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program

Website: <http://myakhipp.com/>

Phone: 866-251-4861

Email: CustomerService@MyAKHIPP.com

Medicaid eligibility: <https://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS – Medicaid

Website: <http://myarhipp.com/>

Phone: 855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program

Website: <http://dhcs.ca.gov/hipp>

Phone: 916-445-8322

Fax: 916-440-5676

Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado website: <https://www.healthfirstcolorado.com/>

Health First Colorado Member Contact Center: 800-221-3943 / State relay 711

CHP+: <https://hcpf.colorado.gov/child-health-plan-plus>

CHP+ Customer Service: 800-359-1991 / State relay 711

Health Insurance Buy-In Program (HIBI): <https://www.mycohibi.com/>

HIBI Customer Service: 855-692-6442

FLORIDA – Medicaid

Website:

<https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html>

Phone: 877-357-3268

GEORGIA – Medicaid

GA HIPP website:

<https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>

Phone: 678-564-1162, press 1

GA CHIPRA website:

<https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>

Phone: 678-564-1162, press 2

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults

19-64 website: <http://www.in.gov/fssa/hip/>

Phone: 877-438-4479

All other Medicaid website:

<https://www.in.gov/medicaid/>

Phone: 800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid website:

<https://dhs.iowa.gov/ime/members>

Medicaid phone: 800-338-8366

Hawki website: <http://dhs.iowa.gov/Hawki>

Hawki phone: 800-257-8563

HIPP website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>

HIPP phone: 888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>

Phone: 800-792-4884

HIPP phone: 800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance
Premium Payment Program (KI-HIPP)
website: <https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>

Phone: 855-459-6328

Email: KIHIPP.PROGRAM@ky.gov

KCHIP website: <https://kynect.ky.gov>

Phone: 877-524-4718

Kentucky Medicaid website:
<https://chfs.ky.gov/agencies/dms>

LOUISIANA – Medicaid

Websites: www.medicaid.la.gov or
www.ldh.la.gov/lahipp

Phone: 888-342-6207 (Medicaid hotline) or
855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US

Phone: 800-442-6003

TTY: Maine relay 711

Private Health Insurance Premium webpage:
<https://www.maine.gov/dhhs/ofi/applications-forms>

Phone: 800-977-6740

TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website:
<https://www.mass.gov/masshealth/pa>

Phone: 800-862-4840

TTY: 711

Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: <https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp>

Phone: 800-657-3739

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

Phone: 573-751-2005

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

Phone: 800-694-3084

Email: HSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website:
<http://www.ACCESSNebraska.ne.gov>

Phone: 855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid website: <http://dhcfp.nv.gov>

Medicaid phone: 800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>

Phone: 603-271-5218

Toll-free number for the HIPP program:
800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP

Medicaid website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>

Medicaid phone: 609-631-2392

CHIP website:
<http://www.njfamilycare.org/index.html>

CHIP phone: 800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/

Phone: 800-541-2831

NORTH CAROLINA – Medicaid

Website: <https://medicaid.ncdhhs.gov/>
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <https://www.hhs.nd.gov/healthcare>
Phone: 844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
Phone: 888-365-3742

OREGON – Medicaid

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
Phone: 800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: <https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx>
Phone: 800-692-7462
CHIP website: <https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx>
CHIP phone: 800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>
Phone: 855-697-4347 or
401-462-0311 (Direct Rite Share Line)

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>
Phone: 888-549-0820

SOUTH DAKOTA – Medicaid

Website: <http://dss.sd.gov>
Phone: 888-828-0059

TEXAS – Medicaid

Website: [Health Insurance Premium Payment \(HIPP\) Program | Texas Health and Human Services](https://www.healthinsurancetexas.com/HealthInsurancePremiumPayment(HIPP)Program/TexasHealthandHumanServices)
Phone: 800-440-0493

UTAH – Medicaid and CHIP

Medicaid website: <https://medicaid.utah.gov/>
CHIP website: <http://health.utah.gov/chip>
Phone: 877-543-7669

VERMONT – Medicaid

Website: <https://dvha.vermont.gov/members/medicaid/hipp-program>
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP

Websites: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>
<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>
Medicaid/CHIP phone: 800-432-5924

WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/>
Phone: 800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Websites: <https://dhhr.wv.gov/bms/>
<http://mywvhipp.com/>
Medicaid phone: 304-558-1700
CHIP toll-free phone: 855-MyWVHIPP (855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
Phone: 800-362-3002

WYOMING – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>
Phone: 800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

- ❑ U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866-444-EBSA (3272)
- ❑ U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877-267-2323, Menu Option 4, Ext. 61565¹

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

¹ OMB Control Number 1210-0137 (expires 1/31/2026)

Coverage for reconstructive breast surgery

Coverage is provided for reconstructive breast surgery as follows:

1. All stages of breast reconstruction following a mastectomy
2. Reconstruction of the other breast to produce a symmetrical appearance after mastectomy
3. Prosthetics and treatment of physical complications of all stages of mastectomy, including lymphedemas

Benefits for reconstructive breast surgery will be payable on the same basis as any other illness or injury under the Plan, including the application of appropriate coinsurance amounts.

Several states have enacted similar laws requiring coverage for treatment related to mastectomy. If the law of your state is applicable and is more generous than the federal law, your benefits will be paid in accordance with your state's law.

The Newborns' and Mothers' Health Protection Act

Under the Newborns' and Mothers' Health Protection Act, federal law sets minimum maternity hospital stays at:

1. 48 hours following a vaginal delivery, and
2. 96 hours following a Caesarean section.

However, the Plan may pay for a shorter stay if the attending provider, in consultation with the mother, decides a shorter stay is appropriate. In this case, Plan coverage also includes one home visit for post-delivery care.

Home post-delivery care is defined as health care provided to a woman at her residence by a physician, registered nurse or certified nurse midwife. The healthcare services provided must include, at a minimum:

1. Parent education
2. Assistance and training in breast or bottle feeding, and
3. Performance of necessary and appropriate clinical tests

Any subsequent home visits must be clinically necessary and provided by a licensed healthcare provider.

If the services are not covered by Medicare, you must notify Wellpoint if your inpatient maternity stay is longer than two days for vaginal delivery or four days for Caesarian. Please call Wellpoint Member Services at 800-442-9300 if you have questions.

Member rights and responsibilities (Carelon Behavioral Health)

Your behavioral health benefits are administered by Wellpoint in partnership with Carelon Behavioral Health. Carelon maintains contracts with behavioral health providers as well as providing some other administrative services like case management. This section outlines your member rights and responsibilities for services provided by Carelon.

Member rights

Company and provider information

- ☐ You have the right to receive information about Carelon's services, benefits, practitioners, providers, member rights and responsibilities and clinical guidelines.

Respect

- ☐ You have the right to be treated with respect, dignity and privacy regardless of race, gender, veteran status, religion, marital status, national origin, physical disabilities, mental disabilities, age, sexual orientation, or ancestry.
- ☐ You have a right to receive information in a manner and format that is understandable and appropriate. You have the right to oral interpretation services free of charge for any Carelon materials in any language.
- ☐ You have the right to be free from restraint and seclusion as a means of coercion, discipline, convenience, or retaliation.

Member input

- ☐ You have the right to have anyone you choose speak for you in your contacts with Carelon. You have the right to decide who will make medical decisions for you if you cannot make them. You have the right to refuse treatment, to the extent allowed by the law.
- ☐ You have the right to be a part of decisions that are made about plans for your care. You have the right to talk with your provider about the best treatment options for your condition, regardless of the cost of such care, or benefit coverage.
- ☐ You have the right to obtain information regarding your own treatment record with signed consent in a timely manner and have the right to request an amendment or correction be made to your medical records.
- ☐ You have the right to a copy of your rights and responsibilities. You have a right to tell Carelon what you think your rights and responsibilities as a member should be.
- ☐ You have the right to exercise these rights without having your treatment adversely affected in any way.

Complaints

- ☐ You have the right to make complaints (verbally or in writing) about Carelon staff, services or the care given by providers.
- ☐ You have a right to appeal if you disagree with a decision made by Carelon about your care. Carelon administers your appeal rights as stipulated under your benefit plan.

Confidentiality

- ☐ You have the right to have all communication regarding your health information kept confidential by Carelon and Wellpoint staff and by contracted providers and practitioners, to the extent required by law.

Access to care, services and benefits

- ☐ You have the right to know about covered services, benefits, and decisions about healthcare payment with your plan, and how to seek these services. You have the right to receive timely care consistent with your need for care.

Claims and billing

- ☐ You have the right to know the facts about any charge or bill you receive.

Member responsibilities

- ☐ You have the responsibility to provide information, to the best of your ability, that Carelon or your provider may need to plan your treatment.
- ☐ You have the responsibility to learn about your condition and work with your provider to develop a plan for your care. You have the responsibility to follow the plans and instructions for care you have agreed to with your provider.
- ☐ You are responsible for understanding your benefits, what's covered and what's not covered. You are responsible for understanding that you may be responsible for payment of services you receive that are not included in the covered services list for your coverage type.
- ☐ You have the responsibility to notify the GIC and your provider of changes such as address changes, phone number change, or change in insurance.
- ☐ If required by your benefit, you are responsible for choosing a primary care provider and site for the coordination of all your medical care.
- ☐ You are responsible for contacting your behavioral health provider, if you have one, if you are experiencing a mental health or substance use emergency.

Carelon Behavioral Health's *Member Rights and Responsibilities* is available in both English and Spanish from Carelon's website (www.carelonbehavioralhealth.com). You can also request a copy by calling Carelon at 888-204-5581 (TTY: 711).

Right of reimbursement (subrogation)

These provisions apply when Wellpoint pays benefits as a result of injuries or illnesses you or your dependent (hereafter “you”) sustained and you have a right to a recovery or have received a recovery from any source. A “recovery” includes, but is not limited to, monies received from any person or party, any person’s or party’s liability insurance, uninsured/underinsured motorist proceeds, worker’s compensation insurance or fund, “no-fault” insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements or court orders characterize, allocate, or designate the money you receive as a recovery, it shall be subject to these provisions. Wellpoint’s rights of subrogation and reimbursement are not subject to application of the made whole or common fund doctrines and Wellpoint’s rights will not be reduced due to your negligence.

Subrogation

Wellpoint is subrogated to your rights of recovery and has the right to recover payments it makes from any party responsible for compensating you for your illnesses or injuries. Wellpoint has the right to take whatever legal action it sees fit against such party to recover the benefits it has paid. Wellpoint’s subrogation claim shall be first satisfied before any part of a recovery is applied to your claim, attorney fees, other expenses/costs.

Reimbursement

Wellpoint has the right to be reimbursed from any recovery you receive in the amount of benefits paid on your behalf. This right of reimbursement will be considered a priority lien by agreement against any recovery. You will not have to reimburse Wellpoint for any more than the amount Wellpoint paid in benefits.

Your Duties

You and your legal representative must do whatever is necessary to enable Wellpoint, or its designee, to exercise its rights and will do nothing to prejudice those rights. You must cooperate with Wellpoint in the investigation, settlement and protection of its rights.

You agree to promptly notify Wellpoint of any pursuit of a recovery (filing a lawsuit or otherwise), your retention of a legal representative (if applicable), and the occurrence of a settlement or verdict. You and your legal representative acknowledge that Wellpoint’s lien is automatically created by the terms of this handbook, any recovery will be held in trust, and Wellpoint shall be immediately repaid from the recovery in the amount of the benefits paid on your behalf.

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Notes

Notes

To find out about ...

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| How costs and billing work | Chapter 2 |
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