



Member Handbook

Medicare Extension Plan

For Medicare retirees





Welcome

Medicare Extension plan members

Effective July 1, 2026–June 30, 2027



You are covered under the Wellpoint Medicare Extension plan

The Medicare Extension plan supplements your Medicare benefits by providing you with comprehensive coverage, which includes hospital stays, surgery, emergency care, preventive care, outpatient services, and other medically necessary treatment. The plan covers services from any care provider, but benefits can be different depending on the service, and on the provider you use.

Keep in mind:

- Benefits can differ based on the service and the care provider.
- Not all services are covered.
- Services are covered only when they're needed to take care of your health (medically necessary).

Your benefits are provided through the GIC

The Group Insurance Commission (GIC) is the state agency responsible for benefits for employees and retirees of the state, certain municipalities, and other government entities. The GIC determines who is eligible for its plans. The plan is funded by the Commonwealth of Massachusetts and administered by Wellpoint. Wellpoint is not the fiduciary or the insurer of the Medicare Extension 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 separate Medicare Part D plan. This plan includes Medicare Part D coverage. If you enroll in another Part D plan, the Centers for Medicare and Medicaid Services (CMS) will disenroll you from your GIC coverage. If that happens, you'll lose your GIC health, behavioral health, and prescription drug benefits.

Language interpretation/translation services are available

If you need help with language interpretation or translation, call Member Services. A Wellpoint Health Guide will connect you with an interpreter to translate your conversation in real time. 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.

Important terms to know

Your member costs are lower when you use care providers that have an agreement with Medicare about what they charge for healthcare services.

Important! In this handbook, care providers who have an agreement with Medicare are called **Preferred care providers**.



What is a Preferred provider?

In this handbook, care providers who have an agreement with Medicare are called **Preferred care providers**.

For medical services

- **Preferred care providers** are doctors, hospitals, or other healthcare providers that participate or opt in to Medicare. They are also known as in-network or contracted providers, and you may see these terms used on wellpointmass.com.
- **Nonpreferred care providers** are those that do not participate or opt in to Medicare. They are also known as out-of-network or noncontracted providers. If you use a Nonpreferred medical care provider, your out-of-pocket costs may be higher than if you use a Preferred care provider. This may not apply to every service. Please check the benefit sections in this handbook for details.
- **Balance billing** is when a care provider bills you for the difference between what they charge and what your health plan allows (the allowed amount).
 - **In Massachusetts:** Members cannot be balance billed for medical services.
 - **Outside Massachusetts:** Members may be balance billed for medical services.

Table 1. Location of care cost differences

Location of care	Care provider type	Member cost difference
In or outside Massachusetts	Preferred care provider (providers who participate in Medicare)	Covered, no cost difference
In or outside Massachusetts	Nonpreferred care provider (providers who do not participate in Medicare)	Covered, but at a higher cost to the member

For behavioral health services

- **Preferred (or in-network or contracted) behavioral health care providers** participate or opt in to Medicare. They are also known as in-network or contracted providers, and you may see these terms used on [wellpointmass.com](https://www.wellpointmass.com). Preferred behavioral health care providers won't balance bill you.
- **Nonpreferred (or out-of-network or noncontracted) behavioral health care providers** are those that do not participate or opt in to Medicare. Your plan will pay the allowed amount for covered services, and a Nonpreferred behavioral health care provider may balance bill you for the rest.
- Balance billing is when a care provider bills you for the difference between what they charge and what your health plan allows (the allowed amount).
 - **In Massachusetts:** Members cannot be balance billed for behavioral health services from Preferred facilities or Preferred care providers. Members cannot be balance billed for supplies from any Preferred supplier, or for emergency behavioral health care from any care provider.
 - **Outside Massachusetts:** Members may be balance billed for behavioral health services from Nonpreferred behavioral health care providers.

Important contacts

Medical and behavioral health care coverage

Wellpoint

Contact Wellpoint 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 care provider
- Chapters 1–11 of this handbook

Wellpoint Member Services:

- **Phone: 800-442-9300/TTY: 711** (toll-free)
Monday through Thursday, 7:30 a.m.–6 p.m.;
Friday, 7:30 a.m.–5 p.m.
If you call after business hours, leave a message. Member Services will return your call the next business day.
- **Email:**
contact.ma@wellpoint.com
- **Website:**
wellpointmass.com

Prescription drug coverage

SilverScript

Contact SilverScript, an affiliate of CVS Caremark, for questions about:

- Benefits for a prescription drug
- Status of a prescription drug claim
- Where to get prescriptions filled
- Which drugs are covered
- Chapter 12 of this handbook

CVS Caremark Customer Service:

- **Phone: 877-876-7214** (toll-free)
- **Website:**
gic.silverscript.com



For questions about enrollment, go to mass.gov/forms/contact-the-gic and fill out the GIC online contact form.

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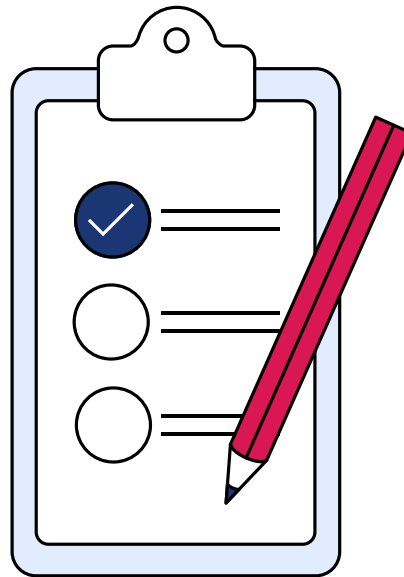
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Getting started

What to know to begin using your plan



**For questions about information in Chapters 1-3 of this handbook,
please call Wellpoint Member Services at 800-442-9300.**



Chapter 1: Getting started with your plan

About this handbook

This handbook looks at features and coverage for medical or general healthcare, behavioral health care, and prescription drugs.

- **Medical services** are administered by Wellpoint.
- **Behavioral health services** are administered by Wellpoint in partnership with Carelon behavioral health. These benefits cover services for mental health and substance use disorder.
- **Prescription drugs** are separately administered by SilverScript.

Important! This handbook is not a description of your Medicare benefits. For more information, visit [medicare.gov/medicare-and-you](https://www.medicare.gov/medicare-and-you) for the Medicare & You handbook, or it's also available from your local Social Security office.

A note about terms and definitions

You can find definitions for many terms used in this handbook in Chapter 11. Also keep in mind:

- In this handbook and other plan materials, we may refer to your Wellpoint health plan as **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 services to treat medical (physical) conditions. **Behavioral health services** are services to treat mental health and substance use disorder conditions. When we're talking about both types of services together, we usually call them **healthcare services**.
- Medical services from care providers in the state of Massachusetts are covered at the highest (Preferred) benefit level. (This does not apply to behavioral health services.)

Symbols used in this handbook

Table 2. What the handbook symbols mean

Icon/treatment	Meaning
Important!	Important information — this may affect your benefits or costs.
⊗	No coverage, limited coverage, or benefit restriction — Chapter 7 includes a full list of plan exclusions and limitations.
⚠	May need preapproval review — this service may need review to determine if it is eligible for benefits. Check Chapter 3.
☑	Use Medicare-participating or Preferred care providers and suppliers — to get the best benefit, use a Medicare-participating care provider or supplier for this service or product. Find Medicare-participating providers at medicare.gov . If no Medicare-participating care providers are available, find Preferred care providers at wellpointmass.com .

Do you have other health insurance?

If you or one of your dependents has health coverage from a different insurer than Wellpoint, you may need to send us an Other Health Insurance (OHI) form. Wellpoint needs this information to coordinate your benefits with other plans. To learn more about how this works, turn to “Coordination of benefits with other health plans” in Chapter 9.

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
- You have other coverage but it's from Medicare
- You've already submitted an OHI form and your information hasn't changed

You do need to submit an OHI form if:

- You're covered under another health plan that isn't Medicare
- You haven't submitted an OHI form before or you need to update your information


Your member ID card

Each member will get a Wellpoint member ID card. Your ID card lists key telephone numbers and information about your benefits.

- Order replacement ID cards through the member portal at wellpointmass.com.
- Access a digital member ID card in the **Sydney® Health** app. Go to sydneyhealth.com to download the app.

Your prescription drug card is separate. SilverScript will send it. Call SilverScript at **877-876-7214** if you have questions.

Preapproval for certain services

We review certain services ahead of time to make sure they are safe and appropriate. This is called **preapproval** or **preauthorization**. Services that need preapproval from Wellpoint are marked with a **caution icon** . For those services to be covered, your care provider must notify Wellpoint in advance. For more about preapprovals, check Chapter 3.

Getting the most from your plan

Your GIC plan gives you access to quality, cost-effective care. To get even more from your plan, follow these tips.

Keep costs down by using Preferred care providers

Use Medicare-participating care providers and suppliers for the best benefit. These providers have agreed to accept Medicare's payment as payment in full for covered medical services and supplies. Look for Medicare suppliers at medicare.gov.

Choose Preferred care providers and suppliers

If you can't find a Medicare provider for the services, supplies, or equipment you need, choose a Preferred provider. These providers accept the plan's payment as payment in full and won't bill you for the rest. Find Preferred care providers at wellpointmass.com.

Important! Medical services from care providers in the state of Massachusetts are covered at the highest (Preferred) benefit level. (This does not apply to behavioral health services.)

Know before you go

Learn the difference between preventive and diagnostic care. Preventive services don't include treating health conditions you already have. If you have diagnostic services during a preventive visit with your doctor, you may owe member costs. Learn about your preventive benefits in Chapter 6.

Choose your urgent care center ahead of time. Urgent care centers (and ambulatory surgery centers) may bill as hospitals if they're hospital owned. That can cost you more. If you aren't sure, ask how they'll bill your visit.

If you need care quickly and it isn't a medical emergency, 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, your copay is \$50.



A note about networks

In this handbook, we use the term “in network” for care providers and suppliers who accept your plan's payment as payment in full for services, supplies, and equipment. This means they won't bill you for anything above what your plan pays them.

In Massachusetts: You can see any care provider in Massachusetts for medical care, and they won't bill you for anything above what your plan pays. This isn't a formal network, but they accept your plan's payment as payment in full.

Outside Massachusetts: Use in-network suppliers and care providers. They won't bill you for anything above your plan's payment.

Getting care outside of Massachusetts

When you're out of state, visit Preferred care providers. Make sure out-of-state dependents do too. These care providers have agreed to accept Wellpoint's payment as payment in full — they won't bill you for the rest. Confirm care providers are in your plan's network ahead of time. Care provider status can change at any time. Find Preferred care providers at [wellpointmass.com](https://www.wellpointmass.com).

Chapter 2: Costs and billing

The basics

Medical bills can be hard to understand. What was covered? Has insurance paid? How much do you owe? Here are a few things to know about your medical bills.

A single appointment can include many medical services

If you visit your doctor for a tetanus shot, for example, you'll find a list of charges on the bill:

- The office visit with your doctor
- The service of administering the vaccine (giving you the injection)
- The material used in the injection (tetanus serum, in this case)

This is how medical billing works. Each part of a visit has a unique code, and medical bills list them separately.

Not all services are covered by insurance

Health insurance covers, or pays for, services you need to take care of your health. These are called **medically necessary** services. Other services aren't covered by insurance. Most insurance plans have a list of services that are **excluded** (never covered). For example, cosmetic treatments aren't covered because they aren't medically necessary most of the time. You can find the list of excluded or limited services in Chapter 7.

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 won't 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 and you'll lose your GIC health, behavioral health, and prescription drug benefits.

What the Medicare Extension plan covers

Medicare Extension covers all or part of the costs that Medicare does not pay for covered services. For example, if Medicare pays 80% of a claim, the Medicare Extension plan will pay some or all of the remaining 20%. Medicare Part A provides benefits for hospital services, and Medicare Part B provides benefits for physician and some other care provider services. The Medicare Extension plan also covers the Medicare Part A inpatient deductible, the Part B deductible, and Part B coinsurance. Medicare Extension covers some services that Medicare doesn't cover, like immunizations and hearing aids.

How benefits are determined between Medicare and Medicare Extension

- Your plan only pays for services that are covered under Medicare or the Medicare Extension plan.
- The maximum amount that can be paid is the Medicare-approved amount, or Wellpoint's allowed amount if the service isn't covered by Medicare.
- We subtract any Medicare payments from the original amount of the claim, then apply Medicare Extension benefits to any remaining claim balance.

Allowed amounts and Medicare-approved amounts

Medicare sets an allowed cost for each covered service. Even if your doctor charges more, Medicare won't pay more than the allowed cost. If Medicare covers 80% of a service, that means 80% of the allowed cost Medicare approved.

Wellpoint also sets an allowed amount for each service that it covers. For services covered by Medicare, Wellpoint's allowed amount matches the Medicare-approved amount.

Important! 100% coverage means 100% of the allowed amount, not 100% of the bill.

Some care providers take the allowed amount as their full payment, and some don't

Care providers and suppliers that have agreed to accept your plan's allowed amount as payment in full are called Preferred providers. Nonpreferred care providers are those who haven't agreed to your plan's allowed amounts. They can bill you for the difference between what they charge and what your plan paid. This is called **balance billing** or **surprise billing**. In the pages ahead, you'll find more information about surprise medical bills.

Who pays what?

In the example of the tetanus shot, your plan pays the allowed amount. You also may owe a fee, called a **copay**, at the doctor's office. When you pay something toward your healthcare services, that's known as **cost sharing**.

Member costs (out-of-pocket costs)

Costs you pay toward your medical bills are your **member costs**. They're also called **out-of-pocket costs**, **member share**, or **cost sharing**.

Table 3. Types of member costs

Member cost	Definition
Copay	A fixed fee you pay for each visit, service, or prescription
Coinsurance	A percentage of the cost of a service; for example, your plan pays 80%, and the other 20% is your coinsurance

There is a limit on member costs. An **out-of-pocket maximum** caps how much you'll spend each plan year on the combination of copays and coinsurance.

How member costs work

Medicare pays its portion of your claims first. Then, because you are in Wellpoint's Medicare Extension plan, the rest of the claim balance is sent to Wellpoint. If you owe any member costs after a medical visit, we'll send you an Explanation of Benefits (EOB). An EOB shows how the claim was paid and what costs you owe.

Here is how we pay claims:

1. Start with the allowed amount for the claim.
2. Subtract any member costs from the allowed amount. First the copay (if any), then the coinsurance amount (if any).
3. Wellpoint sends payment to your care provider.
4. The care provider bills you for the member costs we subtracted from their payment. (If you had any services that weren't covered, the care provider's bill may include those charges too.)

Wellpoint processes claims as they come in, so claims may not be paid in the same order you got the services.

How the providers you choose affect your costs

You may owe different amounts for the same services, depending on a provider's payment arrangement with Medicare.

Medicare-enrolled providers are those that accept Medicare payments.

Medicare-participating providers are sometimes referred to as providers who accept "Medicare assignment," because they allow Medicare to assign each service's cost. These providers accept Medicare's payment for covered services as payment in full.

Medicare-nonparticipating providers have not allowed Medicare to assign the costs of their services. They might charge more than the Medicare-approved amount, and you're responsible for the additional cost.

Private contract providers don't do any business with Medicare. Medicare doesn't cover any services from these providers, so they'll have you sign an Advance Beneficiary Notice of Noncoverage (ABN) contract to pay for the services yourself.

Important! If you visit a private contract provider for a Medicare-covered service, your Wellpoint Medicare Extension 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 about how Medicare pays providers, check the Medicare & You handbook and other Medicare publications, available at [medicare.gov](https://www.medicare.gov).

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

Table 4. How Medicare-provider arrangements affect benefits

Type of provider	Claim amount	Allowed amount	Medicare pays	Wellpoint pays	You owe
Medicare-participating providers (accept Medicare assignment)	\$150	\$100	\$80	\$20	\$0
Medicare-nonparticipating providers	\$150	\$100	\$80	\$20	\$50 ¹
Private contract providers (Medicare opt-out 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.

Choosing in-network care providers and suppliers

For certain services and supplies, you get the highest benefit when you use a provider or supplier that is contracted with or in network with your health plan. For the Wellpoint Medicare Extension plan, these are Medicare suppliers, Wellpoint-contracted suppliers, or both that provide one or more of the following services and supplies:

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

You get the highest benefit for these services 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, look for a supplier contracted or in network with Wellpoint.

In-network suppliers are covered at 100% of the allowed amount. For other suppliers, the plan covers 80% of the allowed amount, and you owe the remaining 20% coinsurance. This is true even when the item or service isn't available from an in-network or contracted supplier. If you live outside Massachusetts, contracted suppliers won't balance bill you for charges over the allowed amount, but other suppliers might.

Find in-network 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.

Copays

What is a copay?

A **copay** is a member cost you owe at the time you get a service. For example, you pay a copay when you visit your doctor for a sore throat, when you have outpatient surgery, or when you're admitted to a hospital. You have copays for some medical services and for some behavioral health services. Services that have copays include:

- Doctor visits, in person or through virtual care
- Urgent care centers and retail health clinic visits
- Routine eye exams

- Emergency room (ER) visits
- Behavioral health outpatient services

Which services have copays?

Care provider visits

You owe a copay for each in-person or virtual care visit (telehealth) with a care provider at a medical practice or clinic, including urgent care centers and retail clinics. The dollar amount of the copay depends on the type of facility you use and whether you visit a primary care provider (PCP) or a specialist.

- A **PCP (primary care provider)** can be a nurse practitioner, physician assistant, or physician whose specialty is family medicine, general medicine, pediatrics, geriatrics, or internal medicine.
- A **specialist (specialty care provider)** can be a nurse practitioner, physician assistant, or physician. You owe the specialist copay whether you visit for primary care or specialty care services.

ER visits

You owe an ER copay each time you go. If you're admitted to the hospital from the ER, the ER copay is waived.

Outpatient behavioral health services

You owe a per-visit copay for many outpatient services when you use behavioral health care providers contracted with Carelon (a Wellpoint-affiliated company). You don't owe a copay to visit a Nonpreferred behavioral health care provider, but you'll owe 20% coinsurance. Also, Nonpreferred care providers may bill you for charges that are over the allowed amount (balance billing).

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%. Coinsurance applies to any balance left after Medicare processes your claim — this applies to all member costs.

Out-of-pocket (OOP) maximums

There is a limit on member costs toward covered services. An **out-of-pocket (OOP) maximum** caps how much you'll spend each year on the combination of copays and coinsurance. Once you reach the OOP maximum, your plan pays 100% of the allowed amounts for services for the rest of the year.

Your Medicare Extension plan has three separate out-of-pocket maximums:

- A coinsurance OOP maximum for medical services
- An OOP maximum for services from in-network behavioral health care providers
- An OOP maximum for services from out-of-network behavioral health care providers

Table 5. Your OOP maximums

Out-of-pocket maximum	Amount
Coinsurance limit	\$500
OOP max with in-network behavioral health providers	\$1,000
OOP max with out-of-network behavioral health providers	\$3,000

These costs **do not** count toward your OOP maximums:

- Prescription drug costs.
- Premiums.
- Balance bills (charges over the plan’s allowed amounts). Check “Your rights and protections against surprise medical bills” for information about balance billing protection.
- Costs for healthcare services your plan doesn’t cover.



Questions?

Contact Member Services at **800-442-9300** for help finding a Preferred care provider, so you get the most from your Wellpoint plan.

Your rights and protections against surprise medical bills

When you visit a doctor or other care provider, you may owe out-of-pocket costs like a copay, coinsurance, or deductible. If you visit a Nonpreferred care provider, you might owe more.

Nonpreferred doctors and facilities can bill you for the difference between their charges for a service and Wellpoint’s allowed amount. This is called **balance billing**. Balance bills from Nonpreferred care providers don’t count toward your out-of-pocket maximum.

Surprise billing is a balance bill you didn’t expect. This can happen when you can’t control who is involved in your care — like when you have an emergency or when you schedule a visit at a Preferred facility but you’re unexpectedly treated by a Nonpreferred doctor.

Protections against surprise billing

You're protected from receiving surprise bills — balance bills that you don't expect — under some circumstances.

- **Emergency services in Massachusetts and elsewhere:** No care provider can balance bill for medical or behavioral health emergency services, by federal law. This applies to Preferred and Nonpreferred care providers.
- **Medical services in Massachusetts:** No medical care provider in Massachusetts can balance bill Wellpoint members, by state law.
- **Medical services outside Massachusetts:** No care provider can balance bill for services you have at a Wellpoint-contracted facility. Some care providers at these facilities may be Nonpreferred, but by federal law they can't balance bill you.
- **Behavioral health services in Massachusetts and elsewhere:** Behavioral health care providers contracted with Carelon won't balance bill you. Nonpreferred behavioral health care providers might, but federal laws against surprise billing apply to medical providers and behavioral health providers alike.

If you use a Nonpreferred care provider, you could be balance billed. The balance bill is your responsibility to pay, and it doesn't count toward your out-of-pocket maximum. Always make sure a care provider is still Preferred before your visit because that status can change.

Important! You **never** have to give up your protection from balance billing, and you **never** have to get care from Nonpreferred doctors or facilities.

What to do if you get a surprise bill

If you get a balance bill from any of the following types of care providers and suppliers, contact Wellpoint Member Services at **800-442-9300**. These providers aren't allowed to balance bill Wellpoint members:

- Any care provider of emergency medical or emergency behavioral health care
- Any care provider at Preferred facilities
- Medical care providers in Massachusetts
- Preferred suppliers
- Preferred medical care providers outside of Massachusetts
- Preferred behavioral health care providers both in and outside of Massachusetts

Balance bills from other suppliers and care providers are your responsibility to pay. Since the plan doesn't cover balance bills and they don't count toward your out-of-pocket maximum, using from suppliers and Nonpreferred care providers can end up being very costly.

Chapter 3: Preapproval

What is preapproval?


Your plan needs to approve some services ahead of time. This is called **preapproval** (or prior authorization). Once a service is preapproved, you can be sure it's covered by your 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 covered by Medicare. Wellpoint may review services that aren't covered by Medicare, or when you've hit your Medicare benefit limit for certain services.

In most cases, care providers know to send Wellpoint the information needed. There may be times when you'll need to ask your care provider to contact Wellpoint about preapproval — for example, if you use a Nonpreferred care provider outside Massachusetts.

If you don't get preapproval for a service that needs it, your plan may not cover it. If you need help with preapproval, Wellpoint Member Services can reach out to your care provider.

Other helpful information about preapproval

- Your care provider must contact Wellpoint for preapproval before the service takes place.
- You don't need to get preapproval if you're outside the continental United States (the continental U.S. includes all states except Alaska and Hawaii).
- In this handbook, the  caution icon marks services that need preapproval.
- If you're not sure whether a service needs preapproval, ask your doctor to check the lists on the next few pages or contact Wellpoint to find out.

Who handles preapproval reviews?

Depending on the service, preapproval reviews are handled by Wellpoint, Carelon Medical Benefits Management, or CarelonRx. If you have questions or need help with preapproval review, call Wellpoint Member Services at **800-442-9300**.

Table 6. Preapproval reviewers

Medical and behavioral health reviewers	Services
Wellpoint <ul style="list-style-type: none"> • 800-442-9300/TTY: 711 (toll-free) • wellpoint.com/mass/providers/preapprovals 	Behavioral health services and some medical services

Specialty pharmacy reviewers
SilverScript <ul style="list-style-type: none"> • 800-237-2767 (toll-free) • Check the “Prescription benefits” section for more information.

Preapprovals for medical services

These are some of the types of medical services that need preapproval. This is a general list, and it could change. If you need help deciding if a service needs preapproval, contact Wellpoint Member Services at **800-442-9300**.

Examples of medical services that need preapproval

- Durable medical equipment (DME)
- Enteral and oral therapy
- Home healthcare
- Inpatient admissions
- Surgeries such as organ transplants

Preapprovals for behavioral health services

Care providers can contact Wellpoint 24 hours a day, seven days a week, for preapproval of behavioral health services. You don't need preapproval for Medicare-covered services from a care provider who participates in Medicare. Otherwise, you or your care provider must get preapproval before the service will be covered. Below are behavioral health services that need preapproval.

Table 7. Inpatient services for mental health treatment (if not covered by Medicare)

☑ Service	With Preferred care providers	With Nonpreferred care providers
<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 (TCUs) 	<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

**What is a DPH-licensed provider?**

The Massachusetts Department of Public Health (DPH) licenses healthcare facilities that meet quality and safety standards.

Table 8. Inpatient services for substance use disorders (if not covered by Medicare)

☑ Service	With Preferred care providers	With Nonpreferred care providers
<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 care providers in Massachusetts: Notify Wellpoint within 48 hours All other Nonpreferred care providers: Needs preapproval
Crisis stabilization units (CSUs)	Preapproval needed for stays over 5 days	Preapproval needed for stays over 5 days

* ASAM stands for American Society of Addiction Medicine. These are levels of criteria based on a set of guidelines that help care providers evaluate a person's needs and recommend the right level of treatment.

Table 9. Outpatient services, including office services (if not covered by Medicare)

☑ Service	With Preferred care providers	With Nonpreferred care providers
<ul style="list-style-type: none"> Acupuncture withdrawal management Community support programs (CSPs) Day treatment 	N/A	Needs preapproval
<ul style="list-style-type: none"> Applied Behavior Analysis (ABA) Dialectical behavioral therapy (DBT) Family stabilization teams (FSTs) Partial hospitalization programs (PHPs) for mental health conditions Psychiatric visiting nurse services Transcranial magnetic stimulation (TMS) 	Needs preapproval	Needs preapproval
<p>PHPs for substance use disorders (ASAM level 2.5)*</p>	<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 care providers in Massachusetts: Notify Wellpoint within 48 hours All other Nonpreferred care providers: Needs preapproval
<ul style="list-style-type: none"> Intensive outpatient programs (IOPs) Structured outpatient addiction programs (SOAPs) 	<ul style="list-style-type: none"> Notify Wellpoint within 48 hours 	<ul style="list-style-type: none"> DPH-licensed care providers in Massachusetts: Notify Wellpoint within 48 hours All other Nonpreferred care providers: Needs preapproval

* ASAM stands for American Society of Addiction Medicine. These are levels of criteria based on a set of guidelines that help care providers evaluate a person's needs and recommend the right level of treatment.

Your benefits and coverage

What to know about your coverage for medical and behavioral health services





Benefits are administered by Wellpoint. For questions about any information in Chapters 4–6 of this handbook, please call Wellpoint Member Services at 800-442-9300.

Chapter 4: Summary of covered services

Important! Services are covered only when they're needed to take care of your health (medically necessary). Your plan covers up to the allowed amount for a service.

Table 10. Summary of your costs for covered medical and behavioral health services

Service	Member costs and benefit limits
Ambulances	No member costs
 Applied Behavior Analysis (ABA)	<ul style="list-style-type: none"> Preferred care providers — \$10 copay (no member costs first four visits) Nonpreferred care providers — 20% coinsurance for visits 1–15, 50% coinsurance for visits beyond 15
Bereavement counseling	20% coinsurance (your plan will pay up to \$1,500 for a family in a calendar year)
Cardiac rehab programs	No member costs
Chemotherapy	No member costs
Chiropractic care	No member costs (limited to 20 visits in a calendar year)
<input checked="" type="checkbox"/> Diabetic supplies	<ul style="list-style-type: none"> Preferred suppliers — no member costs (you also have a \$100 copay for the emergency room visit) Nonpreferred — 20% coinsurance
Dialysis	No member costs
Doctor visits	\$10 copay
Doctors — other services	<ul style="list-style-type: none"> At an emergency room — no member costs For inpatient hospital care — no member costs For outpatient hospital care — \$10 copay
 <input checked="" type="checkbox"/> Durable medical equipment (DME)	<ul style="list-style-type: none"> Preferred suppliers — no member costs Nonpreferred — 20% coinsurance
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 room visits	\$50 copay
Eye exams (routine)	\$10 copay (limited to one exam every 24 months)
Eyeglasses and contact lenses	No member costs (limited to the first lenses within six months of eye injury or cataract surgery)



Important! Services are covered only when they're needed to take care of your health (medically necessary). Your plan covers up to the allowed amount for a service.

Service	Member costs and benefit limits
Family planning services	No member costs
Fitness reimbursement	Your plan will reimburse (pay back) up to \$100 per member in a calendar year
Hearing aids	<ul style="list-style-type: none"> • Age 21 and younger — no member costs (your plan will pay up to \$2,000 for each impaired ear every 24 months) • Age 22 and older — no member costs (your plan will pay up to \$1,700 for each impaired ear every 24 months)
Hearing exams	\$10 copay
High-tech imaging (like MRIs or CT scans)	<ul style="list-style-type: none"> • Emergency room — no member costs • Inpatient hospital — no member costs • Outpatient hospital and non-hospital-owned facilities — no member costs
 <input checked="" type="checkbox"/> Home healthcare	<ul style="list-style-type: none"> • Preferred suppliers — no member costs • Nonpreferred suppliers — 20% coinsurance
<input checked="" type="checkbox"/> Home infusion therapy	<ul style="list-style-type: none"> • Preferred suppliers — no member costs • Nonpreferred suppliers — 20% coinsurance
Hospice care	No member costs
Immunizations (vaccines)	No member costs (but you may have costs for the office visit)
 Inpatient behavioral health care	<ul style="list-style-type: none"> • Preferred — No member costs • Nonpreferred — 20% coinsurance
 Inpatient medical care	<ul style="list-style-type: none"> • At a hospital or rehab facility in a semiprivate room — no member costs • At a hospital or rehab facility in a medically necessary private room — you pay the dollar difference between a semiprivate room and a private room
Lab services	No member costs
Medical services not listed elsewhere	20% coinsurance
Medication-assisted treatment (MAT)	No member costs

Important! Services are covered only when they're needed to take care of your health (medically necessary). Your plan covers up to the allowed amount for a service.

Service	Member costs and benefit limits
Medication management (outpatient)	Preferred — \$5 copay (no member costs first four visits) Nonpreferred — 20% coinsurance visits 1–15, then 50% coinsurance each visit after 15
Mobile Crisis Intervention (MCI)	No member costs
Nutritional counseling	No member costs
⚠ Occupational therapy	<ul style="list-style-type: none"> • If Medicare pays — no member costs • If Medicare doesn't pay — 20% coinsurance
⚠ Outpatient behavioral health office services	<ul style="list-style-type: none"> • Preferred care provider — \$10 copay (no member costs first four visits) • Nonpreferred care provider — deductible and 20% coinsurance
Outpatient behavioral health services not mentioned elsewhere	<ul style="list-style-type: none"> • Preferred — no member costs • Nonpreferred — 20% coinsurance
Outpatient hospital services not listed elsewhere	No member costs
☑ Oxygen	<ul style="list-style-type: none"> • Preferred suppliers — no member costs • Nonpreferred suppliers — 20% coinsurance
Personal Emergency Response Systems (PERS)	<ul style="list-style-type: none"> • Installation — 20% coinsurance (your plan will pay up to \$50 in a calendar year) • Rental — no member costs (your plan will pay up to \$40 each month)
Physical therapy	<ul style="list-style-type: none"> • If Medicare pays — no member costs • If Medicare doesn't pay — 20% coinsurance
Prescription drugs	SilverScript administers your benefits for prescription drugs. Benefits are described in Chapter 12. Call SilverScript at 877-876-7214 for more information.
Preventive care	No member costs. Check Table 13.
Prosthetics and orthotics	<ul style="list-style-type: none"> • Breast prosthetics — no member costs • Other prosthetics and orthotics <ul style="list-style-type: none"> – If Medicare pays — no member costs – If Medicare doesn't pay — 20% coinsurance

Important! Services are covered only when they're needed to take care of your health (medically necessary). Your plan covers up to the allowed amount for a service.

Service	Member costs and benefit limits
Radiation therapy	No member costs
Radiology (like X-rays and ultrasounds)	<ul style="list-style-type: none"> • Emergency room — no member costs • Inpatient hospital — no member costs • Outpatient hospital and non-hospital-owned facilities — no member costs
Retail health clinic visits	\$10 copay
 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 not paid by Medicare — 20% coinsurance until plan benefit limit is reached (your plan will pay up to \$13,400 each calendar year)
Speech therapy	\$20 copay
Substance use disorder assessment or referral	No member costs
Surgery	<ul style="list-style-type: none"> • In Massachusetts — no member costs • Outside Massachusetts <ul style="list-style-type: none"> – Medicare participating — no member costs – Medicare nonparticipating — 20% of the differences between the plan's allowed amount and the provider's charge
Therapy or counseling (outpatient)	<ul style="list-style-type: none"> • Preferred care provider — \$10 copay (no member costs first four visits) • Nonpreferred care provider — 20% coinsurance visits 1–15, 50% coinsurance after 15 visits
Tobacco cessation counseling	No member costs
 Transplants	<ul style="list-style-type: none"> • At a Medicare-certified transplant facility — no member costs • At other hospitals — 20% coinsurance
Urgent care center visits	\$10 copay

Important! Services are covered only when they're needed to take care of your health (medically necessary). Your plan covers up to the allowed amount for a service.

Service	Member costs and benefit limits
Virtual care (telehealth)	\$10 copay
Virtual care (telehealth) — behavioral health	<ul style="list-style-type: none"> Preferred care provider — \$10 copay (you don't owe a copay for your first three visits) Nonpreferred care provider — deductible and 20% coinsurance



Important! Coverage is subject to all plan provisions:

- Only medically necessary care is covered.
- Use Preferred care providers for more savings.
- Get preapproval when needed.
- Benefit limits apply.

For help with preapproval, call Wellpoint Member Services at **800-442-9300**.

Chapter 5: Explanation of your coverage

Your benefits for covered medical services

Important! Coverage is subject to all plan provisions: Only medically necessary care is covered. Use Preferred providers for the best benefit. Get preapproval when needed. Benefit limits apply.

Allergy shots

Allergy shots are covered. You might find separate charges on your bill for:

- Giving you the shot (administering the shot)
- The allergy serum in the shot
- The office visit when you got the shot

Important! Coinsurance applies to any balance left after Medicare processes your claim — this applies to all member costs.

Service	Member costs	Preapproval needed
Shot (injection)	No member costs	No
Allergy serum	20% coinsurance	No
Office visit	\$10 copay	No

Ambulance transportation

Ambulance transportation is covered in medical emergencies and in some nonemergency situations. Examples of emergencies are heart attack, trouble breathing, severe pain, or stroke.

In an emergency, your plan covers transportation by ground, air, or water ambulance.

⊗ Restrictions

- Ambulance must be needed for your health (medically necessary).
- Ambulance must take you to the nearest hospital that can help you.
- Air and water ambulance are covered only when ground ambulance risks your health.

Your plan doesn't cover:

- Transportation in chair cars or vans
- Transportation that's mostly for convenience
- Nonemergency ambulance transportation

Service	Member costs	Preapproval needed
Emergency transportation	\$10 copay	No

Anesthesia

Anesthesia is medicine to help with pain during surgery or other procedures. When you need it for a covered procedure, your plan covers:

- Anesthesia (the medicine)
- Administering anesthesia (giving you the medicine)

⊗ Restrictions

Your plan only covers anesthesia for covered procedures.

Important! Anesthesia for electroconvulsive therapy (ECT) is covered under your medical benefit. Other charges for ECT are covered under your behavioral health benefit.

Service	Member costs	Preapproval needed
Anesthesia and its administration	No member costs	No

Autism Spectrum Disorders (ASDs)

Your plan covers medical care for Autism Spectrum Disorders (ASDs) like any other health condition. ASDs include pervasive developmental disorders. Getting an ASD diagnosis and treatments like occupational therapy are covered medical benefits. Your plan also covers behavioral health care for ASD under your behavioral health benefit.

Cardiac rehabilitation (rehab) programs

Cardiac rehab programs help people recover from things like heart attacks, heart surgery, and procedures to open blood vessels, like angioplasty and stenting. They help improve fitness and teach how to lower the risk of future heart problems. Your plan covers cardiac rehab for the active phase of rehabilitation, which is usually three months.

Cardiac rehab must be:

- Ordered by a doctor after a cardiac event (heart attack, surgery, or procedure)
- Run by a licensed clinic or hospital
- Professionally supervised

⊗ Restrictions

- You must start the program in the first six months after your cardiac event.
- Your plan only covers one cardiac rehab program unless you have another cardiac event.
- Your plan only covers the active phase of cardiac rehab. The maintenance phase is not covered.

Service	Member costs	Preapproval needed
Cardiac rehab programs	No member costs	No

Chemotherapy

Chemotherapy is medicine that kills cancer cells. Your plan covers chemotherapy:

- By injection (a shot)
- By infusion (an IV)
- By mouth (pills, capsules, or liquids you swallow)

Service	Member costs	Preapproval needed
Outpatient chemotherapy	No member costs	No
Inpatient chemotherapy	Covered under hospital admission. Check Inpatient medical care (hospital admissions) in this chapter.	No



What is inpatient versus outpatient?

Inpatient means you stay at the hospital during your treatment. Outpatient means you only come to the hospital for treatment and you spend the night at home.

Chiropractic care

Your plan covers up to 20 visits with a chiropractor each calendar year:

- To treat neuromuscular conditions (problems with the nerves that control your muscles) or musculoskeletal conditions (problems with your bones, joints, muscles, and the tissues that connect them)
- When used short term
- When the treatment could help you have less pain or move more easily

⊗ Restrictions

Many chiropractors offer services your plan doesn't cover, including:

- Group chiropractic care
- Physical therapy from a chiropractor
- Care from a massage therapist or neuromuscular therapist
- Acupuncture, aerobic exercise, craniosacral therapy, diathermy, infrared therapy, kinetic therapy, massage therapy, microwave therapy, paraffin treatment, Rolfing therapy or structural integration, Shiatsu, sports conditioning, ultraviolet therapy, and weight training

Service	Member costs	Preapproval needed
Chiropractic care	No member costs (limited to 20 visits in a plan year)	No

Chronic pain management

Your plan covers care to help you deal with chronic pain (pain that lasts a long time) like any other health condition. Doctor visits, lab tests, physical therapy, and surgery are covered medical benefits.

Important! Your prescription drug plan from CVS covers medicine to stop an opioid overdose at no cost to you. You don't need preapproval. Check "Caremark Prescription Benefits" in Chapter 12 of this handbook to learn more.

Service	Member costs	Preapproval needed
Opioid antagonists like Narcan®	None	No

Circumcision

Circumcision (a short surgical procedure that removes the foreskin from the penis) is covered for newborn babies up to 30 days from birth.

Service	Member costs	Preapproval needed
Circumcision	Deductible	No

Cleft lip and cleft palate

Cleft lip and cleft palate are problems with the way a baby's mouth forms — they're born with an opening in their lip or the roof of their mouth. Your plan covers cleft lip and cleft palate treatment for children under 18. Your child's doctor must certify (legally confirm in writing):

- Treatment is medically necessary (needed for your child's health).
- Treatment is for cleft lip or cleft palate.

Benefits include:

- Audiology (hearing services)
- Nutrition services (help with eating)
- Oral and facial surgery to help with eating, breathing, and speaking
- Speech therapy (help with speaking)
- Follow-up care from oral surgeons and plastic surgeons

You also have these benefits if your dental plan doesn't cover them:

- Preventive dental services to help their teeth stay healthy
- Restorative dental services to make sure they can eat a healthy diet and their teeth and jaw are ready for braces if needed
- Orthodontic treatment like braces or getting the jaw ready for surgery

⊗ Restrictions

Your Wellpoint plan won't cover dental or orthodontic services that are covered by your dental plan.

Service	Member costs	Preapproval needed
Services for cleft lip and cleft palate	Varies by service (check benefits by service)	No

Clinical trials (clinical research studies)

Your plan covers care (services and items) you get as part of a qualified research study (clinical trial) of possible cancer treatments. This benefit includes:

- All covered care needed for your health condition, including donor services, as long as:
 - Care is medically necessary (needed for your health)
 - Care is covered by your plan
 - Care follows the rules of the clinical trial

- The cost (allowed amount) for any drug or device used in the trial, even if the U.S. Food and Drug Administration (FDA) hasn't approved it

Important! All the plan's rules about Preferred care providers, preapprovals, and medically necessary (needed for your health) care apply to care you get as part of a clinical trial.

⊗ **Restrictions**

- Only qualified clinical trials for cancer treatments are covered.
- There is no coverage for:
 - Services or costs that aren't otherwise covered by the plan, except as noted above.
 - Treatments or devices that aren't FDA approved, except as outlined above.
 - Nonhealthcare services that may be required as part of the clinical trial.
 - Costs of managing the research of the clinical trial.
 - Costs that wouldn't be covered for FDA-approved treatments.
 - Items, services, or costs that are paid for by the trial sponsor.
 - Costs of services that aren't consistent with widely accepted national or regional standards of care.
 - Costs of services mostly provided to gather data for the trial. These could include covered tests, measurements, or services being provided more often, with greater intensity, or for a longer time than usual.

To learn more about how Massachusetts law defines qualified clinical trials, go to Appendix B, "Massachusetts state clinical trial definition."

Dental services

Most dental care isn't covered by your Wellpoint medical plan. Some dental care may be covered in these situations:

- **Emergency treatment.** If you accidentally hurt your mouth and natural teeth, your plan may cover care that can help with pain and swelling, trauma care, and X-rays and surgeries that would normally be covered. You must be treated by a dentist in an acute care setting within 72 hours of the injury.
- **Oral surgery that isn't for your teeth.** If you need surgery to remove a tumor or you break your jaw or a bone in your face, that's covered like any other surgery.
- **Serious medical condition.** If you have a health problem like hemophilia or heart disease, it may be safer to have some dental care in a hospital, surgical day care unit, or ambulatory surgery center. Only these services are covered:
 - Removing seven or more teeth
 - Gingivectomy (surgery to remove diseased gum tissue), including osseous surgery (pocket reduction) on two or more quadrants of your gums

- Removing radicular cysts (cysts that form around the roots of damaged teeth) that involve the roots of three or more teeth
- Removing one or more teeth that are impacted (teeth that haven't grown all the way through your gums, usually because there isn't enough space)
- **Cleft lip or cleft palate.** If you don't have a dental plan that covers these services, your Wellpoint medical plan will cover these services specifically for cleft lip or cleft palate:
 - Dental services
 - Orthodontic treatment, like braces or getting the jaw ready for surgery
 - Preventive dental services to keep teeth healthy
 - Restorative dental services to make sure you can speak and eat well and you're ready for braces if you need them

⊗ Restrictions

- Services you get in a dentist's office are not covered by Wellpoint.
- Dental restoration (fixing or replacing teeth) and dental rehabilitation (a process to fix a person's teeth, jaw, and gums) are not covered.
- Your plan won't cover any facility fees, anesthesia, or other charges from dental services that aren't covered.
- Dentures are not covered.
- Dental prosthetics, like crowns, bridges, and implants, are not covered. Surgery to put in a dental prosthetic or prepare your mouth for one is not covered.
- Braces and other orthodontic treatment are not covered, even when the treatment is done to get ready for surgery.
- Temporomandibular joint (TMJ) disorder is when you have pain in your jaw or you can't move your jaw as you usually would when talking, eating, or yawning. If you have TMJ disorder, your plan covers the first medical visit to have it diagnosed, testing for the diagnosis, and medically necessary surgery.

Diabetes care

Your plan covers services to help you take care of yourself when you have:

- Type 1 or insulin-dependent diabetes (when your body doesn't make insulin)
- Type 2 diabetes (when your body stops using insulin the right way)
- Gestational diabetes (when pregnancy hormones make your body ignore insulin)

Covered services include:

- Nutritional therapy (checking your nutrition levels, setting goals, and making a personal nutrition plan)
- Outpatient self-management training (to teach you how to take care of your diabetes)
- Patient management (care providers helping you with these new skills)

Training can be in a group or individual setting. Coverage includes all educational materials for the program.

Your plan covers these services when you're first diagnosed, when you need a refresher, and when your symptoms or medications change. Your doctor must certify these services are part of your full care plan for diabetes, and that you need these services to make sure you have the skills and knowledge you need to care for yourself.

To be covered, the person training you must have experience treating diabetes. Training can be provided by:

- An education program recognized by the American Diabetes Association
- A Certified Diabetes Educator® (CDE®)

Screenings for type 2 and gestational diabetes are covered preventive care services (check Chapter 6 to learn more).

Diabetic supplies and equipment

If you have diabetes, your plan covers supplies, tests, and equipment your doctor prescribes to take care of your health. Your plan covers items like:

- Blood glucose monitors (to check your blood sugar) and test strips
- Insulin infusion devices (insulin pumps) and all related supplies
- Lab tests to check urine, cholesterol, and HbA1C, which shows your average blood sugar over time
- Lancets (small needles) and lancet devices (pen-like tools to draw a small drop of blood)
- Syringes (needles to inject insulin) and tools to help you inject yourself
- Therapeutic shoes (special shoes that allow good blood flow and protect feet from blisters or sores that may not heal well for people with diabetes)
- Urine test strips
- Tools for people who are legally blind or visually impaired, like items to help measure insulin and give it to themselves, and blood sugar monitors that speak step-by-step instructions and test results

Drugs you take for your diabetes, like insulin, are covered under your prescription drug plan. Also, your prescription drug plan may cover diabetic supplies you buy at a pharmacy. Check Chapter 12 of this handbook to learn more.

⊗ Restrictions

- Your plan covers one pair of therapeutic shoes each plan year.
- Shoes you buy to wear after foot surgery or to fit orthotics (splints or pads to support your feet) are not covered.
- Even when you can't get the supplies you need from a Preferred supplier, items you buy from Nonpreferred suppliers are covered at 80%. There is no coverage exception for when items are out of stock from Preferred suppliers.

Use Medicare-participating care providers and suppliers for the best benefit. These providers have agreed to accept Medicare's payment as payment in full for covered medical services, supplies, and equipment. Look for Medicare suppliers at [medicare.gov](https://www.medicare.gov).

Save with Preferred care providers and suppliers. If you can't find a Medicare provider for the services, supplies, or equipment you need, choose a Preferred care provider. These providers accept the plan's payment as payment in full and won't bill you for the rest. Find Preferred care providers at [wellpointmass.com](https://www.wellpointmass.com).

Important! Coinsurance applies to any balance left after Medicare processes your claim — this applies to all member costs.

Service	Member costs	Preapproval needed
Diabetic supplies and equipment from Preferred suppliers	No member costs	Yes, if not covered by Medicare
Diabetic supplies and equipment from Nonpreferred suppliers	20% coinsurance (your plan pays 80% of the allowed amount)	Yes, if not covered by Medicare

Dialysis

Your plan covers dialysis treatment, to filter your blood when your kidneys can't. Both hemodialysis (using a machine to filter blood outside your body) and peritoneal dialysis (using the lining of your abdomen to filter blood inside your body) are covered.

⊗ Restrictions

Hemodialysis to treat a behavioral health condition is not covered.

Service	Member costs	Preapproval needed
Dialysis	No member costs	No

Doctor services (and services from other medical care providers)

Your plan covers medically necessary care (services that are needed for your health) from licensed medical care providers. Visits can be in person or through virtual care (telehealth).

Covered care providers include:

- Certified nurse midwives
- Chiropractors
- Dentists
- Nurse practitioners
- Optometrists
- Physician assistants
- Physicians
- Podiatrists

⊗ Restrictions

- Services must be medically necessary (needed for your health).
- Medical care providers must be licensed.
- Services must be within the scope of the care provider’s license or certification. This means you can’t have a dentist deliver your baby or get stitches from your chiropractor.
- Your plan won’t pay for a care provider to be waiting in case they are needed. It only pays for actual services.
- In-person care must be provided in one of these settings:
 - Medical facility (hospital, clinic, professional office, long-term care)
 - Home care

Service	Member costs	Preapproval needed
Office visits in person or through virtual care (telehealth)	\$10 copay	No
Doctor services at an emergency room	No member costs	No
Doctor services for inpatient hospital care	No member costs	Yes, if not covered by Medicare
Doctor services for outpatient hospital care	\$10 copay	No

Durable medical equipment (DME)

Durable medical equipment (DME) are items your doctor prescribes for you to use daily or for a longer time. These can be things like wheelchairs, crutches, continuous positive airway pressure (CPAP) machines and supplies, oxygen tanks and tubing, walkers, blood sugar monitors, and hospital beds.

Your plan covers DME when it meets all these requirements:

1. It's medically necessary (needed for your health) and ordered by a doctor.
2. It's prescribed to help with an injury or health condition, including pregnancy.
3. It's meant to help with healing or to help your body work better.
4. It can be used over and over.
5. It comes from a DME supplier.

Your plan covers renting or buying DME, depending on the item, how you use it, and the cost.

⊗ Restrictions

- The 20% coinsurance for DME from noncontracted suppliers doesn't count toward your coinsurance limit.
- Your plan does not cover:
 - Equipment for recreation, like sports wheelchairs or exercise equipment
 - Items to help control your environment, like air cleaners and dehumidifiers
 - Items to change your home, like electronic door openers, elevators, ramps, or stairway lifts
 - Added features or accessories, like wheelchair customizations, systems to secure wheelchairs in moving vehicles, or hand controls for driving
 - Items meant to be used outdoors, like hiking equipment or special wheelchairs for the beach
 - Backup items, like a manual wheelchair in case of a problem with your powered wheelchair
 - Upgrades and replacements for items that still work or could be repaired
 - Items you could buy without a prescription, like air conditioners, arch supports, bedpans, blood pressure cuffs, commodes, computer-assisted communications devices, corrective shoes, heating pads, hot water bottles, incontinence supplies, lift or riser chairs, beds that aren't hospital beds, orthopedic mattresses, shower chairs, telephones, televisions, thermal therapy devices, and whirlpools
 - Rental charges above the cost to buy the item
 - More than four pairs of compression stockings in 365 days
- Preapproval is needed for anything not covered by Medicare. You need preapproval for bilevel positive airway pressure (BPAP) and continuous positive airway pressure (CPAP) equipment, and for other items costing more than \$1,000 (except oxygen and oxygen equipment).

- Even when you can't get the supplies you need from a Preferred supplier, items you buy from Nonpreferred suppliers are covered at 80%. There is no coverage exception for when items are out of stock from Preferred suppliers.

⚠️ Preapproval needed for services, items, and equipment not covered by Medicare. For help with preapprovals 24 hours a day, seven days a week, your care provider should call Wellpoint at **800-442-9300** (TTY: 711).



Need help with preapproval?

For help with preapproval, call Wellpoint Member Services at **800-442-9300**.

- For the best benefit, use Medicare care providers and suppliers. Find one at [medicare.gov](https://www.medicare.gov).
- Search for a Wellpoint care provider or supplier at [wellpointmass.com](https://www.wellpointmass.com), if no Medicare provider is available.

Important! Coinsurance applies to any balance left after Medicare processes your claim — this applies to all member costs.

Service	Member costs	Preapproval needed
⚠️ <input checked="" type="checkbox"/> Durable medical equipment (DME)	<ul style="list-style-type: none"> • Preferred suppliers — no member costs • Nonpreferred suppliers — 20% coinsurance 	Yes, for items not covered by Medicare

Early intervention programs

Babies and young children with disabilities or developmental delays can get help from early intervention programs. When needed for a baby's or child's health (medically necessary), your plan covers early intervention services from birth until the child's third birthday. Early intervention includes:

- Occupational therapy
- Physical therapy
- Speech therapy
- Nursing care
- Psychological counseling

- For the best benefit, use Medicare care providers and suppliers. Find one at [medicare.gov](https://www.medicare.gov).
- Search for a Wellpoint care provider or supplier at [wellpointmass.com](https://www.wellpointmass.com), if no Medicare provider is available.

⊗ Restrictions

- Early intervention services must be provided by licensed or certified care providers.
- Early intervention programs must be approved by the Massachusetts Department of Public Health or under a similar law in other states.

Service	Member costs	Preapproval needed
Early intervention programs	No member costs (your plan will pay up to \$5,200 for each child in a calendar year, with a lifetime limit of \$15,600 for each child)	Yes, if not covered by Medicare

Emergency care and urgent care

Your plan covers emergency care and urgent care services.

In a medical or behavioral health emergency, go to the nearest emergency room (ER) or call **911** (or the local emergency services number). Keep emergency numbers and your doctors' phone numbers in a place that's easy to reach.

Emergency care or urgent care?

An **emergency** is a sudden illness or health problem that needs attention right away. It could put a person's life or health in danger if they don't get help quickly.

A person needs emergency care if their health problem could cause:

- Serious harm to their physical or mental health
- Serious harm to the way their body works, or to any body part or organ
- Serious harm to the health or safety of their unborn child, if they are pregnant

Urgent care services are for when you need help right away but your health isn't in serious danger. Look for urgent care centers that are not connected to or part of a hospital — your member costs are lower if you go to a walk-in urgent care center rather than the hospital emergency department. Check the "Walk-in clinics" entry later in this section to learn more.

Examples of where to go for certain types of care

Emergency room

- Severe pain
- Broken bones
- Losing consciousness (passing out)
- Vomiting blood
- Chest pain
- Problems breathing
- Any health problem that's getting worse quickly

Urgent care

- Animal bites
- Stitches
- X-rays or lab tests
- Eye swelling, pain, or redness
- Nausea, vomiting, or diarrhea
- Mild headache
- Burning when you urinate

⊗ Restrictions

When you get nonemergency care from the ER or urgent care, each service is covered under its own benefit. For example, a nonemergency X-ray is covered under the benefit for radiology, described later in this section.


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

Service	Member costs	Preapproval needed
Emergency care from hospital emergency room	\$50 copay (waived if you're admitted to the hospital)	No, but call Wellpoint Member Services if you're admitted to the hospital
Retail health clinic or medical practice visits	\$10 copay	No
Urgent care center visits	\$10 copay	No

Enteral and oral therapy

Your plan covers prescription and nonprescription nutrition formulas when ordered by your care provider to take care of your health.

Enteral therapy is nutrition taken through a tube into your stomach or intestines. Oral therapy is nutrition taken by mouth.

 **Enteral and oral therapies need preapproval if not covered by Medicare.** For help with preapprovals 24 hours a day, seven days a week, your care provider should call Wellpoint at **800-442-9300** (TTY: 711).


For the best benefit, use Medicare care providers and suppliers. Find one at [medicare.gov](https://www.medicare.gov).

Search for a Wellpoint care provider or supplier at [wellpointmass.com](https://www.wellpointmass.com), if no Medicare provider is available.

Important! Coinsurance applies to any balance left after Medicare processes your claim — this applies to all member costs.

Restrictions

- The 20% coinsurance for enteral and oral therapy from Nonpreferred suppliers doesn't count toward your coinsurance limit.
- Coinsurance applies to any balance left after Medicare processes your claim — this applies to all member costs.
- Enteral and oral formulas must be medically necessary (needed for your health) and ordered by a care provider to treat health conditions like Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal (GI) motility issues, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

Service	Member costs	Preapproval needed
 <input checked="" type="checkbox"/> Enteral and oral therapy	<ul style="list-style-type: none"> • Preferred suppliers — no member costs • Nonpreferred suppliers — 20% coinsurance 	Yes, for services not covered by Medicare

Eye care

Your plan covers routine eye exams once every 24 months. It also covers other eye care services when you have eye problems caused by a medical condition.

You can visit an ophthalmologist or optometrist for a routine eye exam. The exam includes:

- Eye health check to screen for eye problems and look at the overall health of your eyes.
- Vision (visual acuity) check to measure how well you can see and whether you need vision correction. Sometimes these checks are called **refraction** or **refractive eye exams**. Vision problems (refractive errors) include astigmatism, nearsightedness, farsightedness, and blurry vision related to aging.

Your plan also covers office visits to check on or treat health problems that can harm your eyes, such as diabetes, glaucoma, keratoconus, cataracts, and macular degeneration.

⊗ Restrictions

- Your plan only covers one routine eye exam, including refractions, every 24 months.
- Routine eye exams only include checking eye health and visual acuity. Other tests, such as visual fields, ophthalmoscopy, or ophthalmic diagnostic imaging, are not covered.
- Surgery or supplies to correct vision problems (refractive errors) are not covered. Orthoptics for vision correction, radial keratotomy, and other laser surgeries are not covered.

Service	Member costs	Preapproval needed
Routine eye exams Eye health and vision check (limited to one exam every 24 months)	\$10 copay	No
Eye care office visits (when needed for your health)	\$10 copay	No
Vision therapy	\$10 copay	No

Eyeglasses and contact lenses

Your Wellpoint medical plan generally doesn't cover eyeglasses or contact lenses. However, your plan covers one set of eyeglasses or contact lenses after an eye injury or cataract surgery. Standard frames and lenses are covered, including bifocal and trifocal lenses.

⊗ Restrictions

- Only one set of eyeglasses or contact lenses are covered, and only within the first six months after the injury or surgery.
- Deluxe frames and specialty lenses are not covered. These include progressive lenses, transitional lenses, tinted lenses, antireflective coating, and polycarbonate lenses.

Service	Member costs	Preapproval needed
Eyeglasses and contact lenses (limited to one set of eyeglasses or lenses in the first six months after an eye injury or cataract surgery)	No member costs	Yes, if not covered by Medicare

Family planning

Your plan covers family planning services, including office visits and procedures to prevent pregnancy.

Covered services include:

- Fitting for a diaphragm or cervical cap

- Insertion, reinsertion, or removal of an IUD or levonorgestrel (Norplant)
- Injection of progesterone (Depo-Provera)
- Office visits for evaluations, consultations, and follow-up care
- Voluntary female sterilization (tubal ligation), sometimes called “getting your tubes tied”
- Voluntary male sterilization (vasectomy)
- Voluntary termination of pregnancy (abortion)

FDA-approved contraceptive drugs, devices, and digital applications are available through your prescription drug plan. Check Chapter 4 for details.

Service	Member costs	Preapproval needed
Family planning services	No member costs	No

Fitness reimbursement

To help you stay active, your plan will reimburse you for fitness activity costs. You can get up to \$100 for each member for costs related to fitness activities each calendar year.

Eligible costs include:

- Gyms, health clubs, fitness centers, Boys & Girls Clubs of America, dance studios, and martial arts centers
- In-person or online classes and programs, like yoga, Pilates, spin, Zumba®, and gymnastics
- Organizations designed for fitness activities, like softball teams, bowling leagues, or hiking clubs
- In-person or online personal trainers

To be reimbursed:

- Participate in fitness activities four or more times each month
- Complete the Fitness Reimbursement form from wellpointmass.com to submit your request
- Submit proof of payment toward an eligible activity

⊗ Restrictions

- Beach club or country club memberships, fees for one-day events, annual or day passes (such as for skiing), spas or spa services, and personal or home fitness equipment are not eligible for reimbursement.
- Reimbursement is paid to the plan subscriber, even when the membership is in a family member’s name.



Who is the subscriber?

The **subscriber** is the main person signing up for coverage. Other people in the family can get health benefits through the subscriber — they are **dependents**.

Foot care (routine)

Routine foot care, like trimming your nails and removing calluses, is covered only when medically necessary (needed for your health).

- If you can walk, foot care is covered when you have poor blood circulation (vascular compromise), like from diabetes or peripheral vascular disease of the lower limbs.
- If you can't walk, foot care is covered when you're at risk for health complications without it.

⊗ Restrictions

Shoe inserts for arch support, like Dr. Scholl's®, are not covered.

Service	Member costs	Preapproval needed
Routine foot care	\$10 copay	No

Gender affirmation services

Your plan covers care for gender affirmation like any other health condition. Getting a diagnosis and medical treatments are covered under your medical benefit. Behavioral health services are covered under your behavioral health benefit (explained later on in this chapter).

Covered services include:

- Breast or chest (“top”) and genital or 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 sperm or eggs

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

⊗ Restrictions

- Fertility storage (storage for sperm or eggs) is limited to a maximum of 24 months under enhanced fertility benefits, effective July 1, 2025.
- Surgical reversal of the original procedure is not covered.

Gynecology exams

Your plan covers exams to check the health of the womb and related organs (gynecological exams) as a preventive service. This includes Pap tests (tests where your doctor collects a few cells from your cervix with a small brush-like tool, then sends them to a lab to be checked). Other gynecology services are covered under the benefit for office visits.

Service	Member costs	Preapproval needed
Annual exam, with Pap test	No member costs	No
Office visits	\$10 copay	No

Hearing aids

Your plan covers hearing aids if testing shows hearing loss.

⊗ Restrictions

- Over-the-counter (OTC) hearing aids are not covered.
- Ear molds aren't covered for members age 22 and older.
- Hearing aid batteries aren't covered.
- Replacement hearing aids are covered only if you haven't reached the benefit limit (\$2,000 for each hearing aid for people 21 and younger, and \$1,700 for each hearing aid for people 22 and older), and if:
 - You need a new hearing aid prescription because your medical condition has changed
 - The hearing aid no longer works properly and can't be fixed

Service	Member costs	Preapproval needed
Hearing aids for members age 21 and younger	No member costs (for each ear with hearing loss, your plan will pay \$2,000 for hearing aids every 24 months)	No
Hearing aids for members age 22 and older	No member costs (for each ear with hearing loss, your plan will pay \$1,700 for hearing aids every 24 months)	No

Hearing exams

Your plan covers hearing exams to diagnose speech, hearing, and language disorders. A doctor or licensed audiologist must give the exam in a hospital, clinic, or private office.

⊗ Restrictions

Services provided through schools are not covered.

Service	Member costs	Preapproval needed
Hearing exams	\$10 copay	No
Hearing screenings for newborns	No member costs	No

High-tech imaging

Your plan covers advanced imaging tests, like MRIs, CT scans, and PET scans, that give a more detailed view than regular X-rays.

Service	Member costs	Preapproval needed
High-tech imaging in the emergency room	Deductible (you may owe a copay for the emergency room visit)	No
High-tech imaging in the hospital (inpatient)	No member costs	No
High-tech imaging at the hospital (outpatient) and at non-hospital-owned facilities	No member costs	No


Home healthcare

Your plan covers home healthcare if you can't leave home because of an illness, injury, or pregnancy.

Home healthcare includes services and supplies ordered by your doctor and given by a home healthcare agency or visiting nurse association (VNA). Services include:

- Medical social services from a licensed medical social worker.
- Nutrition counseling from a registered dietitian.
- Part-time home health aide help with personal care and daily living activities.
- Physical, occupational, speech, and respiratory therapy from a therapist licensed or certified to provide the services.

- DME, if the equipment is a medically necessary part of your care plan. DME is covered under the DME benefit. You can find that entry under “Durable medical equipment (DME),” earlier in this section.

 **Home healthcare needs preapproval.** Preapproval is needed for services, items, and equipment not covered by Medicare. For help with preapproval, call Wellpoint Member Services at **800-442-9300**.


Use Medicare-participating care providers and suppliers for the best benefit. These providers have agreed to accept Medicare’s payment as payment in full for covered medical services, supplies, and equipment. Look for Medicare suppliers at [medicare.gov](https://www.medicare.gov).

Important! Coinsurance applies to any balance left after Medicare processes your claim — this applies to all member costs.

Choose Preferred providers when Medicare-participating providers aren’t available. Your plan pays 100% of the allowed amount for covered care (services and items) from Preferred care providers and suppliers. Medical services from care providers in the state of Massachusetts are covered at the highest (Preferred) benefit level. (This does not apply to behavioral health services.) If you live or travel outside of Massachusetts, be sure to go to Preferred providers for your healthcare. These providers have agreed to accept Wellpoint’s payment as payment in full — they won’t balance bill you. Care from Nonpreferred care providers is covered at 80% of the allowed amount. Items from Nonpreferred suppliers are covered at 80% of the allowed amount, even when they are out of stock from Preferred suppliers. Find Preferred care providers and suppliers at [wellpointmass.com](https://www.wellpointmass.com).

 **Restrictions**

- For services to be covered, a home healthcare agency must be Medicare certified. Home healthcare agencies and VNAs must meet licensing requirements.
- For services to be covered, they must be provided in a noninstitutional setting. You can’t use your home healthcare benefit in a hospital, nursing home, or rehab center.
- There is no coverage for homemaking services, custodial care, or private-duty nursing.
- There is no coverage for services from anyone who shares your legal residence or from anyone in your immediate family. Immediate family includes you, your spouse, your children, and the parents and siblings of both you and your spouse.

Service	Member costs	Preapproval needed
 <input checked="" type="checkbox"/> Home healthcare	<ul style="list-style-type: none"> • Preferred care providers and suppliers — no member costs • Nonpreferred care providers and suppliers — 20% coinsurance 	Yes, if not covered by Medicare

Home infusion therapy


Your plan covers home infusion therapy, so you can get infused medicines and therapies at home from a qualified pharmacy.

- Use Medicare-participating care providers and suppliers for the best benefit. These providers have agreed to accept Medicare’s payment as payment in full for covered medical services, supplies, and equipment. Look for Medicare suppliers at [medicare.gov](https://www.medicare.gov).
- Save with Preferred care providers and suppliers. If you can’t find a Medicare provider for the services, supplies, or equipment you need, choose a Preferred care provider. These providers accept the plan’s payment as payment in full and won’t bill you for the rest. Medical services from care providers in the state of Massachusetts are covered at the highest (Preferred) benefit level. (This does not apply to behavioral health services.) Find Preferred care providers at [wellpointmass.com](https://www.wellpointmass.com).

Important! Coinsurance applies to any balance left after Medicare processes your claim — this applies to all member costs.

Restrictions

- The company that delivers your home infusion therapy must be licensed as a pharmacy and qualified to give home infusions.
- For services to be covered, they must be given in a noninstitutional, residential setting. You can’t use your home infusion therapy benefit in a hospital, nursing home, or rehab center.
- Nononcology-infused drugs need preapproval through your prescription drug plan. You must get subcutaneous and intramuscular drugs through your prescription drug plan. Learn more about your prescription drug plan benefits and coverage in Chapter 12 of this handbook.

Service	Member costs	Preapproval needed
 <input checked="" type="checkbox"/> Home infusion therapy	<ul style="list-style-type: none"> • Preferred pharmacies — no member costs • Nonpreferred pharmacies — 20% coinsurance 	No

Hospice and end-of-life care

Your plan covers hospice care when a doctor certifies you likely have 12 months or less to live. Hospice care addresses the physical, social, emotional, and spiritual needs of people who are in their last year of living.



For services to be covered, they must be delivered as part of a written plan of hospice care, established by a Medicare-certified hospice program, and reviewed by the hospice’s medical director and interdisciplinary team.

Your hospice benefits include:

- Both palliative chemotherapy and radiation therapy
- Part-time nursing care or home health aide services given or supervised by a registered nurse
- Physical, respiratory, occupational, and speech therapy from licensed or certified therapists
- Medical social services
- Medical supplies and appliances, sometimes called **durable medical equipment (DME)**
- Prescribed medications charged by hospice
- Lab services
- Care provider services
- Transportation for covered hospice services
- Counseling from a physician, psychologist, clergy member, registered nurse, or social worker
- Dietary counseling from a registered dietitian
- Respite care in your home or a hospital, skilled nursing facility, or nursing home
- Bereavement counseling for your family members and other loved ones from a physician, psychologist, clergy member, registered nurse, or social worker, within 12 months of death

Use Medicare-participating care providers and suppliers for the best benefit. These providers have agreed to accept Medicare's payment as payment in full for covered medical services, supplies, and equipment. Look for Medicare suppliers at [medicare.gov](https://www.medicare.gov).

Save with Preferred care providers and suppliers. If you can't find a Medicare provider for the services, supplies, or equipment you need, choose a Preferred care provider. These providers accept the plan's payment as payment in full and won't bill you for the rest. Medical services from care providers in the state of Massachusetts are covered at the highest (Preferred) benefit level. (This does not apply to behavioral health services.) Find Preferred care providers at [wellpointmass.com](https://www.wellpointmass.com).

Service	Member costs	Preapproval needed
 Hospice care	No member costs	No
 Bereavement counseling	20% coinsurance (your plan will pay up to \$1,500 for the family in a calendar year)	No

Important! If your care providers expect you to live longer than 12 months but you have symptoms like severe pain or difficulty breathing, your plan covers palliative care. You can find the **palliative care** entry later in this section.



What’s respite care?

Your plan covers respite care as part of your hospice care benefit. Respite care gives the main caregivers — often family members — a break. Other healthcare professionals tend to the person in hospice so the main caregiving team can rest or take care of other responsibilities.

Immunizations (vaccines)

Immunizations or vaccines recommended by the U.S. Preventive Services Task Force are covered at 100% of the allowed amount. Check the preventive care schedule in Chapter 6.

⊗ Restrictions

Blood tests (titers) to find out if you need an immunization aren’t covered unless you’re pregnant.

Service	Member costs	Preapproval needed
At a doctor’s office	No member costs (but you may owe a copay for the office visit)	No
At a travel clinic	No member costs	No
At a pharmacy	Covered under your prescription drug plan (check Chapter 12)	No

Infertility treatment

Your plan covers nonexperimental infertility treatments — those considered to be standard by national organizations like the American Society for Reproductive Medicine and the American College of Obstetricians and Gynecologists. For treatment to be covered, you must meet one of these definitions of infertility:

- Opposite-sex partners younger than 35 who have not conceived (gotten pregnant) after at least 12 months of unprotected intercourse (sex)
- Opposite-sex partners who haven’t gotten pregnant after six months of unprotected sex, if the female partner (who has a uterus and ovaries) is 35 or older
- Someone with a uterus and ovaries who hasn’t gotten pregnant after six or more trials of medically supervised artificial insemination
- Someone with a uterus and ovaries who hasn’t gotten pregnant after three or more trials of medically supervised artificial insemination within six months, and is 35 or older

When infertility services are provided as part of gender affirmation treatment, you don't need to meet these definitions of infertility.

Important! If you get pregnant but have a miscarriage, the time you spent trying to conceive that pregnancy still counts toward your six or 12 months.

Your plan offers benefits for:

- In vitro fertilization and embryo placement (IVF-EP)
- Artificial insemination, also known as intrauterine insemination (IUI) (infertility diagnosis not required for this procedure)
- Cryopreservation of eggs, as part of covered infertility treatment
- Gamete intrafallopian transfer (GIFT)
- Intracytoplasmic sperm injection (ICSI) for treatment of male infertility
- Natural oocyte retrieval with intravaginal fertilization (NORIF)
- Preimplantation genetic testing (PGT)
- Sperm, egg, and/or inseminated egg procurement and processing, from yourself or from a donor (for costs not covered by a donor's health insurance, if any)
- Costs to store or bank sperm, eggs, and/or inseminated eggs
- Zygote intrafallopian transfer (ZIFT)

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

⊗ **Restrictions**

- Infertility treatments are not covered if the reason for your infertility is normal aging (like menopause) or voluntary sterilization.
- Reversing voluntary sterilization (vasectomy, tubal ligation) is not covered.
- Experimental procedures are not covered.
- Your plan will not pay people to donate their eggs or sperm, or to be surrogates (gestational carriers).
- There is no coverage for medical services (including in vitro fertilization) for a surrogate who is not a Wellpoint member.
- Shipping costs (like to ship eggs or sperm between clinics) are not covered.
- Procurement and processing of sperm, eggs, and/or inseminated eggs are covered only to treat infertility or when you're having medical treatment that may cause infertility. (Infertility services provided as part of gender affirmation treatment don't need to meet the definition of infertility described in this section.)
- Your plan will only cover facility fees for licensed hospitals or ambulatory surgery centers.

Inpatient medical care (hospital admissions)

Your plan covers inpatient hospital stays covered by Medicare. If you use all your Medicare benefits for inpatient hospital care, Wellpoint will review your case to find out if you're eligible for continued benefits.

When you're admitted as an inpatient, your plan covers medically necessary hospital care (services and supplies) at acute care hospitals, rehabilitation facilities, long-term care facilities, and skilled nursing facilities.

- **Acute care hospitals** treat severe illness, disease, and trauma, and support recovery from surgery. These hospitals deliver intensive, 24-hour medical and nursing care.
- **Rehabilitation (rehab) facilities** are hospitals that specialize in restoring functioning that was lost because of an illness or injury. Patients with good potential for recovery go to these hospitals, where they spend 3 to 5 hours a day working with therapists to regain the ability to walk, sit upright, feed themselves, or other basic functions.
- **Long-term care facilities** are hospitals that specialize in taking care of people with complex medical needs who don't need as intensive care as they'd get in an acute care hospital. These patients' needs are mostly medical, and they're limited in how much they can participate in rehab or therapy.
- **Skilled nursing facilities** provide lower-intensity rehab and medical services. Patients need skilled nursing care, but they don't need daily care from a doctor. Some need rehab or therapy services and some do not.

⊗ Restrictions

- When a newborn is admitted to the hospital separately from its mother, that's considered a separate hospital admission and you'll owe a separate inpatient copay.
- Your plan does not pay for donated blood.
- There is no coverage for:
 - Services or private rooms that aren't medically necessary
 - Private-duty nursing
 - Convenience items like telephone, radio, and television
 - Services that are considered experimental or investigational
 - Custodial care (help with daily living activities)

Service	Member costs	Preapproval needed
⚠️ Inpatient medical care at a hospital or rehab facility (semiprivate room)	No member costs	Yes, if not covered by Medicare
⚠️ Inpatient medical care at a hospital or rehab facility (medically necessary private room)	You pay the dollar difference between a semiprivate room and a private room	Yes, if not covered by Medicare
⚠️ Inpatient medical care at a skilled nursing or long-term care facility	<ul style="list-style-type: none"> • Days paid by Medicare — no member costs until plan benefit limit is reached • Days not paid by Medicare — 20% coinsurance until plan benefit limit is reached (plan benefit limit is \$13,400 each calendar year) 	Yes, if not covered by Medicare



Important! Coverage is subject to all plan provisions:

- Only medically necessary care is covered.
- Use Preferred providers for the best benefit.
- Get preapproval when needed.
- Benefit limits apply.

For help with preapproval, call Wellpoint Member Services at **800-442-9300**.

Examples of covered inpatient services

These are examples of the services and supplies covered by your inpatient benefit at acute care hospitals, rehabilitation facilities, long-term care facilities, and skilled nursing facilities. For specific questions, contact Wellpoint Member Services at **800-442-9300**.

- Preadmission testing
- Room and board
- Physician and nursing services
- Medically necessary services and supplies charged by the hospital
- Diagnostic tests, radiology, and labs
- Anesthesia, radiology, and pathology
- Surgery
- Intensive care or coronary care

- Dialysis
- Physical, occupational, and speech therapy
- Durable medical equipment
- Ancillary items and services, such as:
 - Pasteurized donor human milk and/or donor human milk-derived products
 - Infusions and transfusions
 - Devices that are an integral part of a surgical procedure, such as hip joints, skull plates, and pacemakers (some devices that aren't directly involved in surgery, like artificial limbs or hearing aids, may be covered under other benefits)
 - Drugs, medications, solutions, biological preparations, and supplies
 - Use of special rooms, like operating rooms
 - Use of special equipment

Laboratory services (lab work) and radiology

Your plan covers lab work and radiology services (like X-rays) when ordered by your care provider to diagnose or monitor a health condition. 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.




Service	Member costs	Preapproval needed
Lab work and radiology	No member costs	No

Long-term care facilities

Your plan covers inpatient care at long-term care and skilled nursing facilities each year. These facilities provide ongoing medical care for complex conditions that no longer need traditional hospital services. To find out more, check the **Inpatient care** entry earlier in this chapter.

Maternity services

Your plan covers maternity care services like any other medical condition. Pregnancy diagnosis and treatment are covered under your medical benefit. Other charges associated with covered maternity services, like amniocentesis, depression screening, lab testing, home visits, ultrasounds, and lactation consultants, are covered under the relevant plan benefit. For example, any medically necessary lab tests would be covered under the benefit for lab tests.

Service	Member costs	Preapproval needed
Amniocentesis	No member costs	No
Breastfeeding counseling	No member costs	No
Depression screening	No member costs	No
 Home healthcare	<ul style="list-style-type: none"> Preferred care providers — no member costs Nonpreferred care providers — 20% coinsurance 	Yes, if not covered by Medicare
 Inpatient medical care at a hospital or rehab facility (semiprivate room)	No member costs	Yes, if not covered by Medicare
 Inpatient medical care at a hospital or rehab facility (medically necessary private room)	The dollar difference between the semiprivate room rate and the private room rate	Yes, if not covered by Medicare
Lactation consultants	<ul style="list-style-type: none"> In hospital — covered under inpatient medical care benefit (above) All other settings — no member costs 	No
Ultrasounds	No member costs	No

Medical care outside the U.S.

Your plan covers emergency services you get outside of the U.S. Medical treatment you receive on a cruise ship or other boat is also considered to be from outside of the U.S.

Wellpoint reimburses non-U.S. services at 100% of the charges, after your copay. The claim is paid based on the exchange rate on the date of service, as found on [oanda.com](https://www.oanda.com).

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

For more information on how to submit reimbursement for a foreign claim, including acceptable forms of proof of payment, check “How to submit a claim” in Chapter 8. If your bill has information in a foreign language, please provide a translation, if possible.

Restrictions

- Ambulance must be medically necessary.

- Ambulance must take you to the nearest hospital that can help you.
- Air and water ambulance are covered only when ground ambulance risks your health.
- There is no coverage for ambulance transportation to a specific facility if a nearer facility could treat you.

Medical services (not listed elsewhere)

Important! The information below applies only to covered medical services that aren't addressed elsewhere in this chapter.

Service	Member costs	Preapproval needed
Covered medical services (if not listed elsewhere)	20% coinsurance	For specific questions, contact Wellpoint Member Services at 800-442-9300

Neuropsychological (neuropsych) testing

Neuropsychological testing, sometimes called **neuropsych testing**, is used to check attention, processing speed, reasoning, problem-solving, and similar mental functions. Your plan covers neuropsych testing, whether it's ordered for a medical condition or a behavioral health condition.

Service	Member costs	Preapproval needed
Neuropsych testing	<ul style="list-style-type: none"> • Preferred care providers — \$20 copay • Nonpreferred care providers — 20% coinsurance 	No

Occupational therapy

Occupational therapy helps you regain or improve daily living skills after an illness or injury, so you can be more independent. When it's ordered by a doctor, your plan covers one-on-one therapy with a licensed occupational therapist or occupational therapy assistant (under the direction of an occupational therapist).

Covered services include:

- One-on-one therapy to help you carry out activities of daily living (like dressing or bathing)
- Checking your home with safety in mind as you return to daily activities
- Recommending adaptive equipment or tools, and training you on how to use them

⊗ Restrictions

- Group occupational therapy is not covered.
- Sensory integration therapy is not covered.
- Occupational therapy for a chronic condition is not covered when the treatment won't cure your condition or restore function you've lost.
- Services provided through schools are not covered.

Service	Member costs	Preapproval needed
Occupational therapy	<ul style="list-style-type: none"> • If Medicare pays — no member costs • If Medicare does not pay — 20% coinsurance 	No

Office visits

Your plan covers office visits with primary care doctors and specialists. You can find out more about office visits under the entry for **Doctor services (and services from other medical care providers)** earlier in this chapter.

Outpatient hospital services (if not listed elsewhere)

Important! The information below applies only to covered medical services that aren't addressed elsewhere in this chapter.

Outpatient hospital services are medical services you receive at a hospital, but usually you don't need to stay overnight. If they keep you overnight for observation (to make sure you're doing well) without admitting you to the hospital, that also counts as outpatient hospital services.

Service	Member costs	Preapproval needed
Outpatient hospital services (if not listed elsewhere)	No member costs	No

Oxygen

Your plan covers oxygen therapy — the oxygen itself and the supplies you need.

For the best benefit, use Medicare care providers and suppliers. Find one at [medicare.gov](https://www.medicare.gov).

Search for a Wellpoint care provider or supplier at [wellpointmass.com](https://www.wellpointmass.com), if no Medicare provider is available.

Important! Items from out-of-network suppliers are covered at 80%, even when they are out of stock from in-network suppliers.

⊗ Restrictions

- Oxygen equipment needed for airplane or other travel is not covered.
- The 20% coinsurance for out-of-network suppliers doesn't count toward the out-of-pocket limit for coinsurance.

Service	Member costs	Preapproval needed
<input checked="" type="checkbox"/> Oxygen therapy and supplies	<ul style="list-style-type: none"> • Preferred suppliers — no member costs • Nonpreferred suppliers — 20% coinsurance 	No

Palliative care

Your plan covers palliative care, which is care to make you more comfortable during a serious illness. Palliative care is covered like any other health condition. Medical services to relieve pain or trouble breathing are covered under your medical benefit. Behavioral health services, like therapy, are covered under your behavioral health benefit.

Personal emergency response systems (PERS)

A personal emergency response system (PERS) helps you quickly call for help in an emergency. Your plan covers PERS installation and rental costs.

⊗ Restrictions

The cost of buying a PERS unit is not covered.

Service	Member costs	Preapproval needed
PERS installation	20% coinsurance (your plan will pay up to \$50 for installation in a calendar year)	No
PERS rental	No member costs (your plan will pay up to \$40 a month for rental of a PERS unit)	No

Physical therapy

Physical therapy helps relieve pain and restore movement after an injury or illness that affects your neuromuscular or musculoskeletal system. When it's ordered by a doctor, your plan covers one-on-one therapy with a licensed physical therapist or physical therapy assistant (under the direction of a physical therapist) on a short-term basis.

Covered services include:

- One-on-one physical therapy to improve movement, strength, or function
- Hands-on treatment such as direct manipulation (moving the affected body part or joint), exercises, movement, or other physical methods to reduce pain or disability

⊗ Restrictions

- Group physical therapy is not covered.
- Services provided by athletic trainers are not covered.
- Services provided by a chiropractor are considered chiropractic care, not physical therapy.
- Massage therapy and services provided by massage therapists or neuromuscular therapists are not covered.
- Physical therapy for a chronic condition is not covered when treatment won't cure your condition or restore function.
- Services must be appropriate for your symptoms, consistent with the diagnosis, and consistent with accepted practices and standards.
- Certain therapy services are not covered. These include 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 through schools are not covered.

Service	Member costs	Preapproval needed
Physical therapy	<ul style="list-style-type: none"> • If Medicare pays — no member costs • If Medicare doesn't pay — 20% coinsurance 	No

Prescription drugs

Benefits for most prescription drugs are administered by SilverScript. Check Chapter 12 of this handbook for benefits information.

Preventive care

Preventive care helps you stay healthy by catching problems early or preventing illness before it starts. Your plan covers preventive or routine office visits, physical exams, and other preventive care services recommended by the U.S. Preventive Services Task Force as part of the Affordable Care Act. When you have these services as recommended, they're covered at 100% of the allowed amount, with no member cost. The schedule and guidelines for preventive services are listed in Chapter 6.

⊗ Restrictions

- Not all preventive healthcare services are recommended for everyone. You and your doctor should decide what care is right for you.
- Claims must be submitted with the correct preventive diagnosis and procedure codes to be covered at 100%.
- Services used to treat a diagnosed illness or condition may not be covered under the preventive benefit. They may be billed as diagnostic instead.

If you get care for an existing illness, injury, or condition during a preventive exam, you may have to pay member costs for those nonpreventive services.

Service	Member costs	Preapproval needed
Preventive care	No member costs	No

Prosthetics and orthotics

Prosthetics and orthotics help replace or support body parts that are missing, injured, or not working properly, so you can move and function more comfortably.

Covered services include:

- Prosthetics (devices that replace a body part or its function), such as artificial limbs and breast prosthetics
- Orthotics (devices that support, align, or correct movement), such as braces, splints, and trusses

⊗ Restrictions

- Orthotics must be ordered by a doctor, custom molded and fitted to your body, and used only by you.
- Replacement prosthetics and orthotics are not covered, except when needed due to normal growth or a pathological change (a change in your medical condition that requires a new prescription). Supporting documentation is required.
- Mastectomy bras are limited to two bras every two years, unless a change to your prosthetic requires a replacement bra. Supporting documentation is required.

- The following items and services are not covered:
 - Arch supports (such as over-the-counter inserts)
 - Temporary or trial orthotics
 - Video gait analysis and diagnostic scanning
 - Orthopedic shoes that do not attach directly to a brace

Service	Member costs	Preapproval needed
Breast prosthetics	No member costs	No
Orthopedic shoe with attached brace	No member costs	No
Other prosthetics and orthotics (including mastectomy bras)	<ul style="list-style-type: none"> • If Medicare pays — no member costs • If Medicare doesn't pay — 20% coinsurance 	No

Pulmonary rehabilitation (rehab) programs

Pulmonary rehab programs combine education and exercise to help improve breathing and lung function for people with certain respiratory conditions. Your plan covers pulmonary rehab during the active rehabilitation phase of the program, which usually lasts three months.

To be covered, pulmonary rehab programs must be:

- Ordered by a doctor
- Provided by a licensed clinic or hospital
- Consistent with accepted pulmonary rehab standards

⊗ Restrictions

- You must have a diagnosed breathing condition, such as chronic obstructive pulmonary disease (COPD) or pulmonary fibrosis.
- Pulmonary rehab programs are limited to 36 visits (three visits each week for 12 weeks).
- The maintenance phase of a pulmonary rehab program (after the first 12 weeks) is not covered.

Service	Member costs	Preapproval needed
Pulmonary rehab programs	No member costs	No

Radiation therapy

Radiation therapy uses targeted radiation to treat certain medical conditions, including cancer. Your plan covers radiation therapy, including radioactive isotope therapy and intensity-modulated radiation therapy (IMRT).

Service	Member costs	Preapproval needed
Radiation therapy	No member costs	Yes

Rehabilitation (rehab) hospitals

Rehab facilities are hospitals that specialize in restoring basic functions lost to an illness or injury, like walking or sitting upright. Services at rehab hospitals are covered under the benefit for inpatient care, listed earlier in this section.

Retail health clinics

Clinics located in retail stores or pharmacies offer basic medical services on a walk-in basis. Learn more about your benefits for retail health clinic services in the emergency care and urgent care listing, earlier in this section.

Skilled nursing facilities

Skilled nursing facilities provide lower-intensity rehab and medical care after a hospital stay or serious illness. Services at skilled nursing facilities are covered under the benefit for inpatient care, listed earlier in this section.

Sleep studies

Sleep studies monitor your breathing and other body functions while you sleep to help diagnose sleep-related breathing problems. You can have a sleep study at a hospital, freestanding sleep center, or at home.

Service	Member costs	Preapproval needed
Sleep studies	No member costs	No

Speech therapy

Speech therapy helps diagnose and treat speech, hearing, and language problems. Your plan covers speech therapy:

- Ordered by a doctor
- Provided in a hospital, clinic, or private office
- Given by a licensed speech-language pathologist or audiologist

Covered services include:

- Diagnosis and treatment of speech disorders caused by a physical condition, Autism Spectrum Disorder, or Down syndrome
- Speech rehabilitation, including physiotherapy, following laryngectomy

Restrictions

- Cognitive rehabilitation is not covered, except when related to COVID-19.
- Speech therapy for a chronic condition is not covered when treatment won't cure your condition or restore function.
- Services provided through schools are not covered.

Service	Member costs	Preapproval needed
Speech therapy	No member costs	No

Surgery

The surgery benefit covers facility charges and surgeon fees for surgical services, including care before, during, and after surgery. Reconstructive breast surgery for all stages of mastectomy is covered under this benefit.

 **Surgical services for organ transplants may need preapproval.**

Restrictions

- Coverage for reconstructive and restorative surgery is limited to:
 - Correcting a physical problem caused by previous surgery or disease
 - Reconstruction after the surgical removal of an organ or body part for the treatment of cancer (must be within five years of the removal surgery)
 - Correcting a congenital anomaly (birth defect) that causes functional impairment for a minor
- Devices that aren't directly involved in the surgery may be covered under a different benefit. For example, prosthetic limbs may be covered under your prosthetics benefit. Hearing aids may be covered under your hearing aid benefit.

- Cosmetic services aren't covered, aside from surgical procedures to correct your appearance after an accidental injury, and treatment for HIV-associated lipodystrophy.
- Coverage for assistant surgeon services is limited:
 - Services of an assistant surgeon must be medically necessary.
 - Assistant surgeon must be licensed and trained in a surgical specialty related to the procedure, and must serve as the first assistant surgeon to the primary surgeon during a procedure.
 - Only one assistant surgeon per procedure. Second and third assistants aren't covered.
 - Interns, residents, and fellows aren't covered as assistant surgeons.

Service	Member costs	Preapproval needed
Surgery in Massachusetts	No member costs	No
Surgery outside Massachusetts	<ul style="list-style-type: none"> • Medicare-participating care providers — no member costs • Medicare-nonparticipating care providers — 20% of the difference between your plan's allowed amount and the care provider's charge 	No

Tobacco cessation counseling

Tobacco cessation counseling helps you stop or reduce your tobacco use through education, support, and behavior changes. Your plan covers up to 300 minutes of tobacco cessation counseling each year. You can have group or one-on-one counseling over the phone or in person.

Your care provider can bill Wellpoint directly, but if they don't take insurance, you can [download a claim form from wellpointmass.com](#) and submit your claim yourself. Your plan pays 100% of the allowed amount for tobacco cessation counseling.

Your prescription drug plan offers nicotine replacement products at no cost, but you need a prescription. Learn more in Chapter 12 of this handbook.

⊗ Restrictions

- Your plan covers up to 300 minutes of tobacco cessation counseling each year.
- Counseling must be provided by doctors, nurse practitioners, physician assistants, nurse midwives, registered nurses, or trained tobacco cessation counselors. Tobacco cessation counselors are care 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.

Service	Member costs	Preapproval needed
Tobacco cessation counseling	No member costs	No

Transplants

Your plan covers medically necessary services for human organ transplants. To get the highest benefit, choose a Medicare-certified transplant facility for organ transplants.

Before the transplant surgery and while you're recovering after, a Wellpoint nurse case manager will support you and your family to:



- Find out what you need and help coordinate services while you're waiting for your transplant
- Stay in communication with the transplant team
- Help you get the most from your plan benefits
- Seek resources to help with your medical expenses, if needed
- Plan for your care after surgery, coordinating where you'll go to recover, how you'll get there, and care plans for when you're back home

Your plan covers:

- The cost to deliver an organ (any part of the human body except blood or blood plasma)
- Medical expenses for the organ donor, even if the donor isn't a Wellpoint member
- Costs to check for a bone marrow transplant match by testing for A, B, or DR antigens (or any combination) through human leukocyte antigen testing or histocompatibility locus antigen testing (must be consistent with the guidelines, criteria, and regulations of the Massachusetts Department of Public Health)

Restrictions

Your 20% coinsurance at non-Medicare hospitals doesn't count toward the out-of-pocket limit for coinsurance.

Service	Member costs	Preapproval needed
 Organ transplants at Medicare-certified transplant facilities	No member costs	Yes, if not covered by Medicare
 Organ transplants at other hospitals	20% coinsurance	Yes, if not covered by Medicare

Travel clinics

Your plan covers visits at travel clinics. Travel clinics provide immunizations and other services to help you get ready for international travel.

⊗ Restrictions

Blood tests (titers) to find out if you need an immunization aren't covered unless you're pregnant.

Service	Member costs	Preapproval needed
Travel clinic visits	No member costs	No

Urgent care

Your plan covers urgent care visits. Urgent care services are for when you need help right away but your health isn't in serious danger. Check the "Emergency care and urgent care" entry earlier in this chapter for more information.

Important! Look for urgent care centers that aren't connected to or part of a hospital — your member costs are lower if you go to a walk-in urgent care center rather than the hospital emergency department.

Service	Member costs	Preapproval needed
Urgent care visits	\$20 copay, then each service is covered under its own benefit	No

Virtual care (telehealth)

Virtual care visits, or telehealth, are video or telephone care provider visits. Your plan covers virtual care just like in-person, face-to-face visits. You can use LiveHealth Online for telehealth through the [Sydney® Health](#) app, but other telehealth services are also covered. Check "Doctor services (and services from other medical care providers)" earlier in this chapter for coverage details.

Walk-in clinics

Walk-in clinics offer basic medical service on a walk-in basis, with no appointment needed. There are a few places you can find walk-in clinics:

- Doctors' offices sometimes offer general primary care services on a walk-in basis.
- Retail health clinics, found in stores and pharmacies, offer basic services like vaccinations and treatment for colds, rashes, or minor infections.
- Urgent care centers offer X-rays, lab tests, and stitches for health issues that aren't life-threatening but need to be taken care of right away.
- Hospital emergency departments sometimes have walk-in clinics for less serious issues.

Important! Before you use a walk-in clinic, it's a good idea to ask how your visit will be billed. 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. What you owe depends on how your visit is billed. For more information, check the "Emergency care and urgent care" listing, earlier in this chapter.

Wigs

Your plan covers wigs if you lose your hair due to burns, chemotherapy, congenital baldness, infection, radiation therapy, traumatic injury, or other medical conditions resulting in alopecia areata or alopecia totalis (capitus).

⊗ Restrictions

- Your care provider must submit a written statement of medical necessity in order for wigs to be covered.
- There is no coverage for wigs when hair loss is due to female pattern baldness, male pattern baldness, or natural or premature aging.

Service	Member costs	Preapproval needed
Wigs	20% coinsurance (your plan will pay up to \$350 in a calendar year)	No

Your benefits for covered behavioral health services

Important! Coverage is subject to all plan provisions: Only medically necessary care is covered. Use Preferred care providers for the best benefit. Get preapproval when needed. Benefit limits apply.

Behavioral health services

The plan offers comprehensive benefits for behavioral health services to help treat mental health and substance use conditions. Wellpoint has partnered with Carelon to give you access to experienced behavioral health care providers.

As a Wellpoint member, you can get services from any appropriately licensed behavioral health care provider. However, Preferred care providers agree to accept Wellpoint's payment as payment in full. This means they won't bill you for the difference. Also, you won't owe any coinsurance when you use Preferred care providers.

Important! If you use a Nonpreferred care provider, you may get a bill for charges over the amount allowed (the amount your plan pays), whether you get the services in Massachusetts or out of state. Check Chapter 2 for information about balance billing protection.

Your behavioral health benefits include coverage for:

- Applied Behavior Analysis (ABA)
- Autism Spectrum Disorders (ASDs)
- Emergency care
- Inpatient care
- Medication-assisted treatment (MAT)
- Outpatient services
- Substance use disorder assessments and referrals
- Therapy
- Virtual care (telehealth)


Applied Behavior Analysis

Applied Behavior Analysis (ABA) is a specialized therapy for people with Autism Spectrum Disorders or Down syndrome. Therapy focuses on improving appropriate behaviors and minimizing negative ones.

Important! If you have more than one office service from the same care provider on the same day, you only owe one copay.


For the best benefit, use Medicare care providers and suppliers. Find one at [medicare.gov](https://www.medicare.gov).

Search for a Wellpoint care provider or supplier at [wellpointmass.com](https://www.wellpointmass.com), if no Medicare provider is available.

 **Applied Behavior Analysis needs preapproval if not covered by Medicare.** For help with preapprovals 24 hours a day, seven days a week, your care provider should call Wellpoint at **800-442-9300** (TTY: **711**).

Restrictions

The person carrying out the treatment plan must be supervised by a licensed clinician.

Service	Member costs	Preapproval needed
 <input checked="" type="checkbox"/> Applied Behavior Analysis	<ul style="list-style-type: none"> With Preferred care providers — \$10 copay (no member costs first four visits) With Nonpreferred care providers — 20% coinsurance for visits 1–15, then 50% coinsurance for visits after 15 	Yes, if not covered by Medicare

Autism Spectrum Disorders (ASDs)

Your plan covers care for Autism Spectrum Disorders (ASDs) like any other health condition. ASDs include conditions like autism, Asperger's syndrome, and other similar developmental disorders defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders guide.

Getting an ASD diagnosis and treatments like occupational therapy are covered medical benefits. Your plan also covers behavioral health care for ASD under your behavioral health benefit. Covered services for ASD include:

- **Applied Behavior Analysis (ABA)**, which focuses on improving appropriate behaviors and minimizing negative ones
- **Psychiatric services** to treat behaviors that get in the way of daily functioning or pose a danger to self, others, or property

Services can include:

- Diagnostic evaluations and assessment
- Treatment planning
- Referral services
- Medication management
- Inpatient/24-hour supervisory care
- Partial hospitalization/day treatment
- Intensive outpatient treatment
- Care at an acute residential treatment facility
- Individual, family, therapeutic group, and care provider–based case management services
- Psychotherapy, consultation, and training session for parents
- Paraprofessional and resource support for the family
- Crisis intervention
- Transitional care

Behavioral Health Help Line

The Massachusetts Behavioral Health Help Line (BHHL) connects you to help when and where you need it, even if you're not sure what kind of help you need. Through the BHHL, individuals and families can access a full range of treatment services for mental health and substance use, including outpatient, urgent, and immediate crisis care in your community.

The Help Line:

- Is free and confidential, and no health insurance is required.
- Offers real-time interpretation in 200+ languages.
- Provides help for the deaf or hard of hearing. Contact MassRelay at **711** or use the video relay or caption provider of your choice. Your messages will be relayed to a BHHL staff member, and their responses will be typed back to you.
- Is available 24 hours a day, 365 days a year. Call or text **833-773-2445** or [chat online at masshelpline.com](https://www.masshelpline.com).



Behavioral Health Help Line

In Massachusetts, call or text the Behavioral Health Help Line at **833-773-2445** for real-time support, initial clinical assessment, and connection to the right evaluation and treatment.

Community Behavioral Health Centers and Mobile Crisis Intervention

Important! In a life-threatening emergency, go to the closest emergency room. Seek urgent care if you have a health problem that could become an emergency without quick treatment. Call Wellpoint at **800-442-9300** for help finding nonemergency care or an available behavioral health care provider.

In Massachusetts, Community Behavioral Health Centers (CBHCs) and Mobile Crisis Intervention (MCI) services provide behavioral health crisis assessment, intervention, and stabilization services.

If you or a family member is experiencing a mental health or substance use crisis and feel like you need help within one hour, call **877-382-1609**. Listen to the message and enter your ZIP code when asked to do so. Your call will be transferred automatically to the CBHC closest to you.

You do not need a referral to go to a CBHC. You can go to a CBHC for your behavioral health needs instead of a hospital emergency department.

You can also get help through MCI, which is available to people of all ages. This mobile service provides crisis assessment, intervention, and stabilization services **in your home or at other locations in the community**, helping you avoid the high cost and long wait time at the hospital emergency room.

MCI provides crisis assessment at your location within an hour. If you're in crisis and call for help, a care provider will come to you to evaluate the types of services you need. If you need inpatient care, the MCI team will find you a bed and get the necessary preapproval.



Need more information?

Visit mass.gov/info-details/community-behavioral-health-centers to find more information and a list of CBHCs near you. You can also call **877-382-1609** to learn more about CBHCs and MCI.

Service	Member costs	Preapproval needed
Mobile Crisis Intervention	No member costs	No (call Wellpoint if you're admitted to the hospital)

Inpatient behavioral health care (hospital admissions)

When you're admitted as an inpatient, your plan covers medically necessary behavioral health care (services and supplies) at acute care hospitals, psychiatric hospitals, substance use treatment facilities, or residential facilities. Check Table 11 for examples of the services and supplies covered by your inpatient benefit. Most of these services are available for both adults and adolescents, unless otherwise noted.

For the best benefit, use Medicare care providers and suppliers. Find one at [medicare.gov](https://www.medicare.gov).

Search for a Wellpoint care provider or supplier at [wellpointmass.com](https://www.wellpointmass.com), if no Medicare provider is available.

⚠ Inpatient behavioral health services need preapproval if not covered by Medicare. For help with preapprovals 24 hours a day, seven days a week, your care provider should call Wellpoint at **800-442-9300** (TTY: **711**).

⊗ Restrictions

- Your plan doesn't cover nonacute residential treatment, which is long-term, structured treatment for conditions that aren't immediately life-threatening. For example:
 - Clinically managed, low-intensity residential services
 - Clinically managed, population-specific, high-intensity residential services
 - Recovery residences
 - Sober homes
- Your plan doesn't cover treatment performed in nonconventional settings, such as:
 - Spas and resorts
 - Therapeutic or residential schools
 - Educational, vocational, or recreational locations
 - Day care or preschools
 - Outward Bound
 - Wilderness, camp, or ranch programs

Service	Member costs	Preapproval needed
⚠ <input checked="" type="checkbox"/> Inpatient behavioral health care	<ul style="list-style-type: none"> • With Preferred providers — no member costs • With Nonpreferred providers — 20% coinsurance 	Yes, if not covered by Medicare

Table 11. Behavioral health inpatient services

Inpatient services	Description
Acute residential treatment	Short-term, 24-hour programs that provide treatment within a protected and structured environment

Inpatient services	Description
Acute residential withdrawal management (American Society of Addiction Medicine [ASAM] level 3.7 detox)*	Drug or alcohol withdrawal (detox) that is medically monitored, for those at risk of severe withdrawal
Adult Community Clinical Services (ACCS)	24-hour observation and supervision when inpatient hospital care isn't needed
Youth Community Clinical Services (YCCS)	24-hour observation and supervision when inpatient hospital care isn't needed
Clinical stabilization services (CSS) for substance use disorder (ASAM level 3.5)*	Clinically managed detox and recovery services provided in a nonmedical setting
Community-based acute treatment (CBAT)	Treatment for children and adolescents with serious behavioral health disorders in a protected and structured environment
Dual diagnosis acute treatment (DDAT) (ASAM level 3.5)*	Clinically managed detox and recovery services in a protected environment for individuals with both substance use and mental health conditions
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 for extended assessment or observation when inpatient admission isn't needed. (typically lasts 24 hours or less, up to 72 hours)
Transitional care units (TCUs)	Facilities that help children and adolescents transition from an acute care facility to a residential program or home environment



What is ASAM?

ASAM stands for American Society of Addiction Medicine. This is the organization that establishes guidelines that help care providers evaluate a person's needs and recommend the right level of treatment.

* ASAM stands for American Society of Addiction Medicine. These are levels of criteria based on a set of guidelines that help care providers evaluate a person's needs and recommend the right level of treatment.

Medication-assisted treatment (MAT)

Your plan covers medication-assisted treatment (MAT) to help people stop using opioids. Treatment is usually given through **opiate treatment programs (OTPs)** that are licensed to give these medications.

There is no cost to you for treatment through an OTP. Both the drug and its administration are covered at no member cost.

Important! You can get this treatment from an individual care provider in an office setting, but you'll owe a copay for the visit. You'll also need to fill a prescription for the medication at a pharmacy.

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

Service	Member costs	Preapproval needed
Medication-assisted treatment from OTPs	No member costs	No
Medication-assisted treatment from individual care providers	You may owe an office visit copay and you'll pay to fill your prescription	No

Outpatient services

The plan covers medically necessary services for treating mental health and substance use conditions that don't require an inpatient hospital admission. Outpatient services include office services as well as more intensive types of treatment. Most of these services are available for both adults and adolescents, unless otherwise noted. Check Table 12 for a list of the outpatient services covered under this benefit.

Important! If you have more than one outpatient service from the same care provider on the same day, you only owe one copay.

For the best benefit, use Medicare care providers and suppliers. Find one at [medicare.gov](https://www.medicare.gov).

Search for a Wellpoint care provider or supplier at [wellpointmass.com](https://www.wellpointmass.com), if no Medicare provider is available.

⚠️ Outpatient behavioral health services may need preapproval if not covered by Medicare. For help with preapprovals 24 hours a day, seven days a week, your care provider should call Wellpoint at **800-442-9300** (TTY: **711**).

⊗ Restrictions

- Your plan doesn't cover treatment performed in nonconventional settings like:
 - Spas or resorts
 - Therapeutic or residential schools
 - Educational, vocational, or recreational locations
 - Day care or preschools
 - Outward Bound
 - Wilderness, camp, or ranch programs
- Therapy visits, office services, and medication management visits all count toward your Preferred or Nonpreferred visit limits.



Service	Member costs	Preapproval needed
Outpatient medication management	<ul style="list-style-type: none"> Preferred care providers — \$5 copay (no member costs first four visits) Nonpreferred care providers — 20% coinsurance visits 1–15, 50% coinsurance after visit 15 	Behavioral health outpatient services may need preapproval if not covered by Medicare.
  Outpatient services	<ul style="list-style-type: none"> With Preferred care providers — \$10 copay (no member costs first four visits) With Nonpreferred care providers — 20% coinsurance visits 1–15, 50% coinsurance after visit 15 	Behavioral health outpatient services may need preapproval if not covered by Medicare

Table 12. Behavioral health outpatient services

Outpatient service	Description
Acupuncture withdrawal management (detox)	The use of acupuncture to ease the symptoms of drug or alcohol withdrawal
Community Behavioral Health Center (CBHC) core services	Outpatient programs offering 24/7 crisis intervention, mental health and substance use treatment, care coordination, and support services for all ages
Community support programs (CSPs)	Programs to help people access and use behavioral health services

Outpatient service	Description
Day treatment	Structured, goal-oriented treatment to improve one's functioning in the community
Dialectical behavioral therapy (DBT)	Therapies to help change unhealthy behaviors and treat behavioral health disorders
Electroconvulsive therapy (ECT)	Psychiatric treatment that electrically induces seizures for relief from mental disorders
Family stabilization teams (FSTs)	Intensive home services for children, adolescents, and families dealing with complex life stress
Intensive outpatient programs (IOPs) <ul style="list-style-type: none"> • For mental health • For substance use disorder (ASAM level 2.1)* 	Regularly scheduled treatment in a structured environment for mental health and substance use disorder for at least three hours per day, up to seven days a week
Medication management	<p>The long-term prescribing of medication that's an alternative to an opioid (on which the person was previously dependent). This treatment is usually given through OTPs that are licensed to distribute and administer these medications.</p> <p>Medication management also includes ambulatory withdrawal management, more commonly known as outpatient detox. In this drug or alcohol withdrawal process, the detoxing person has daily visits with a care provider throughout withdrawal.</p>
Mobile Crisis Intervention (MCI)	An emergency, short-term, face-to-face therapy response for youth in behavioral health crisis
Neuropsychological testing	Testing to find out if a problem with the brain is affecting one's ability to reason, concentrate, solve problems, or remember
Partial hospitalization programs (PHPs) <ul style="list-style-type: none"> • For mental health • For substance use disorder (ASAM level 2.5)* 	Nonresidential, structured outpatient psychiatric and substance use treatment programs that are alternatives to inpatient care, offering at least five hours of therapy a day, up to seven days a week
Psychiatric visiting nurse association (VNA) services	Short-term in-home treatment with medication for behavioral health disorders
Psychological testing	Standardized testing tools to diagnose and assess overall psychological functioning

Outpatient service	Description
Structured outpatient addiction programs (SOAPs)	Nonresidential, structured substance use treatment programs that are more intensive than care in a doctor's office but are an alternative to inpatient care, offering at least three hours of therapy a day, up to seven days a week
Transcranial magnetic stimulation (TMS)	Noninvasive brain stimulation to treat major depression

* ASAM stands for American Society of Addiction Medicine. These are levels of criteria based on a set of guidelines that help care providers evaluate a person's needs and recommend the right level of treatment.

Substance use assessment/referral

Your plan covers the cost of substance use disorder assessment. After a thorough assessment, your care provider can refer you for treatment if needed.

Service	Member costs	Preapproval needed
Substance use disorder assessment and referral	No member costs	No

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, like a medical office, home, hospital, other medical facility, or through virtual care (telehealth).

Important! If you have more than one outpatient service from the same care provider on the same day, you only owe one copay. If the copays that apply to the services differ, you owe the higher copay.

For the best benefit, use Medicare care providers and suppliers. Find one at [medicare.gov](https://www.medicare.gov).

Search for a Wellpoint care provider or supplier at [wellpointmass.com](https://www.wellpointmass.com), if no Medicare provider is available.

Restrictions

- Family and individual therapy must happen in a care provider's office, a healthcare facility, or your home, if appropriate. There is no coverage for therapy performed in nonconventional settings like:
 - Spas or resorts
 - Therapeutic or residential schools

- Educational, vocational, or recreational locations
- Day care or preschools
- Outward Bound
- Wilderness, camp, or ranch programs
- Group therapy sessions must be 50 minutes or less.
- Therapy visits, office services, and medication management visits all count toward the four-visit limit (contracted) or the 15-visit limit (noncontracted), whichever applies.

Service	Member costs	Preapproval needed
Individual therapy or family therapy	<ul style="list-style-type: none"> • With Preferred care providers — \$10 copay (no member costs first four visits) • With Nonpreferred care providers — 20% coinsurance visits 1–15, 50% coinsurance for visits after 15 	No
Group therapy	<ul style="list-style-type: none"> • With Preferred care providers — \$5 copay (no member costs first four visits) • With Nonpreferred care providers — 20% coinsurance visits 1–15, 50% coinsurance for visits after 15 	No

Chapter 6: Covered preventive services

The plan covers preventive or routine office visits, physical exams, and other related preventive services listed in Table 13 below. Covered preventive services include those services recommended by the U.S. Preventive Services Task Force as part of the Affordable Care Act (ACA), which is the health care reform legislation that was passed in March 2010. 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, which means there is no out-of-pocket cost for you. You'll find recommended services for each gender and age group and how often to have them.

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 health condition. If during your preventive visit you get services to treat an existing condition, you may owe your member costs for those services.

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

Table 13. Recommendations for preventive care services

Preventive service	Males	Females	Recommendations
Abdominal aortic aneurysm screening	Yes	Yes	One-time screening for people 65 or older
Alcohol misuse screening and counseling	Yes	Yes	Part of a preventive exam
Anemia screening	No	Yes	Part of a preventive exam
Anxiety screening	Yes	Yes	Part of the preventive exam for children and adolescents 8 to 18 years old
Aspirin to prevent cardiovascular disease and colorectal cancer	Yes	Yes	Subject to your prescription drug benefit
Blood pressure screening	Yes	Yes	Part of a preventive exam
Bone density testing to screen for osteoporosis	No	Yes	Every 2 years for women 40 and older
BRCA risk assessment and genetic counseling/testing for breast cancer	No	Yes	One-time screening

Preventive service	Males	Females	Recommendations
Breast cancer counseling, preventive medications, and screening	No	Yes	Part of preventive exam
Breastfeeding counseling	No	Yes	Part of perinatal exams
Cardiovascular disease prevention — includes nutritional and physical activity counseling	Yes	Yes	Part of a preventive exam for high-risk adults
Chlamydia screening	No	Yes	Every 12 months
Cholesterol screening	Yes	Yes	Every 12 months
Colorectal cancer screening — includes colonoscopies, fecal occult blood testing, and other related services and tests	Yes	Yes	As recommended by care provider
CT lung cancer scan for adults who have smoked	Yes	Yes	Each year for current and former smokers 50 to 80 years old
Depression screening — includes screening for perinatal depression during and after pregnancy	Yes	Yes	Part of preventive and perinatal exams
Developmental and behavioral screening	Yes	Yes	Part of a preventive exam for children
Diabetes screenings — type 2 and gestational	Yes	Yes	Part of a preventive exam
Domestic violence screening	No	Yes	Part of a preventive exam for women of childbearing age
Drug use screening	Yes	Yes	Part of a preventive exam
Falls prevention — includes vitamin D counseling and/or physical therapy	Yes	Yes	For at-risk community-dwelling adults age 65 and over
Fluoride supplements	Yes	Yes	Starting at the age of primary tooth eruption, up to age 5

Preventive service	Males	Females	Recommendations
Folic acid supplements to help prevent birth defects	No	Yes	During pregnancy to prevent birth defects (subject to your prescription drug benefit)
Gonorrhea preventive medication	Yes	Yes	For newborns at birth
Gonorrhea screening	No	Yes	Every 12 months
Gynecological exams	No	Yes	Every 12 months
Hearing screening	Yes	Yes	For newborns at birth
Height, weight, and body mass index (BMI) measurements	Yes	Yes	Part of a preventive exam
Hepatitis B screening and/or titers	Yes	Yes	As recommended by care provider
Hepatitis C screening	Yes	Yes	As recommended by care provider
HIV Pre-Exposure Prophylaxis (PrEP) — includes medications, testing, monitoring, and adherence counseling	Yes	Yes	Medications subject to your prescription drug benefit
HIV screening — for the virus that causes AIDS	Yes	Yes	As recommended by care provider
Human papillomavirus (HPV)	No	Yes	Every 5 years for women 30 and older with normal cytology (cell) results
Hypothyroidism screening	Yes	Yes	For newborns at birth
Immunizations	Yes	Yes	As recommended by care provider
Iron supplements for anemia	Yes	Yes	For at-risk babies 6 to 12 months old

Preventive service	Males	Females	Recommendations
Lab tests — includes hemoglobin, urinalysis, and chemistry profile, including: <ul style="list-style-type: none"> • Complete blood count (CBC) • Glucose • Blood urea nitrogen (BUN) • Creatinine • Alanine aminotransferase (ALT) • Aspartate aminotransferase (AST/SGOT) • Thyroid stimulating hormone (TSH) 	Yes	Yes	Part of the preventive exam, as recommended by care provider
Lead exposure screening	Yes	Yes	For children
Mammogram screening for breast cancer	No	Yes	As recommended by care provider
Nutritional counseling	Yes	Yes	For children at high risk of obesity
Obesity screening and counseling	Yes	Yes	Part of a preventive exam
Oral health assessment	Yes	Yes	Part of children’s preventive exams
Pap test screening for cervical cancer	No	Yes	As recommended by care provider
Phenylketonuria (PKU) screening	Yes	Yes	For newborns at birth
Preeclampsia screening and prevention	No	Yes	During pregnancy
Preventive exams (adults)	Yes	Yes	Yearly for those age 19 and older
Preventive exams (children)	Yes	Yes	<ul style="list-style-type: none"> • Newborn: four exams in the hospital • 0 to 6 months: monthly exams • 6 to 18 months: every 2 months • 18 months to 3 years: every 3 months • 3 to 19 years: yearly

Preventive service	Males	Females	Recommendations
Prostate cancer screening with digital rectal exam and PSA test	Yes	No	Digital exam part of preventive exam for those 50 and older; PSA test every 12 months
Rh incompatibility screening	No	Yes	During pregnancy
Sexually transmitted infections (STI) counseling	Yes	Yes	Part of a preventive exam
Sickle cell disease screening	Yes	Yes	For newborns at birth
Skin cancer behavioral counseling	Yes	Yes	Part of a preventive exam
Syphilis screening	Yes	Yes	As recommended by care provider
Tobacco use counseling and interventions — includes drugs and deterrents subject to your prescription benefit	Yes	Yes	Counseling is part of a preventive exam
Tuberculosis screening	Yes	Yes	As recommended by care provider
Urinary tract infection (UTI) screening — asymptomatic bacteriuria	No	Yes	During pregnancy
Vision screening	Yes	Yes	Part of children's preventive exams
Vision screening (instrument based)	Yes	Yes	Every 3 to 5 years



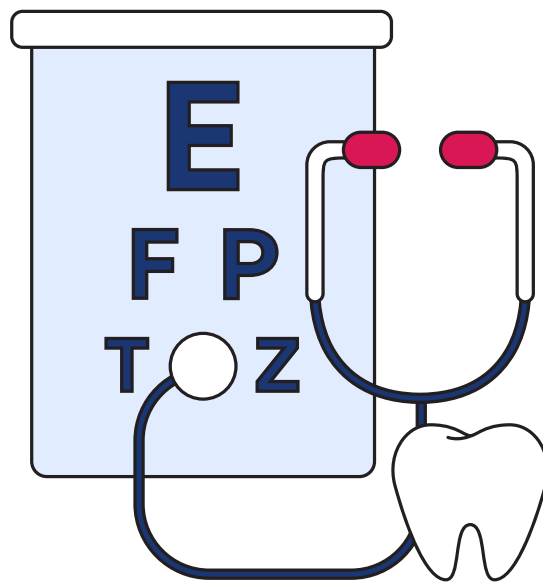
Questions about immunizations?

The Centers for Disease Control and Prevention lists which vaccines a person should have based on their age at [cdc.gov/vaccines/imz-schedules](https://www.cdc.gov/vaccines/imz-schedules).

- Check the [childhood immunization schedule](#).
- Check the [adult immunization schedule](#).

Using your plan

Details about your plan and coverage



Benefits are administered by Wellpoint. For questions about any of the information in Chapters 7-11 of this handbook, please call Wellpoint Member Services at 800-442-9300.



Chapter 7: Excluded and limited services

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

Important! Costs for services that the plan doesn't cover don't count toward your deductible or your out-of-pocket maximum. Member costs like the deductible and your out-of-pocket maximum only apply to covered services.

Table 14. Excluded, restricted, and limited benefits

Service	What is not covered or has limited coverage
A	
Acne-related services	Services to diagnose or treat the underlying condition causing the acne are covered. No coverage for removing acne cysts, injections to raise acne scars, cosmetic surgery, dermabrasion, or similar services.
Acupuncture	Covered as a behavioral health service only when acupuncture is used as part of an alcohol or drug withdrawal management program.
Allowed amounts	No coverage for charges over the plan's allowed amounts.
Alternative treatments	No coverage for alternative treatments used in place of conventional medicine, as defined by the National Center for Complementary and Integrative Health (National Institutes of Health).
Ambulances	<ul style="list-style-type: none"> Ambulance transportation must be needed for your health (medically necessary). Ambulance must take you to the nearest hospital that can help you. Air and water ambulance are covered only when ground ambulance risks your health. Nonemergency ground ambulance is not covered. Your plan doesn't cover transportation in chair cars or vans, transportation that's mostly for convenience, or nonemergency air ambulance or water ambulance.
Anesthesia for behavioral health services	Covered for electroconvulsive therapy (ECT) only.

Service	What is not covered or has limited coverage
Animals	No coverage for expenses related to service animals, pet therapy, or hippotherapy (therapeutic or rehabilitative horseback riding).
Arch supports	Not covered.
Assistant surgeons	An assistant surgeon must be a licensed care provider (like a physician or physician’s assistant) acting within the scope of their license. Your plan does not cover interns, residents, or fellows serving as assistant surgeons. Your plan only covers one assistant surgeon per procedure.
Athletic trainers	Not covered.
B	
Beds and bedding	No coverage for non-hospital beds, orthopedic mattresses, or weighted blankets.
Behavioral health services	<p>Primary care visits associated with a behavioral health diagnosis are covered. Otherwise, your plan does not cover the diagnosis, treatment, or management of mental health/substance use disorder conditions by medical (nonbehavioral health) care providers.</p> <p>Your plan only covers services for conditions that are classified in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).</p> <p>Other noncovered behavioral health services include:</p> <ul style="list-style-type: none"> • Services that aren’t consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury, or substance use disorder • Services that aren’t consistent with national standards of clinical practice for the treatment of such conditions • Services that aren’t consistent with professional research showing the service or supplies will have a measurable and beneficial health outcome
Biofeedback	Not covered for treating behavioral health conditions.
Blood	The plan does not pay for donated blood.
Blood pressure cuffs (sphygmomanometers)	Not covered.

Service	What is not covered or has limited coverage
C	
Cardiac rehab programs	Covered only when started within six months of a cardiac event.
Chair cars and vans	No coverage for transportation in chair cars or vans.
Chiropractic care	Services provided by a chiropractor are considered chiropractic care, not physical therapy. Group chiropractic care is not covered.
Chronic conditions	No coverage for physical therapy, occupational therapy, or speech therapy to treat a chronic condition when that treatment won't cure your condition or restore function.
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.
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.
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	<p>No coverage for cosmetic procedures or services except for:</p> <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 <p>Cosmetic services are not covered even if they are intended to improve one's emotional outlook or treat a mental health condition. Cosmetic services are services done mainly to improve appearance. They don't restore bodily function or correct functional impairment.</p>
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 designed to assist with activities of daily living, and cannot reasonably be expected to restore physical health or bodily function.

Service	What is not covered or has limited coverage
D	
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.
Dentures, dental prosthetics, and related surgery	Not covered.
Dialysis	No coverage for dialysis to treat a behavioral health condition.
Driving evaluations	Not covered.
⚠️ Drugs — non-oncology -infused drugs	Dispensed by the prescription drug plan.
Drugs — off label	Not covered unless the off-label use meets your plan’s definition of medical necessity or the drug is specifically designated as covered by the plan. Off-label use is the use of a drug for a purpose other than that approved by the U.S. Food and Drug Administration (FDA).
Drugs — over the counter	Never covered without a prescription. Some over-the-counter drugs, like tobacco cessation products, are covered by the prescription drug plan when you have a prescription.
Drugs — specialty	Your plan covers some specialty drugs, which need preapproval. Other self- or office-administered specialty drugs are dispensed under the prescription drug plan. Specialty drugs are certain pharmaceutical and/or biotech or biological drugs (including “biosimilars” or “follow-on biologics”) used in the management of chronic or genetic disease. Specialty drugs include, but are not limited to, injectables; infused, inhaled, or oral medications; or those that otherwise require special handling.
Duplicate services	Your plan will only cover a service or procedure once per day. No coverage for multiple charges for the same service or procedure on the same date.

Service	What is not covered or has limited coverage
Durable medical equipment (DME)	<p>Only medically necessary equipment is covered. Your plan does not cover:</p> <ul style="list-style-type: none"> • Equipment for recreation, like sports wheelchairs or exercise equipment • Items to help control your environment, like air cleaners and dehumidifiers • Items to change your home, like electronic door openers, elevators, ramps, or stairway lifts • Added features or accessories, like wheelchair customizations, systems to secure wheelchairs in moving vehicles, or hand controls for driving • Items meant to be used outdoors, like hiking equipment or special wheelchairs for the beach • Backup items, like a manual wheelchair in case of a problem with your powered wheelchair • Upgrades and replacements for items that still work or could be repaired
E	
Ear molds	Not covered except when needed for hearing aids for members age 21 and under.
Enteral and oral therapy	<p>Prescription and nonprescription enteral and oral formulas are covered only when ordered by a doctor 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>Baby formula is not covered by your medical plan. Call SilverScript at 877-876-7214 to find out if it's covered by your prescription drug plan.</p>
Equipment transportation and setup	No coverage for costs associated with transporting and setting up equipment, such as portable X-ray equipment.
Exercise and recreational equipment	No coverage for equipment for recreation, like sports wheelchairs or exercise equipment.
Experimental or investigational services or supplies	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. If a doctor ordered it, or that this treatment's being tried after others have failed, does not make it medically necessary.

Service	What is not covered or has limited coverage
Eyeglasses and contact lenses	Only one set of eyeglasses or contact lenses is covered, and only within the first six months after the injury or surgery. No coverage for deluxe frames or specialty lenses such as progressive or transitional lenses, tinted lenses, antireflective 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 yourself or someone in your immediate family. Your immediate family includes you, your spouse, your children, and the parents and siblings of you and your spouse.
Fees for nonmedical services	Your plan doesn't cover fees for nonmedical services like day care, food services, diet programs, lab handling fees, membership fees (except for the fitness reimbursement program), record processing fees (unless required by law), shipping costs, storage fees, or equipment transportation and setup costs.
Fitness reimbursement	To be eligible, you must participate in physical activity at least four times a month, on average. Any family member may have the fitness membership, but the reimbursement is paid to the plan enrollee only. Beach club or country club memberships, fees for one-day events, annual or day passes (such as for skiing), spas or spa services, and personal or home fitness equipment are not eligible for reimbursement.
"Free" or no-cost services	No coverage for charges you have no legal responsibility to pay, or for any medical service or supply that wouldn't cost anything without medical insurance.
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

Service	What is not covered or has limited coverage
Group therapies	No coverage for group therapy for chiropractic care, occupational therapy, or physical therapy.
H	
Hearing aids	No coverage for hearing aid batteries or over-the-counter (OTC) hearing aids.
Herbal medicine	Not covered.
Home modifications or environmental controls	No coverage for items to help control your environment, like air cleaners and dehumidifiers; or for items to change your home, like electronic door openers, elevators, ramps, or stairway lifts.
Homemaking services	Not covered.
Homeopathic, holistic, or naturopathic care	Not covered.
Household residents	No coverage for services received from anyone who shares your legal residence.
Hypnotherapy	Not covered.
I	
Immunization titers	Covered for pregnant women only. Immunization titers are lab tests to find out if a person needs a vaccination.
Incontinence supplies	Not covered.
Infertility treatment	<ul style="list-style-type: none"> • Experimental infertility procedures aren't covered. • Your plan does not pay people to donate their eggs or sperm. • Your plan does not pay people to be surrogates (gestational carriers), and there is no coverage for medical services, including in vitro fertilization, for a surrogate who is not a Wellpoint member. • 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, or when you're undergoing medical treatment that could cause infertility.

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 or 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.
Mastectomy bras	Limited to two bras every two years, unless you need a new bra because your prosthesis has changed. Supporting documentation is required.
Medical necessity	<p>No coverage for any treatment that is not medically necessary. The only exceptions to this requirement are:</p> <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 in the same hospital • Covered preventive care provided by a hospital or doctor • A service or supply that qualifies as covered hospice care
Medical orders	There is no coverage for any service or supply that hasn’t been ordered by a doctor. All covered services and supplies need a medical order from a doctor.
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 Health Administration).
Missed appointments	Not covered.

Service	What is not covered or has limited coverage
N	
Narconon treatment and facilities	Not covered.
Newborn admissions	If a newborn is admitted to the hospital independently of its mother, that's considered a separate hospital admission and you'll owe a separate inpatient copay.
Nonconventional behavioral health treatments	No coverage for nonconventional behavioral health treatments, like aversive or counter-conditioning; brain imaging or mapping to diagnose behavioral health disorders; hemodialysis; olfactory/gustatory release; primal therapy; Prometa (GABASYNC) treatment protocol; Rolfing; or structural integration.
Nonconventional treatment settings	No coverage for treatment performed in a nonconventional setting, like a spa or resort; a therapeutic or residential school; educational, vocational, or recreational locations; day care or preschool; Outward Bound programs; or wilderness, camp, or ranch programs.
Noncovered services and associated services	Noncovered services include those for which there is no benefit and those that aren't medically necessary, as determined by your plan. If a service isn't covered, any associated services are also not covered. For example, anesthesia and facility fees associated with a noncovered surgery are not covered.
Nutritional counseling	Services or counseling (therapy) must be performed by a registered dietitian.
Nutritional supplements (oral)	<p>No coverage for nutritional supplements administered by mouth, including:</p> <ul style="list-style-type: none"> • Orally administered dietary and food supplements and related supplies • Nutritional supplements to boost caloric or protein intake, including sport shakes, puddings, and electrolyte supplements
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, videotape gait analysis, diagnostic scanning, or arch supports.

Service	What is not covered or has limited coverage
Oxygen equipment for travel	No coverage for oxygen equipment needed 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, such as air conditioners, arch supports, bedpans, 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, and whirlpools.
Physical therapy	No coverage for group physical therapy or for certain therapy services including, but not limited to, acupuncture, aerobic exercise, craniosacral therapy, diathermy, infrared therapy, kinetic therapy, microwave therapy, paraffin treatment, Roling therapy, Shiatsu, sports conditioning, ultraviolet therapy, and weight training.
Private-duty nursing	Not covered.
Programs with multiple services	No coverage for programs that provide multiple services but that bill at a single, nonitemized rate (for example, a daily fee for a full-day rehab program). Itemized bills are always required.
Providers	No coverage for services from sanctioned or unlicensed providers; no coverage for services outside the scope of a provider's license.
R	
Reiki therapy	Not covered (Reiki is a hands-on energy-based therapy).
Religious facilities	No coverage for services received at nonmedical religious facilities.
Residential treatment for behavioral health services	<p>No coverage for nonacute residential treatment. Examples of such treatment include:</p> <ul style="list-style-type: none"> • Clinically managed low-intensity residential services • Clinically managed population-specific, high-intensity residential services • Recovery residences • Sober homes

Service	What is not covered or has limited coverage
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 in Chapter 6.
S	
School services	No coverage for services provided through schools.
Sensory integration therapy	Not covered.
Serious preventable adverse events	Costs associated with serious preventable adverse healthcare events aren't covered, in accordance with Department of Public Health (DPH) regulations. Massachusetts care providers cannot bill members for designated serious reportable healthcare events.
Shipping costs	No coverage for shipping costs, such as the cost of shipping eggs or sperm between fertility clinics.
Shoes	<p>No coverage for shoes, including special shoes to fit orthotics or to wear after foot surgery, except for:</p> <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 or stimulation treatments	Transcranial magnetic stimulation is covered under your behavioral health benefit. Otherwise, there is no coverage for stimulators or stimulation treatments, including Alpha-Stim cranial electrotherapy stimulators; Fisher Wallace neurostimulators; and vagus nerve stimulation.
Storage for blood or 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.

Service	What is not covered or has limited coverage
T	
Temporomandibular joint (TMJ) disorder	Treatment of TMJ disorder is limited to the initial diagnostic examination, initial testing, and medically necessary surgery. 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.
Therapy (behavioral health)	Group therapy sessions must be 50 minutes or less. Family and individual therapy must be conducted in a care provider’s office; a facility; or, if appropriate, at a member’s home.
Thermal therapy	No coverage for any type of thermal therapy, including hot packs, cold packs, or continuous thermal therapy devices.
Third parties	No coverage for any medical supply or service required by a third party (like your employer, the court, an insurance company, a school, or a sober living facility) but not otherwise medically necessary (such as a court-ordered test or an insurance physical).
Tobacco cessation counseling	Counseling is also covered as part of your preventive exam.
Transportation to and from appointments	Transportation to a hospice facility or location is covered. Nonemergency ground transportation may be covered if it’s medically necessary and your medical condition is such that no other form of transportation is viable. Nonemergency ambulance transportation requires preapproval.
Travel time	No coverage for travel time to or from medical appointments.
V	
Vision correction	No coverage for surgery to correct refractive errors like astigmatism, myopia (nearsightedness), hyperopia (farsightedness), and presbyopia (aging-related blurry vision). Noncovered services include orthoptics for vision correction, radial keratotomy, and other laser surgeries.

Service	What is not covered or has limited coverage
W	
Weight loss	Services for weight loss treatment are limited to members whose body mass index (BMI) is 40 or more while under the care of a doctor. 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 burns, chemotherapy, congenital baldness, infection, radiation therapy, traumatic injury, or other medical conditions resulting in alopecia areata or alopecia totalis (capitus). No coverage for wigs when hair loss is due to female pattern baldness, male pattern baldness, or natural or premature aging.
Workers' compensation	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. Occupational injury or disease is an injury or disease that arises out of and in the course of employment for wage or profit.
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.

Important! Costs for services that the plan doesn't cover don't count toward your out-of-pocket maximums. Only member costs for covered services apply to your out-of-pocket limits.

Chapter 8: Your plan and coverage

Types of care providers

A care provider is a person, place, or organization that delivers healthcare services or supplies. A care provider can be a **person** (like a doctor), a **place** (like a hospital), or an **organization** (like hospice). Read below to learn more about the different kinds of care providers.

Primary care providers

We strongly encourage all Wellpoint members to choose a primary care provider (PCP), also known as a family doctor. A PCP:

- Is a doctor who is familiar with you and your healthcare needs
- Can help you understand and coordinate care you get from other care providers, such as specialists, who may not know you as well
- Can be a nurse practitioner, physician assistant, or doctor who specializes in family medicine, general medicine, pediatrics, geriatrics, or internal medicine

Important! Although some specialists may also provide primary care, they're still considered specialists. This means if you have a visit with them, you'll pay the specialist visit copay whether you visit them for primary care or specialty care.

Specialists

Specialists (also called **specialty care providers**) are doctors, 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 visit a specialist.

Behavioral health care providers

Behavioral health care providers can be doctors, therapists, hospitals, and other facilities that treat mental health and substance use conditions.

Some behavioral health care providers are Preferred through Carelon to provide services to Wellpoint members. **You have lower copays when you use these Preferred behavioral health care providers.** They've gone through a credentialing process and must meet and follow the quality standards Wellpoint requires.

Important! Wellpoint's payments to all behavioral health care providers are subject to the allowed amount for the claim.

- Preferred care providers accept allowed amounts as payment in full and will not send you a bill with a balance due.
- Nonpreferred care providers, both in Massachusetts and elsewhere, may send you a bill for charges over the allowed amount (which is above the amount the plan paid). Check “Your rights and protections against surprise medical bills” for information about balance billing protection.

Wellpoint will only pay claims from care providers who are independently licensed in their specialty area or are working in a facility or licensed clinic under the supervision of an independently licensed care provider. This is true for both Preferred and Nonpreferred behavioral health care 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
- PhD
- PsyD (doctorate in psychology)
- EdD (doctorate in education)
- BCBA (board-certified behavioral analyst)
- LICSW (licensed social worker)
- LMHC (licensed mental health counselor)
- LMFT (licensed marriage and family therapist)
- RNCS (registered nurse clinical specialist)

Hospitals and other inpatient facilities

The plan covers inpatient medical care when you are admitted to an inpatient facility. Your benefits for these services depend on the type of inpatient facility and care you receive. Check “Inpatient medical care (hospital admissions)” in Chapter 5 for coverage details.

Table 15. Types of inpatient facilities

Facility	What they are and services they provide
Acute care hospitals	Medical centers and community hospitals that: <ul style="list-style-type: none"> • Treat severe illnesses, diseases, and trauma • Provide surgery recovery with 24-hour intensive medical and nursing care

Facility	What they are and services they provide
Long-term care facilities	Specialized hospitals for patients with complex conditions who need medical care but not within a traditional hospital setting. Their ability to participate in rehab is limited.
Rehabilitation (rehab) facilities	Specialized hospitals that help restore basic functions like walking or sitting upright after an illness or injury. Patients have a good chance for recovery and can have 3–5 hours of therapy a day.
Skilled nursing facilities	Provide lower-intensity rehab and medical services for patients who have ongoing medical needs that require skilled nursing care but not daily care from a doctor. Some patients may or may not require rehab, while others may need long-term custodial care. The plan does not cover custodial care.

Non-hospital-owned facilities

Non-hospital-owned facilities are independent, stand-alone offices that perform outpatient medical services and not owned and operated by a hospital. They often bill differently than hospital-owned facilities.

A facility’s name isn’t always a guide to whether it’s owned by a hospital. 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. Facilities that can be hospital-owned or non-hospital-owned include:

- Ambulatory surgery centers
- Walk-in clinics, such as urgent care centers (check “Walk-in clinics” below)
- Specialized health facilities, such as imaging centers (check “Specialized health facilities” in Chapter 11 for more information)

Important! Before you use a facility, ask how your visit will be billed — which will determine how much you owe.

Walk-in clinics

Important! Before you use a walk-in clinic, ask if your visit will be billed as a hospital service. Check “non-hospital-owned facilities” (in the previous entry) for why this is important.

Walk-in clinics are sites that allow you to walk in for medical care without an appointment. Walk-in clinics have a variety of different names but fall into four general categories based on the services they offer and how they bill for their services.

Table 16. Types of walk-in clinics

Type of walk-in clinic	Services it provides
Hospital	Some hospitals have walk-in clinics connected to their emergency departments.
Medical practices	Doctors' offices that take walk-in patients and provide primary care services.
Retail health clinic	Located in stores or pharmacies and offer basic services like vaccines and care for minor illnesses like colds and sinus infections.
Urgent care center	Independent, stand-alone centers for illnesses or injuries that need immediate care but are not life-threatening. Services include things like X-rays, lab tests, and stitches.

Virtual care (telehealth) through LiveHealth Online

LiveHealth Online is a telehealth company that offers virtual care with licensed medical and/or behavioral health care providers. Using your smartphone, tablet, or computer with a camera, you can meet with a doctor about common health concerns like colds, the flu, fevers, rashes, infections, and allergies. Doctors are available 24 hours a day, 365 days a year.



You can access **LiveHealth Online** at livehealthonline.com or download the Sydney® Health app from sydneyhealth.com.

Medicare-participating providers

Participating care providers are healthcare providers who have signed an agreement with Medicare to accept Medicare's payment as payment in full for covered services. No matter where you live, participating care providers will not balance bill you for charges over the allowed amount. Find Medicare-participating providers at [medicare.gov](https://www.medicare.gov).

Wellpoint Preferred suppliers

If there aren't any Medicare suppliers for the equipment or supply you need, there may be a Wellpoint Preferred supplier you can use. Preferred suppliers are those that have agreed to accept Wellpoint's allowed amounts for the services listed below:

- Durable medical equipment (DME)
- Medical or diabetic supplies
- Home healthcare
- Home infusion therapy (including enteral and oral therapy)

Services from Preferred suppliers are covered at 100% of the allowed amount. Nonpreferred suppliers are covered at 80%, so you'll owe 20% coinsurance.

Important! Nonpreferred suppliers are covered at 80% even if you're only using them because the item isn't available from a Preferred supplier.

Nonpreferred suppliers outside of Massachusetts can send you a balance bill for any charges over the allowed amount. Since the plan doesn't cover balance bills, you'll have to pay the amount due. Federal law prohibits Nonpreferred suppliers from sending you surprise balance bills. Check "Your rights and protections against surprise medical bills" in Chapter 2 for information about balance billing protection.

You can find Preferred suppliers at [wellpointmass.com](https://www.wellpointmass.com).

Preferred care providers

Preferred care providers are care providers — such as doctors, hospitals, and health facilities — who have agreed to accept the plan's payment as payment in full. Preferred care providers won't balance bill you for charges over Wellpoint's allowed amount. (The allowed amount is the maximum amount that Wellpoint pays for a covered service.)

Medical care providers

In Massachusetts, you can get care from any medical care provider because state law prohibits Massachusetts medical care providers from balance billing Wellpoint members. Outside of Massachusetts, you can be billed for the balance if you choose to go to a Nonpreferred care provider for elective services.

Behavioral health providers

Important! Nonpreferred behavioral health care providers in Massachusetts and elsewhere may send you a bill for the balance. To avoid being balance billed, choose Preferred behavioral health care providers. Be sure to always verify a care provider's status as a Preferred care provider when you receive care, as their status can change anytime during the calendar year.

How to find care providers

To find Medicare-participating providers and suppliers, go to [medicare.gov](https://www.medicare.gov). You can find care providers at [wellpointmass.com](https://www.wellpointmass.com). You can also use the [Sydney Health app](#) to look for:

- Doctors and hospitals, both in and outside of Massachusetts
- Behavioral health care providers who are Preferred with Carelon
- Preferred suppliers
- Other kinds of facilities in Massachusetts, like urgent care centers and ambulatory surgery centers



How do I find care providers on Sydney Health?

The [Sydney Health app](#) lets you search for medical and behavioral health care providers in and outside of Massachusetts.

Once online or in the app, select **Care**, then **Find Care**, to search for care providers in your plan's network. Choosing Preferred care providers will save you money.

How Wellpoint reimburses care providers

The plan usually pays care providers for each service they deliver. With healthcare legal reforms taking place in Massachusetts, some care providers might also earn additional payments for hitting quality and cost goals that we set, such as providing quality care that meets our standards, lower costs, and better care coordination.

Details about these payments are on the plan's website and available upon request. Care providers can discuss their payment methods with you.

How to submit a claim

To receive benefits from your plan, a claim must be filed for each service. Most hospitals, doctors, and other care providers will submit claims for you. If your care provider files claims on your behalf, they will be paid directly.

If you submit your own claim, you must provide written proof of the claim with the:

- Diagnosis.
- Date of service.
- Amount of charge.
- Name, address, and type of care provider.

- Provider tax ID number, if known.
- Name of enrollee.
- Enrollee's ID number.
- Name of patient.
- Description of each service or purchase.
- Other insurance information, if it applies.
- Accident information, if it applies.
- Proof of payment. If the proof of payment you get from a care provider contains information in a language other than English, please provide Wellpoint with a translation, if possible.

Proof of payment is a record that shows you paid for the services you received. This includes a receipt, bank statement, invoice provided by the care provider that shows payment was made, or other record that shows the payment was successful. Wellpoint's claim form may be used to submit written proof of a claim.

To learn more about the allowed amount for a claim, check Chapter 2.

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



How do I submit a prescription drug claim?

Prescription drug claims must be submitted to SilverScript, the administrator of your prescription drug plan. Check Chapter 12 of this handbook for more information.

Deadlines for filing claims

You need to submit your claim to Wellpoint within two years from the service date. If it's submitted after two years, it will only be reviewed if you're able to show the person treated was unable to submit it on time due to mental or physical reasons.

Recovery of overpaid claims

If the plan makes an overpayment for a claim, it has the right to recover the payment from one or more of the following:

- The person who received the payment or to whom the payment was made
- Other insurance companies
- Other organizations

Checking the claims for billing accuracy

The Bill Checker program

The Bill Checker program helps find overpayments that happen because of billing errors that only you may notice. The plan encourages you to review all of your medical bills for accuracy, just as you might do with your utility bills. If you find a billing error and get a corrected bill from your doctor, you get to share in any savings the plan finds.

What you need to do

Ask the doctor to send you an itemized bill for the services you received. As soon as possible, review this bill for any charges for treatment, services, or supplies you didn't receive.

Ask yourself:

- Did I receive the therapy described on the bill?
- Did I receive X-rays as indicated on the bill?
- Are there duplicate charges on the same bill?
- Have I been charged for more services than I received?
- Did I receive the laboratory services described on the bill?
- Does the room charge reflect the correct number of days?
- Was I charged for the correct type of room?

If you find a billing error

If you find a billing error, contact the doctor or the doctor's billing office and let them know which charges you're concerned about. Ask for an explanation on those charges and a revised itemized bill showing the adjustments they make.

How to get your share of the savings

To get your share of the savings:

1. Send copies of both the original and revised bills and the completed Bill Checker form to the plan.
2. Be sure to include the plan enrollee's name and ID number on the Bill Checker form.

Download the Bill Checker form from [wellpointmass.com](https://www.wellpointmass.com).

The plan will review the two bills, and if a billing error is confirmed, you'll receive 25% of any savings. All reimbursements are subject to state and federal income taxes.

Care provider bills eligible under the program

- All bills that Wellpoint provides the primary benefits for are eligible under the Bill Checker program.
- Members who have Medicare as their primary coverage cannot use Bill Checker.
- This program may not apply to certain inpatient bills paid under the Diagnosis Related Group (DRG) methodology.
- Bills for prescription drugs are also excluded because Wellpoint does not administer those benefits.

Claim reviews for fraud and other inappropriate activity

Wellpoint regularly checks claims to make sure bills are correct. This is why we may ask your doctor for documents, such as office and procedure notes and X-ray and pathology reports.

To spot fraud, waste, abuse, and other inappropriate activity, we review claims before and after making payments. If your doctor doesn't provide the records we need, we might deny the claim, which means the doctor could bill you. If we suspect fraud or abuse with the claim, you might need to be examined by a doctor chosen by Wellpoint, which would be at no cost to you.

Deadlines on bringing legal action

If you're filing a lawsuit to recover benefits for charges that occurred while you were covered under the plan, you can do so 60 days to 3 years after Wellpoint gets complete written proof of the claim. If your state has a longer limit, that limit applies.

Right of reimbursement (payment from a third party)

If you or your dependents get money from a third party for an injury or illness that Wellpoint already paid for, Wellpoint has a right to some of that money (called a "lien"). This could include payments you received from the person responsible for the injury or disease, their insurers, or an auto insurance carrier (including uninsured and underinsured motorist coverage).

You only need to pay back Wellpoint the amount they paid for your benefits. You must provide any documents Wellpoint needs and help them get back the money they paid for your claims.

You can find more information under "Right of reimbursement (subrogation)" in Appendix B.

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 it. The notice also explains your rights as well as the GIC's legal duties and privacy practices.

The review process

Wellpoint reviews certain medical services and inpatient admissions to make sure they're eligible for benefits. Check Chapter 3 for information about preapprovals. These preapproval reviews — sometimes called **pre-service reviews** or **preauthorizations** — are a standard practice for most health plans. These reviews help make sure that benefits are paid for services that are medically necessary, safe, and appropriate for you.

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 care provider will contact Wellpoint when a service requires review. If calling after business hours, leave a message and Member Services will return the call on the next business day. When they call back, Wellpoint staff will say their name, title, and organization.

Associates, consultants, and other care 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 people based on the idea they will deny benefits. Decisions are based only on appropriateness of care and service and your coverage.

When preapproval is first requested

When Wellpoint learns that you've been admitted to the hospital or you're 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 care providers.
- The reviewing nurse goes over the information to make sure it meets Wellpoint's medical policies and guidelines and is eligible for benefits.
- If the nurse can certify that the service is eligible for benefits, it will be approved.
- If the nurse can't certify the service, they'll forward your request to a Wellpoint physician adviser for further review.

If the service is approved

When a service is approved, Wellpoint will let your care providers know.

If the service isn't approved

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

You and your doctor have a couple of options:

- **Your doctor can ask Wellpoint to reconsider.** Your doctor can send more supporting information or ask to speak with a physician adviser. A request for reconsideration must occur within three business days of getting the adverse benefit determination.
- **You can appeal.** You and your doctor have a legal right to appeal an adverse benefit determination. Check Appendix C for instructions on how to file an appeal.

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 (a denial) made by the plan within 180 days of getting it. Check Appendix C for instructions on how to file an appeal.

If you're appealing a prescription drug service, you must file your appeal with SilverScript, the administrator of those services. Check Chapter 12 of this handbook for more information.

Chapter 9: Enrollment and membership

Here you'll learn more about enrolling yourself and your spouse and eligible dependents for health coverage. You'll also find information on when coverage starts and continuing it if your eligibility status changes.

Free or low-cost health coverage for children and families

If you're eligible for health coverage from your employer but can't afford the premium cost, your state may have a program to help you pay for it. For information, check Appendix B in this handbook, "Mandates and required member notices."

Information for disabled dependents

A physically or mentally disabled child age 26 and older who is incapable of self-support may obtain handicapped dependent coverage. Coverage is subject to Group Insurance Commission (GIC) approval and the insured parent's continued coverage with GIC. You must apply to the GIC to enroll a dependent in this coverage.

Applying for coverage

The GIC determines who is eligible for coverage and when coverage begins. You must apply to the GIC for enrollment in the Wellpoint plan — visit mass.gov/mygiclink-member-benefits-portal for instructions on how to enroll. You or your dependents must be enrolled in Medicare Parts A and B to be eligible for the Medicare Extension plan. If you have a dependent who isn't covered by Medicare, they can enroll in one of the GIC's non-Medicare plans. Retirees can contact the GIC at mass.gov/forms/contact-the-gic or by calling **617-727-2310**.

To enroll a newly eligible dependent, submit an enrollment form before the end of their enrollment window.

Table 17. Dependent enrollment windows and required documentation

Dependent	Enrollment window	Additional documentation
Newborn child (your child or the newborn child of your covered dependent)	Within 60 days of birth	Copy of hospital announcement letter or the child's certified birth certificate
Adopted child	Within 60 days of placement in the home	Copy of proof of placement letter, court decree of adoption, or amended birth certificate
Foster child	Within 60 days of placement in the home	Copy of proof of placement letter or court order
Spouse or stepchild	Within 60 days of marriage	Copy of certified marriage certificate



Questions?

Retirees can contact the GIC at mass.gov/forms/contact-the-gic or by calling **617-727-2310**.

When coverage begins

For new employees

Health plan coverage starts on the first day of the month after your hire date, or on the date of hire if it's the first day of the month, whichever comes first.

Employees and retirees who choose not to join a health plan when first eligible must wait until the next annual enrollment period to join, or they may enroll within 60 days of a qualifying event.

If applying during an annual enrollment period

Coverage begins each year on July 1.

For spouses and dependents

Coverage begins for your spouse and/or dependents on the date your own coverage begins, or the date that the GIC has determined your spouse or dependent is eligible — whichever date is later.

For new retirees or Medicare enrollees and surviving spouses

When you apply for coverage, the GIC will let you know the date it will begin.

When coverage ends for enrollees

Your coverage ends on the earliest of these dates:

1. The end of the month covered by your final premium payment
2. The end of the month in which you're no longer eligible for coverage
3. The date of your death
4. The date a surviving spouse remarries
5. The date this health plan ends

When coverage ends for dependents

A dependent's coverage ends on the earliest of these dates:

1. The date the enrollee's coverage under this plan ends (as described above)
2. The end of the month covered by your final premium payment
3. The date the enrollee becomes ineligible to have a spouse or dependents covered
4. The end of the month when the dependent no longer qualifies as a dependent
5. The marriage date of a dependent child who was permanently and totally impaired by age 19
6. The date a divorced enrollee or their covered divorced spouse remarries
7. The date of the dependent's death
8. The date this health plan ends

Duplicate coverage

No one can be covered under a health plan as both a dependent and an employee, retiree, or surviving spouse, or as a dependent of more than one covered person.

Enrolling dependents after the new-hire period

If you didn't enroll your spouse or dependents when you were able to as a new hire, they can only enroll during a 60-day period following a qualifying event or during GIC's spring annual enrollment period. For enrollment instructions, visit mass.gov/mygiclink-member-benefits-portal. Learn more about qualifying events at mass.gov/service-details/gic-qualifying-events.



Questions?

Retirees can contact the GIC at mass.gov/forms/contact-the-gic or by calling **617-727-2310**.

Continuing coverage when employment ends

You have options for continuing your coverage even if your job is terminated, you're laid off, your hours are cut, or you retire. For continuation options, visit mass.gov/gic.

Continuing health coverage for survivors

If the enrollee dies, their surviving spouse and eligible dependent children may be able to continue coverage. Orphan coverage is available for some dependents. For more details, contact the GIC.

To continue coverage, submit a form to the GIC within 30 days of the enrollee's death and keep paying your share of the cost.

Coverage ends on the earliest of these dates:

1. The end of the month the surviving spouse dies
2. The end of the month covered by the last premium payment
3. The date the coverage ends
4. The date this health plan ends
5. For dependents: the end of the month they no longer qualify
6. The date the surviving spouse remarries

Option to continue coverage for dependents age 26 and over

A dependent child is no longer eligible for coverage under this plan when they turn 26. However, dependents age 26 or older who are full-time students at accredited educational institutions can continue coverage if you pay 100% of the individual premium. They must submit an application to the GIC within 30 days after their 26th birthday. If they miss that window, they can apply during the GIC's spring enrollment period. Students age 26 and over are ineligible if there has been a two-year break in GIC coverage.

Option to continue coverage after a change in marital status

Your former spouse can stay a dependent under this plan even after a divorce is granted unless the judgment says something different. You must tell the GIC within 60 days of a divorce and provide sections of the divorce decree, including the Divorce Absolute Date, Signature Page, and Health Insurance Provisions.

You must also tell the GIC if you or your former spouse remarries. Not reporting a divorce or remarriage could lead to you having to repay claims or premiums.

Under M.G.L. Ch. 32A and GIC regulations, your former spouse will lose dependent status when any one of these situations happens:

1. When the judgment states coverage ends.
2. At the end of the month of the last premium payment.
3. When they remarry.
4. When you remarry. If they're covered on your remarriage date and the judgment allows continued coverage, it will be available at full premium cost under a divorced spouse rider, or they may enroll in COBRA continuation coverage. Check the next section for information on COBRA.

Notice of COBRA continuation coverage rights

Introduction

Because you're now covered under a group health plan, it's important to understand your right to COBRA continuation coverage, if you need it in the future. This section explains:

- What COBRA coverage is
- Qualifying events
- When it applies to you and your family
- How to maintain your rights to it
- Other coverage options besides COBRA

For more information about your rights and obligations under your Wellpoint plan and federal law, you should review the Plan's Summary Plan Description or contact the plan administrator.

What is 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 allows you to keep your group health coverage (health, dental, and vision plans) if you lose it due to a "qualifying life event." When one of these events occurs, COBRA must be offered to qualified beneficiaries, which would include you and your covered spouse and dependents. You must pay for COBRA if you choose to have it.

Qualified beneficiaries and qualifying events explained

For enrollees, you become a qualified beneficiary if you lose your plan coverage due to:

- Reduced work hours
- Employment ending — for any reason other than gross misconduct

For spouses, you're a qualified beneficiary if you lose your plan coverage because:

- Your spouse dies
- Your spouse has reduced work hours
- Employment of your spouse ends — for any reason other than gross misconduct
- Your spouse qualifies for Medicare (Part A, Part B, or both)
- You divorce or legally separate

For dependent children, qualifying events include:

- The parent-enrollee's death
- Reduced work hours for the parent-enrollee
- Parent-enrollee's employment ends (for any reasons other than gross misconduct)
- Parent-enrollee becomes eligible for Medicare
- Parents divorcing or separating
- Child no longer eligible as a dependent

When is COBRA continuation coverage available?

The health plan will offer COBRA to qualified beneficiaries only after the plan administrator is aware of a qualifying event. Employers will notify plan administrators when there are:

- Reduced employee work hours
- Employment-ending events
- Employee deaths
- People eligible for Medicare

For divorce, separation, or losing child-dependent status, you must tell the plan administrator within 60 days. Doing this through the GIC member portal at mygiclink.my.site.com is easier and faster than mailing it. However, you can mail your notice to:

Group Insurance Commission

P.O. Box 556

Randolph, MA 02368

For legal separation or divorce, you must send a copy of your divorce decree and the parts of your divorce or separation agreement that apply to GIC benefits, such as your health, dental, vision, or other coverage. The GIC has the right to require any additional information or documents.

How is COBRA continuation coverage provided?

Once notified of a qualifying event, the plan administrator offers COBRA coverage to qualified beneficiaries, with each person having the right to choose COBRA or not. Covered employees can choose for spouses, and parents for children.

COBRA coverage usually lasts 18 months, based on job loss or reduced hours. An extension of coverage may be allowed in cases of disabilities and additional qualifying events, which are described in the next section.

Disability extension

If the Social Security Administration (SSA) determines that you or a family member covered under the plan is disabled:

- You and your family can get up to 11 extra months of COBRA coverage, totaling 29 months.
- The disability must occur within the first 60 days of COBRA coverage and last until the end of the initial 18-month coverage period.
- You need to provide documents to the GIC that show the SSA has confirmed your disability. You must inform the plan administrator of this immediately, but no later than 60 days after they approved it. You have until the end of the 18-month COBRA coverage period to submit the documents.

Provide this Notice of COBRA continuation coverage rights to the GIC through the member portal at mygiclink.my.site.com, or mail it to:

Group Insurance Commission

P.O. Box 556
Randolph, MA 02368

If you don't submit the required notice or documents by the deadlines, you'll lose your right to extending COBRA coverage.

Second qualifying event extension

If another qualifying event happens during the initial 18 months of COBRA coverage:

- Your spouse and dependent children may get 18 additional months of coverage, totaling 36 months, if you properly notify the plan
- The extension is available to them if the enrollee dies, gets Medicare Part A and/or Part B benefits, divorces or legally separates, or if a child is no longer a dependent under the plan
- The extension is valid only if this second event would have caused a coverage loss if the first event hadn't happened

Other coverage options besides COBRA

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family, such as:

- Health Insurance Marketplace®
- Medicare or Medicaid
- Children’s Health Insurance Program (CHIP)
- Other group health plan coverage options, such as a spouse’s plan, through a “special enrollment period”



Some of these options may cost less than COBRA continuation coverage. Learn more about other coverage options at [healthcare.gov](https://www.healthcare.gov).

Enrolling in Medicare instead of COBRA when employment ends

In general, if you don’t enroll in Medicare Part A or B when you’re first eligible because you’re still employed, you have an eight-month special enrollment period to sign up. This period begins either the month after your employment ends or the month after group health plan coverage ends (based on current employment), whichever comes first.

- If you don’t enroll in Medicare and elect COBRA continuation coverage instead, and decide you want Part B later, you may have to pay a Part B late enrollment penalty and could have a gap in coverage.
- If you choose 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 your eligibility for Medicare, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you’re 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’re not enrolled in Medicare.

For more information, visit [medicare.gov/medicare-and-you](https://www.medicare.gov/medicare-and-you) for the “Medicare & You” handbook.

Contact the GIC if you have questions about your health plan

- Send a message through the member portal at mygiclink.my.site.com.
- Use the online contact form at mass.gov/forms/contact-the-gic.
- Call **617-727-2310**.
- Mail questions to:

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

For more information about COBRA and your rights, the Affordable Care Act (ACA), and other laws affecting group health plans:

- Visit healthcare.gov.
- Contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area. Visit dol.gov/ebsa for addresses and phone numbers of regional and district EBSA offices.

Important! 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.

Converting to nongroup health coverage

If your group plan coverage is ending, you might have the option to switch to nongroup health coverage through Wellpoint. This type of coverage might have fewer benefits and cost more compared to COBRA or state health insurance marketplaces. Contact Wellpoint for details.

You can get a nongroup health coverage certificate in 1 of 2 ways:

1. Your employment ends for any reason other than retirement
2. Your status changes, making you ineligible for continued health plan coverage (including if you've used up your COBRA benefits)

A coverage certificate is also available for:

- Your spouse or dependents if they lose coverage due to your death
- Your child if they're no longer eligible as a dependent
- Your spouse or dependents if they lose coverage because of a change in your marital status

The certificate covers you and dependents when your plan coverage ends, including children born within 31 days after that end date.

You cannot get this certificate of coverage if:

- You're still eligible under your group plan or if your coverage ended due to nonpayment
- Wellpoint isn't licensed to issue it in your state or country

Rules for issuing a certificate of coverage

- You must submit a written application and your first premium payment within 31 days after your plan coverage ends.
- The certificate of coverage follows Wellpoint's rules for converted coverage that are in place when they receive your application. These rules cover the certificate's format, benefits, who's covered, the cost of the premium, and all other terms and conditions.
- If the certificate will be delivered to a state outside of Massachusetts, it may be issued on the form offered by that state.
- Coverage starts the day after your group plan ends.
- You won't need to prove you're insurable.

Coordination of benefits with other health plans

It's common for family members to have coverage through multiple healthcare plans, such as when both spouses have family coverage through their employers. If you or your dependents have more than one health plan, insurance companies use a process called **coordination of benefits (COB)** to determine how to cover your medical expenses. One plan will be identified as the primary plan, and any other plan will be secondary.

Coordination of benefits ensures that payments from all your health plans don't add up to more than your healthcare expenses.

Definition of "plan"

When it comes to COB, "plan" means any health plan that provides medical or dental care coverage. Examples include but aren't 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

- Coverage under a governmental plan, or coverage required or provided by law, including any legally required, no-fault motor vehicle liability insurance. (This doesn't include a state plan under Medicaid or any plan when, by law, its benefits are more than those of any private insurance program or other nongovernmental program.)

The word “plan” doesn't include school-accident type plans or coverage that you purchased on a nongroup basis.

Determining the order of coverage

Medicare is your primary plan, and Medicare Extension is secondary. Medicare Extension covers all or part of the costs that Medicare does not pay for covered services. For example, if Medicare pays 80% of a claim, the Medicare Extension plan will pay some or all of the remaining 20%. Medicare Part A provides benefits for hospital services, and Medicare Part B provides benefits for physician and some other care provider services. The Medicare Extension plan also covers the Medicare Part A inpatient deductible, the Part B deductible, and Part B coinsurance. Medicare Extension covers some services that Medicare doesn't cover, like immunizations and hearing aids.

How benefits are determined between Medicare and Medicare Extension

- Your plan only pays for services that are covered under Medicare or the Medicare Extension plan.
- The maximum amount that can be paid is the Medicare-approved amount, or Wellpoint's allowed amount if the service isn't covered by Medicare.
- We subtract any Medicare payments from the original amount of the claim, then apply Medicare Extension benefits to any remaining claim balance.

Wellpoint (and most other plans) use these five rules to help determine which plans are primary and secondary:

1. A plan without a COB provision is the primary plan.
2. A plan covering someone as an employee or retiree (not a dependent) is primary, while a plan covering a person as a dependent is secondary.
3. The order of coverage for a dependent child who is covered under both parents' plans follows the birthday rule:
 - The primary plan is the plan of the parent whose birthday comes first in the calendar year.
 - 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 have divorced or separated parents follows court decree, also known as the court decision. If there isn't a court decision on which parent is financially responsible for the child's healthcare expenses, this is the order of coverage:
 - a. The plan covering the parent with custody of the child (the custodial parent)
 - b. The plan covering the custodial parent's spouse, if applicable
 - c. The plan covering the noncustodial parent
 - d. The plan covering the noncustodial 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 also applies to their 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 determine the order.

If none of these five rules apply, the plan that has covered the person for a longer period of time is primary. The plan that has covered that same person for the shorter period of time is secondary.

Right to receive and release information

When it comes to the COB provision:

- You must provide the plan with necessary information.
- The plan will get information from or release it to another person or organization as needed.

Facility of payment

If a payment is made under another plan and there is an amount that should have been paid by Wellpoint, Wellpoint may pay that amount to the organization that made the original payment. It will be treated as a benefit payable under Wellpoint. Wellpoint won't have to pay that amount again.

Right of recovery

If Wellpoint pays more than it should have under the COB provision, they may recover the overpayment from:

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

COB for people enrolled in Medicare

If you and your dependents are covered by both Wellpoint and Medicare Part A and/or B, here's how coordination of benefits works:

1. Expenses payable under Medicare will be considered for payment only up to the limit they're covered under the Wellpoint plan and/or Medicare.
2. Wellpoint will then determine your covered expenses by reducing by the amount that your Medicare benefits paid toward them.
3. Wellpoint plan benefits will then be applied to any remaining balance of those expenses.

Chapter 10: Other plan resources

The Sydney Health app

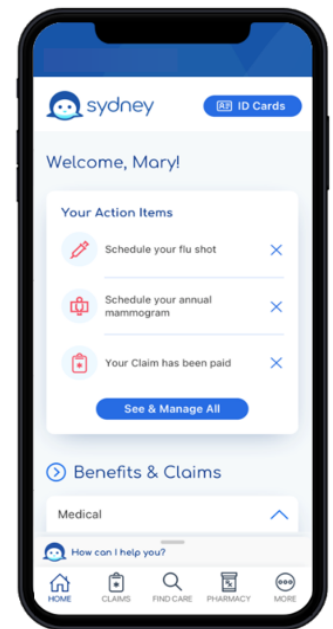
The Sydney® Health app, which lets you access your health plan information and reach Wellpoint Member Services anywhere, anytime from your mobile device. Go to sydneyhealth.com to download the app.

The Sydney Health app connects you to benefits and resources in one convenient location



Access your plan details, virtual care, and other resources to help prioritize your wellness. To download the app, go to sydneyhealth.com. Once you've registered and logged in, you'll find tools and resources so you can:

- Access and share your digital member ID card
- Live chat with Member Services
- Send messages through a secure message center
- Find doctors, hospitals, labs, and other care providers
- Get information about your plan benefits and claims
- Seek urgent virtual care through LiveHealth Online
- Receive suggestions and tips for managing health conditions
- Get reminders about scheduling checkups and important tests
- Check your deductible, copay, and share of costs
- Find lower-cost sites of care and compare procedure costs



How do I access the Sydney Health app?

Download the Sydney Health app or go to sydneyhealth.com.

Behavioral health quality programs

Wellpoint and Carelon work together to always be improving the quality of care and services provided for you. We want to make sure that every Wellpoint member receives safe, effective, and responsive treatments to address their healthcare needs.

We're committed to:

- Providing you with timely service that you're satisfied with
- Making services easier to access while also meeting your cultural needs
- Correcting any issues with the services you receive



You can find more information about Carelon's quality programs at [carelonbehavioralhealth.com](https://www.carelonbehavioralhealth.com).

About the [wellpointmass.com](https://www.wellpointmass.com) website

You can find additional information and resources at [wellpointmass.com](https://www.wellpointmass.com). On this website, you can:

- **Register for an account by selecting "Register Now"** (if you haven't already done so through the Sydney Health app). If you're already registered, simply log in. Dependents age 18 or older can access individual claims information by establishing their own user IDs and passwords.
- **Check on your claims and other account information.** To access your account and resources anytime, you'll need to register as a Wellpoint member, as mentioned above.
- **Download forms, flyers, and other materials, including this handbook.** We recommend using this handbook as a PDF on your computer or mobile device because it's always easier and faster to find information by searching in this PDF electronically.
- **Search for care, such as:**
 - Doctors and hospitals, both in and outside of Massachusetts
 - Behavioral health care providers who are Preferred with Carelon
 - Preferred care providers and suppliers
 - Other kinds of facilities in Massachusetts, like urgent care centers and ambulatory surgery centers



Explore resources and find more information at [wellpointmass.com](https://www.wellpointmass.com).

Calling the 24-Hour Nurse Line

The 24-Hour Nurse Line is an educational resource for you and provides toll-free access to extensive health information anytime. If you're under the care of a doctor and getting treatment for a specific medical condition and have questions, always talk with your doctor.

When you call the 24-Hour Nurse Line, you'll speak with registered nurses who can:

- Address your concerns, questions about procedures, and symptoms
- Help you prepare for a doctor's visit
- Discuss your medications and potential side effects
- Refer you to local, state, and national self-help agencies



Need to speak to a nurse?

To speak with a nurse, call the Nurse Line toll-free at **800-424-8814**.
When prompted, 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 it by contacting us in one of three ways:

1. Call Wellpoint Member Services at **800-442-9300**.
2. Log in to your Wellpoint account to send a message or use Live Chat.
3. Mail your written request to:

Wellpoint Claims Department
P.O. Box 4095
Woburn, MA 01888

Be sure to provide us with any additional information about your claim. We'll let you know the result of the investigation and the final determination.

To get your medical information released

We'll 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 lets us know who is able to see your information.

Download the **Member Authorization Form** from 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, check the "Notice of Group Insurance Commission Privacy Practices" in Appendix A.

Chapter 11: Plan definitions

Table 18. Glossary of healthcare terms

A

- **Acupuncture withdrawal management (detox):** Using 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 safe, organized environment.
- **Acute residential withdrawal management:** Drug or alcohol withdrawal (detox) that is medically monitored, for members at risk of severe withdrawal.
- **Adverse benefit determination:** A decision to deny, reduce, terminate, or not pay for a service can be made for these reasons:
 - The case does not meet the plan’s requirements for medical necessity, appropriateness, healthcare setting, or 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 service was subject to a source of injury exclusion, network exclusion, or other limitation of an otherwise covered benefit.
 - The plan pays less than the total amount of expenses submitted with regard to a claim, including deductible, coinsurance, and copays.
 - The coverage was canceled (not because of any failure to pay premiums).
- **Allowed amount:** The maximum amount the plan pays for a covered healthcare service. Wellpoint sets allowed amounts based on payments most often made to similar providers for the same services. If a non-Massachusetts care provider charges more than the allowed amount, you may have to pay the difference. (Also check the definition of “Balance billing”.)
- **Ambulatory surgery center:** An independent medical facility with operating and recovery rooms that offers same-day medical services. These centers are separate from hospitals. If a place has a hospital name, it’s a hospital, not an ambulatory surgery center.
- **Ambulatory withdrawal management:** Also called outpatient detox, this is a drug or alcohol withdrawal process in which a member has daily visits with a care provider while experiencing withdrawal.
- **American Society of Addiction Medicine (ASAM):** This is the organization that establishes guidelines that help care providers evaluate a person’s needs and recommend the right level of treatment.

- **Appeal:** A request that Wellpoint review an **adverse benefit determination** or a grievance, which is a formal documented complaint.
- **Applied Behavior Analysis (ABA):** Specialized therapy used to treat Autism Spectrum Disorders, focusing on supporting appropriate behaviors and reducing negative ones.

B

- **Balance billing:** When a care provider bills you for the difference between what they billed and the amount paid by the plan (the allowed amount). For example, if the care provider's charge is \$100 and the plan's allowed amount is \$70, the provider may balance bill you for the remaining \$30.
- **Behavioral health services:** Services to treat mental health and substance use conditions.

C

- **Calendar quarter:** The year is split into four parts (quarters):
 - Q1: July, August, and September
 - Q2: October, November, and December
 - Q3: January, February, and March
 - Q4: April, May, and June
- **Care provider:** A person (like a nurse practitioner or doctor), a place (like a hospital or a business that rents medical supplies), or an organization (like hospice).
- **Clinical stabilization services (CSS):** Detox and recovery support provided in a nonmedical setting and managed by a healthcare professional.
- **Coinsurance:** Your share of the cost for a covered healthcare service, which is a percentage (such as 20%) of the total cost. This is in addition to any copays and deductibles you may have as part of your plan.
- **Community-based acute treatment (CBAT):** Treatment for children and teens with serious mental health issues in a secure and supportive place.
- **Community support programs (CSPs):** Programs to help members access and use behavioral health services within their communities.
- **Contracted care provider:** Also called a **network** or **Preferred care provider**. This refers to any care provider — such as a doctor, hospital, or facility — that has agreed to accept the plan's payment as payment in full. Preferred care providers have gone through a credentialing process and must meet the quality standards set by Wellpoint.
- **Contracted suppliers:** Also called **Preferred** or **network suppliers**. This refers to suppliers the plan contracts with to provide certain services or equipment, such as durable medical equipment (DME), medical supplies, and home healthcare. Using them often means better coverage or benefits.
- **Copay:** A fixed amount you pay when you receive a covered healthcare service. The dollar amount of the copay depends on the type of visit, service, or procedure. Not all services have copays.

- **Cosmetic service:** Services performed to improve appearance. These services do not restore bodily function or correct functional impairment, so they're not covered.
- **Cost sharing:** Your share of the cost for a covered service that you must pay out of your own pocket. Your share can include a copay, coinsurance, and/or deductible.
- **Crisis stabilization units (CSUs):** 24-hour observation and supervision for behavioral health conditions when longer inpatient care isn't needed.
- **Custodial care:** A level of care that is designed to help with daily living and activities but not restore health or bodily function.

D

- **Day treatment:** Behavioral health programs that provide structured, goal-oriented treatment to help someone to function more easily in the community.
- **Deductible:** A set dollar amount you pay toward covered services before the plans starts to pay. For example, if your deductible is \$500, the plan won't pay anything until you've paid that amount toward services that have a deductible. Not all services have a deductible.
- **Dependent:**
 - A spouse or ex-spouse of an employee or retiree eligible for dependent coverage as listed in Massachusetts General Laws.
 - A Group Insurance Commission (GIC)-eligible child, stepchild, adoptive child, or foster child (of the member or their spouse) covered until the end of the month after the dependent turns 26.
 - An unmarried GIC-eligible child who, at 19, can't support themselves due to a mental or physical condition. Proof must be on file with the GIC.
 - A dependent of a dependent if the primary one is either a full-time student or an IRS dependent.

If you have questions about coverage for someone who isn't listed above, contact the GIC.

- **Dialectical behavioral therapy (DBT):** A combination of behavioral, cognitive, and supportive therapies that work together to help change unhealthy behaviors and treat people suffering from behavioral health disorders.
- **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):** Supervised detox and recovery treatment in a safe, organized setting for those who have both substance use and mental health issues.
- **Durable medical equipment (DME):** Equipment and supplies ordered by a care provider for everyday or extended use. Oxygen equipment, wheelchairs, and crutches are examples of DME.

E

- **Elective:** A medical service or procedure that you choose to have done, can schedule in advance, and/or choose where to have it done.
- **Electroconvulsive therapy (ECT):** Treatment that uses electrical impulses to trigger seizures to provide relief from mental health conditions.
- **Emergency:** Sudden illness, injury, or health problem that needs attention right away. It could put your life or health in danger if you don't get help quickly.

You need emergency care if your health problem could cause:

- Serious harm to physical or mental health
 - Serious harm to the way your body works or to any body part or organ
 - Serious harm to the health or safety of a pregnant woman and unborn child
- **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 is not covered if the plan finds that it's not effective or lacks proof that it's needed, even if a doctor orders it. The plan determines this by using objective scientific studies.

F

- **Family stabilization teams (FSTs):** Programs offering in-home services to help children, teens, and their families deal with life stress.
- **Family support and training:** Peer support (someone with a similar background or family situation) to help caregivers find the right help for a child with serious emotional challenges.

G

- **Grievance:** A formal complaint that you make to the health plan.

H

- **Healthcare services:** Any medical and behavioral health (mental health) service that focuses on diagnosing and treating health conditions, as well as maintaining, improving, or restoring health.
- **High-tech imaging:** Tests like magnetic resonance imaging (MRI), CT scan, and PET scan that show a better view inside the human body than plain film X-rays. Usually more expensive than traditional X-rays.
- **Home state:** The state where you live and get regular healthcare.

- **Hospital or acute care hospital:** A medical center or community hospital that treats serious illnesses, injuries, and trauma injuries, and helps with surgery recovery. They provide 24/7 medical and nursing care and must:
 - Follow legal requirements
 - Offer continuous 24/7 nursing care
 - Have equipment for diagnosis and major surgery
 - Provide urgent medical, surgical, or rehabilitation care
 - Be officially licensed
 - Have patients who stay less than 25 days

I

- **In-home behavioral services:** Specialized behavior management therapy and monitoring at home for young people or youth.
- **Injury:** Accidental harm caused by something that comes from outside the body.
- **In-network care provider:** Also called a **network, contracted,** or **Preferred provider.** This refers to any care provider — such as a doctor, hospital, or facility — that has agreed to accept the plan's payment as payment in full. These care providers have gone through a credentialing process and must meet the quality standards set by Wellpoint.
- **Inpatient behavioral health services:** Treatment for serious mental health conditions that have severe symptoms but can improve with short-term care.
- **Inpatient medical care:** Medical care in a hospital that usually requires admission and an overnight stay, also known as hospitalization.
- **Intensive care coordination:** Organizing different services for members who need several types of support.
- **Intensive outpatient programs (IOPs):** Regularly scheduled therapy in a structured environment, usually lasting at least three hours each day, up to seven days a week.

L

- **Long-term care facilities:** Specialized hospitals that treat patients who need more involved care for ongoing and/or challenging medical conditions.

M

- **Medical necessity:** For care to be covered by the plan, it must:
 - Be necessary and appropriate for your symptoms and diagnosis, defined in the standard medical guidelines Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) or International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10CM)
 - Be likely to improve or ease your condition or functioning

- Be safe and effective according to medical standards recognized by professionals
- Be the most suitable and cost-effective treatment available for your health matter
- Be based on scientific evidence for services that aren't common

Important! A doctor's recommendation alone doesn't guarantee the treatment is medically necessary. Check "Experimental or investigational procedure" in this section for more information.

- **Medical services:** In this booklet, these services are for treating physical conditions, not mental health.
- **Medical supplies or equipment:** Items prescribed by doctors as necessary for treating an illness or injury, like surgical dressings, splints, and braces, that can later be thrown away.
- **Medication-assisted treatment (MAT):** Long-term medication used in place of opioids, which usually involves daily clinic visits.
- **Medication management:** Appointments with a mental health provider for evaluation and prescriptions, if needed.
- **Member:** A person enrolled in the plan; can include dependents.
- **Member cost:** Expenses you pay out of your own pocket for medical bills, including deductibles, copays, and coinsurance.
- **Mobile Crisis Intervention:** Emergency service that provides immediate, face-to-face help for young people during a mental health crisis.

N

- **Network care provider:** Also called a **Preferred, contracted, or in-network provider**. This refers to any care provider — such as a doctor, hospital, or facility — that has agreed to accept the plan's payment as payment in full. Care providers have gone through a credentialing process and must meet the quality standards set by Wellpoint.
- **Neuropsychological (neuropsych) testing:** Testing to find out if a problem in the brain is affecting a person's ability to reason, concentrate, solve problems, or remember.
- **Noncontracted supplier:** Also called an **out-of-network** or **Nonpreferred supplier**, is a supplier that doesn't have a contract with the plan to provide certain services or equipment, such as DME and medical supplies. You will pay more if you use Nonpreferred suppliers, so it's important to use Preferred suppliers as much as you can.
- **Non-hospital-owned facility:** Facilities that do outpatient medical services but aren't owned by or operated by a hospital. Examples are ambulatory surgery centers and urgent care centers.
- **Nonpreferred supplier:** Also called an out-of-network or noncontracted supplier. This is a supplier that doesn't have a contract with the plan to provide certain services or equipment, such as DME and medical supplies. You will pay more if you use Nonpreferred suppliers, so it's important to use Preferred suppliers as much as you can.

O

- **Observation care:** Short-term treatment and/or tests to decide if a patient needs to be admitted to the hospital or can go home. This care is typically done at outpatient medical centers or community hospitals.
- **Opiate treatment programs (OTPs):** Licensed programs that provide different medications than opioids, for those who may have been dependent on opioids.
- **Out-of-pocket cost:** Check “Member cost” in this section under the letter “M.”
- **Out-of-pocket (OOP) maximum:** The most you’ll pay in a calendar year for deductibles, copays, and coinsurance for covered healthcare services. After reaching this limit, the plan covers 100% of the allowed costs for the rest of the year. It covers medical, behavioral health services, and prescriptions but doesn’t cover premiums, balance bills, and noncovered services.
- **Outpatient behavioral health services:** Treatment that doesn’t require admission to a hospital or an overnight stay anywhere. Services include office visits and more intensive therapy.
- **Outpatient hospital service:** Care at a hospital that doesn’t require admission to a hospital and usually doesn’t include an overnight stay. Outpatient services sometimes means healthcare provided at any nonhospital facility, such as a doctor’s office or walk-in clinic.

P

- **Palliative care:** Care that focuses on treating symptoms like pain or breathing difficulties to make you more comfortable. It doesn’t cure the condition.
- **Partial hospitalization programs (PHPs):** Structured outpatient treatment programs for mental health and substance use conditions. Provide more intensive care than a regular doctor’s visit but don’t require a hospital stay. Includes at least five hours of therapy a day, up to seven days a week.
- **Physician or care provider:** Care providers who’ve earned a doctor of medicine or doctor of osteopathic medicine degree or equivalent. This can also include:
 - Certified nurse midwife
 - Chiropractor
 - Dentist
 - Nurse practitioner
 - Optometrist
 - Physician
 - Physician assistant
 - Podiatrist

- **Plan year:** The health plan year starts on July 1 and ends on June 30 of the following year. Your coinsurance limit, benefits limits, out-of-pocket maximum for behavioral health costs with Preferred care providers, and out-of-pocket maximum for behavioral health costs with Nonpreferred care providers are based on a **calendar year**.
- **Preapproval:** A review process makes sure a service you're going to have will be covered by your insurance plan. It's done ahead of time, before you have the service.
- **Preferred care provider:** Also called a **network, contracted, or in-network provider**. This refers to any care provider — such as a doctor, hospital, or facility — that has agreed to accept the plan's payment as payment in full. These care providers have gone through a credentialing process and must meet the quality standards set by Wellpoint.
- **Preferred vendors:** Check “In-network suppliers” under the letter “I” in this section.
- **Provider:** Check the entry for “Care provider.”
- **Psychiatric visiting nurse association (VNA):** Short-term treatment in your home or other living environment; uses medication for mental health conditions.
- **Psychological (psych) testing:** Standard tools used to diagnose and evaluate mental health ability.

R

- **Rehabilitation (rehab) facilities:** Special hospitals that provide more involved, short-term rehab services to restore basic functioning (such as walking or sitting upright) that was affected by an illness or injury.
- **Rehabilitation (rehab) services:** Care that helps a person keep, restore, or improve basic functioning (such as walking, talking, or sitting upright) that was affected by an illness, injury, or disability. This can include physical, speech, and/or occupational therapy at inpatient and/or outpatient settings.
- **Respite care:** Care for a sick patient that helps give the family or primary care person a break from caregiving functions for a period of time.
- **Retail health clinic:** 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 care provider.
- **Skilled nursing facility:** A facility that provides lower-intensity rehab and medical services, which is a step down from rehab. Skilled nursing facilities must meet all of the following conditions:
 - Operate according to law
 - Be approved as a skilled nursing facility for payment of Medicare benefits, or qualified to receive such approval, if requested

- Be licensed or accredited as a skilled nursing facility (if applicable)
- Primarily provide room and board and skilled care under the supervision of a physician
- Provide continuous 24/7 skilled care by or under the supervision of a registered nurse (RN)
- Maintain a daily medical record for each patient

A facility does not qualify as a skilled nursing facility if it is used primarily for:

- Rest
- Mental health or substance use disorder treatment
- Educational care
- Custodial care (such as in a nursing home)
- **Specialized health facilities:** Independent, freestanding centers that provide a variety of outpatient medical services. The four types of specialized health facilities are:
 - Dialysis centers
 - Fertility clinics
 - Imaging centers
 - Sleep study centers
- **Spouse:** A person legally married to the covered employee or retiree.
- **Structured outpatient addictions programs (SOAPs):** Structured substance use disorder programs that provide support in someone's home or community. They're more intensive than care in a doctor's office and 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 or referral:** A thorough evaluation of someone with a substance use disorder; allows a provider to refer them to appropriate care.

T

- **Telehealth companies:** Companies that allow people to get virtual care (care through video or live chat using a smartphone, tablet, or computer) with licensed medical and/or behavioral health providers. LiveHealth Online is Wellpoint's preferred telehealth care provider that can be accessed through the Sydney® Health app. Go to sydneyhealth.com to download the app.
- **Therapeutic mentoring services:** One-on-one support, coaching, and skill-building to help the youth with daily living, social, and communication needs.
- **Transcranial magnetic stimulation (TMS):** A noninvasive method of brain stimulation that can help treat major depression.
- **Transitional care units (TCUs):** Facilities that help children and teens transition from an acute care facility to home, a residential program, or foster care.

U

- **Urgent care:** Medical treatment for illnesses and injuries that need immediate care but aren't life-threatening. Life-threatening medical conditions should be treated at the emergency room.
- **Urgent care center:** An independent, freestanding facility that treats conditions that need immediate care but that aren't life-threatening. Urgent care centers often do X-rays, lab tests, and stitches.

V

- **Virtual care (telehealth):** The ability to see a care provider using digital or electronic communication methods instead of an in-person meeting. Telephone calls, live chats, and video visits through a smartphone, tablet, or computer are considered virtual care. LiveHealth Online is Wellpoint's preferred virtual care provider that can be accessed through the Sydney Health app. Go to sydneyhealth.com to download the app.
- **Visiting nurse association (VNA):** An agency certified by Medicare that has necessary licenses and offers part-time skilled care and other home care services where someone lives.

W

- **Walk-in clinics:** 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.

Prescription benefits

Your coverage for prescription drugs



For questions about any of the information in this chapter,
call SilverScript at 877-876-7214.

Administered by

SilverScript[®]

Chapter 12: Prescription benefits

GIC's pharmacy benefit and your pharmacy plan

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. administers your prescription drug benefits and manages how you receive and pay for your medications.

The SilverScript pharmacy network includes:

- Major chain pharmacies nationwide
- Independent pharmacies
- A mail-order pharmacy
- A specialty drug pharmacy

Prescription medications are only covered by the plan if they've been approved by the U.S. Food and Drug Administration (FDA). Medications are also only covered if you need a prescription to get them, except when you're purchasing preventive drugs that are available over the counter. Diabetes supplies and insulin are also covered by the plan.

Please visit gic.silverscript.com for the most current drug list, also known as a formulary.



Questions?

Call SilverScript Member Services at **877-876-7214** (option 2).

Cost sharing for prescription drugs

For prescription medications, your cost sharing (deductible and copay) are based on the tier or type of prescription you have and what pharmacy you use.

A multitier copay system allows your plan to cover quality, lower-cost medications:

- Tier 1 (mostly generic drugs, which are lower-cost versions of brand-name drugs)
- Tier 2 (preferred, brand-name drugs)
- Tier 3 (nonpreferred drugs)
- Drugs that require no copays

The information below shows your deductible and copay based on the tier or type of prescription you have and where you get it from.

Deductible (fiscal year July 1 through June 30)

Your prescription drug plan has a yearly deductible — a set amount you pay for your medicines before your plan starts sharing the cost.

Important! You have a separate deductible for medical and behavioral health services. It's described in Chapter 2 of this handbook.

Table 19. Copays for prescription drugs

Drug type	Participating retail pharmacy (up to a 30-day supply)	Mail order or CVS Pharmacy (up to a 90-day supply)
Tier 1 — Generic drugs	\$10	\$25
Tier 2 — Preferred drugs	\$30	\$75
Tier 3 — Nonpreferred drugs	\$65	\$165
Orally administered anticancer drugs	\$0 member cost (deductible does not apply)	\$0 member cost (deductible does not apply)
ACA preventive drugs	\$0 member cost (deductible does not apply)	\$0 member cost (deductible does not apply)



What are ACA preventive drugs?

Under the Affordable Care Act (ACA), most insurance plans must cover specific preventive medications at 100% with no deductible or copay, provided they are prescribed and on your plan's drug list. Refer to the "Preventive Drugs" section for details or visit <https://info.caremark.com/oe/gic> for more information.

Table 20. Copays for specialty prescription drugs

Specialty drug type	Specialty drugs must be filled only through CVS Specialty, a specialty pharmacy
Tier 1	\$10 per 30-day supply
Tier 2	\$30 per 30-day supply
Tier 3	\$65 per 30-day supply
Orally administered anticancer drugs	\$0 per 30-day supply

Important! Specialty drugs must be filled only through CVS Specialty, a specialty pharmacy. Please call CVS Specialty toll-free at **800-237-2767**. Specialty medications may be dispensed up to a 30-day supply. **Some exceptions may apply.**

Table 21. Copays for attention deficit hyperactive disorder (ADHD) prescription drugs

ADHD drug type	Copay per 30-day supply	Copay per 60-day supply	Copay per 90-day supply
Tier 1	\$10	\$20	\$30
Tier 2	\$30	\$60	\$90
Tier 3	\$65	\$130	\$195

Medications may be filled through mail order or any network pharmacy. Quantities are limited up to a 90-day supply per state statute.

Out-of-pocket limit

Your drug plan has an out-of-pocket limit that is combined with your medical and behavioral health out-of-pocket limit. This means the deductibles and copays you pay for prescription drugs during the year count toward this limit. Once you reach that limit, your prescription drugs are covered at 100%.

Important! If you choose to pay for a brand-name drug when there is an exact generic equivalent available, or buy a drug that isn't covered by the plan at all, your payment won't count toward the out-of-pocket limit.

Table 22. Out-of-pocket limits

Deductible type	Deductible amount
Individual	\$5,000
Family	\$10,000

How to get started and use the plan

After you first enroll in the plan, SilverScript will mail you a welcome packet and SilverScript prescription ID card. You will receive ID cards for you and your dependents (if any). Show your new card to your pharmacy so they can correctly process your prescription drug benefits.

Register at gic.silverscript.com on your drug plan effective start date. Once you register, you can check drug costs, place mail-order refills, and review your prescription drug history 24/7. You can also use the SilverScript app.

Filling your prescriptions

1. **For nonspecialty drugs** at any participating retail pharmacy, or through mail order from SilverScript
2. **For specialty medications** through CVS Specialty Pharmacy



If you're a new member, insurers must put in place a continuation of care policy. This gives you a 30-day fill of your existing prescriptions so you have enough medicine on hand.

Participating retail pharmacies

A retail pharmacy is the most convenient option when you need a short-term prescription medication immediately, such as antibiotics for strep throat or painkillers for an injury.

To use your pharmacy benefits, you must:

- Have a prescription
- Show your SilverScript prescription card to your pharmacist (except for situations listed under “Claim Forms” later in this section)
- Pay the required copay

If you do not have your prescription card, the pharmacist can verify eligibility by calling the SilverScript Pharmacy Help Desk at **800-552-8159**. You can also get your pharmacy ID card information from the SilverScript app.

Important! Prescriptions filled at a nonparticipating retail pharmacy are not covered. You can find the nearest participating retail pharmacy online after registering at gic.silverscript.com or by calling **877-876-7214** (option 2).

Maintenance medications — up to 30 days

After you fill two 30-day supplies of a maintenance medication (a medication you take regularly) at a retail pharmacy, you'll receive a letter from SilverScript explaining how you can change your prescription to a 90-day supply to be filled either through mail order or at a CVS Pharmacy.

- You'll have coverage for additional fills of that medication only **if you convert your prescription to a 90-day supply**.
- SilverScript will assist you in transitioning your maintenance prescription.

Maintenance medications — up to 90 days

You have the choice of filling maintenance prescriptions for up to a 90-day supply at the mail-order copay or at a CVS Pharmacy.

- The **CVS Mail Service Pharmacy** is a convenient option for prescription drugs that you take on a regular basis for chronic conditions such as asthma, diabetes, high blood pressure, and high cholesterol. Your prescriptions are filled and conveniently delivered directly to your home or to another location that you prefer.

If you would like to receive your prescription(s) by mail order or if there are no refills left on your prescription, request a new prescription by visiting caremark.com/manage-prescriptions/get-prescriptions and we'll contact your doctor for you, or you can ask your doctor to send a new prescription to CVS Caremark Mail Service Pharmacy.

- **In person at a CVS Pharmacy** is another option for getting your 90-day maintenance medications for the same copay amount as mail order. Prescriptions can be filled at any CVS Pharmacy location across the country.

By getting a 90-day supply of your maintenance medications, you'll have lower copays, need fewer refills, and have fewer visits to your pharmacy. Once you begin using mail order, you can order refills online or by phone, or you can use your local CVS Pharmacy.

Important! SilverScript will allow two 30-day fills for long-term medications at your regular pharmacy before being asked to switch to 90-day supplies. If you want to keep filling your long-term medication prescriptions at your current pharmacy in 30-day supplies without paying the full cost, you must opt out once your new plan starts by calling SilverScript at **877-876-7214** (option 2).

CVS Specialty

CVS Specialty is a full-service specialty pharmacy that offers a complete range of services and specialty drugs. They provide personalized care to each patient and medications for a variety of health conditions, such as hemophilia, hepatitis, cancer, multiple sclerosis, and rheumatoid arthritis.

Specialty medications must be filled through CVS Specialty. They can only be filled at a maximum of a 30-day supply (some exceptions may apply). Many of these medications may need to be reviewed by SilverScript (before they send them to you) to make sure the medications are being prescribed appropriately.

CVS Specialty offers:

- Quick delivery of your medications to an approved location that works best for you, such as your home, family member's home, doctor's office, or local CVS Retail Pharmacy, at no additional charge. They ship to all 50 states through one of their preferred expedited carriers. They don't ship to P.O. Boxes.
- Convenient access to pharmacists and nurses who can answer your specialty medication questions.
- Patient education materials.
- Ongoing refill reminders.
- Language-interpreting services for non-English-speaking patients.



To begin receiving your specialty drugs through CVS Specialty

Call toll-free at **800-237-2767**, Monday through Friday, 7:30 a.m. to 9 p.m. ET or 9 a.m. to 4 p.m. ET on Saturday (closed on Sunday).

Claim forms

Retail purchases made outside of the U.S., as well as purchases made at a participating retail pharmacy without the use of your SilverScript prescription card, are covered as follows:

- Claims incurred **within** 30 days of your eligibility effective date will be covered at full cost, minus any copay.
- Claims incurred *more than* 30 days after your eligibility effective date will be reimbursed at a discounted cost, minus any copay.

To get a claim form, register and/or log in to your account on gic.silverscript.com or call **877-876-7214** (option 2).

Other plan provisions

The ACA (health care reform act) requires your health plan to cover certain preventive medications with no member cost.

Table 23. Drugs your plan covers with no cost sharing

Drug	Generic, brand name, or over the counter (OTC)
Aspirin*	Generic over-the-counter aspirin: 81 mg to help prevent illness and death from preeclampsia in females ages 12 to 59.
Bowel preparation medications	Generic and brand names until generics become available (prescription only), for adults ages 45 to 75.
Contraceptives*	Generic and brand names of contraceptive drugs and devices, and OTC contraceptive products. Brand names are covered at no cost until a generic becomes available. State law says some oral contraceptives can be dispensed up to a three-month supply for the first fill and up to a 12-month supply for refills.
Diabetes prevention	Generic (prescription only) metformin 850 mg for preventing or delaying diabetes in adults ages 35 to 70.
Folic acid supplements*	Generic OTC products (0.4 mg–0.8 mg strengths only) when prescribed for women age 55 or younger.
HIV Pre-Exposure Prophylaxis (PrEP)	Generic (prescription only).
Immunization vaccines	Generic or brand name prescribed for children or adults.
Oral fluoride supplements	Generic and brand names for children age 5 or younger for the prevention of dental cavities.

Drug	Generic, brand name, or over the counter (OTC)
Breast cancer treatment	Generic prescriptions (anastrozole, exemestane, raloxifene, tamoxifen) for the primary prevention of breast cancer for females age 35 and older who are at increased risk.
Tobacco cessation medications*	Generic (prescription and OTC) tobacco cessation products and brand-name prescription products (Nicotrol, Nicotrol NS) until generics become available — annual limit of two 12-week cycles (168 days).
Statins	Generic-only, single-entity, low-to-moderate dose statin agents for adults ages 40 to 75.

* OTC requires prescription for claims processing.

Call SilverScript at **877-876-7214** (option 2) for additional coverage information on specific preventive drugs.

Please visit gic.silverscript.com to read the most current drug list.

Table 24. Pharmaceutical access, costs, and transparency for specific conditions

Effective July 1, 2025, insurers are required to cover one brand and one generic drug for diabetes, asthma, and two prevalent heart conditions (high cholesterol and coronary artery disease). Coverage and lower costs will be provided for the following health conditions and drugs:

Health condition	Drugs: generic or brand name
Diabetes	Preferred brand-name insulins: capped at \$25 for a 30-day supply
Asthma	Generic albuterol sulfate HFA: \$0; preferred brands capped at \$25 for a 30-day supply
High cholesterol	Generic atorvastatin: \$0; preferred brands capped at \$25 for a 30-day supply
Coronary artery disease	Generic amlodipine besylate and metoprolol succinate: \$0; preferred brands capped at \$25 for a 30-day supply

Please visit gic.silverscript.com for the most current drug list.

Expansion of coverage for substance use disorder treatments

Generic and brand-name drugs used to treat opioid use disorder, such as buprenorphine-naloxone and Naltrexone, and opioid antagonists such as Naloxone, are \$0 and bypass the deductible.

Brand-name drugs with exact generic equivalents

The plan encourages the use of generic drugs, as they provide the same benefit at a lower cost. There are many brand-name drugs, such as Lipitor®, Ambien® and Fosamax®, that have exact generic equivalents. If you choose the brand name over the generic version, you’ll pay the price difference between the two drugs plus the generic copay. This amount won’t go toward your out-of-pocket limit.

Exceptions to this may apply to certain brand-name preventive drugs. Contact SilverScript for more information.

Prescription drugs with OTC equivalents

Some prescription drugs have OTC equivalent products available. These OTC products have strengths, active chemical ingredients, routes of administration, and dosage forms that match the prescription drug products. Your plan does not provide benefits for prescription drugs with OTC equivalents, with the exception of some preventive drugs. Check the pharmacy section “ACA preventive drugs” earlier in this section for information on preventive OTC drugs.

Some prescription drugs also have OTC product alternatives available. These OTC products, though not identical, are similar to the prescription drugs.

Prior authorization

Some drugs in your plan require prior authorization. Prior authorization is a process that makes sure you’re receiving the right drug for your specific condition and in the amount approved by the FDA.

For select drugs, prior authorization also includes a medical necessity review. This process makes sure less expensive first-line formulary prescription drugs — which are safe and effective — are used before the plan will pay for more expensive prescription drugs.

If one of your prescription drugs requires prior authorization, your doctor will need to call SilverScript at **800-294-5979** to check that the prescription meets the plan’s conditions for coverage.

Table 25. Current examples of drugs requiring prior authorization for specific conditions

Drug class	Products requiring prior authorization
Topical acne products	<ul style="list-style-type: none"> • Akliel®, Arazlo® Tazorac® 0.05% and 0.1% cream, gel • Fabior 0.1% foam; (Retin-A®, Retin-A Micro®; Avita®; Atralin™ gel; other generic topical tretinoin products) • Clindamycin Phosphate 1.2% • Tretinoin 0.025% gel (Ziana®; Veltin™) • Winlevi®

Drug class	Products requiring prior authorization
Testosterone — topical	<ul style="list-style-type: none"> • Androderm • AndroGel • Axiron • Fortesta • Natesto • Testim • Vogelxo
Testosterone — injectable	<ul style="list-style-type: none"> • Aveed® • Depo-Testosterone® (testosterone cypionate injection, generics) • Delatestryl® • Xyosted® (testosterone enanthate injection, generics) Testopel® (testosterone pellet)
Compounded — select medications	<p>A compounded medication is made by combining, mixing, or changing ingredients, based on a doctor’s prescription, to create a customized medication for a specific person.</p>
Diabetes GLP-1 agonists	<ul style="list-style-type: none"> • Adlyxin® • Byetta® • Bydureon® BCISE • Mounjaro® • Ozempic®, Rybelsus® • Trulicity® • Victoza® (liraglutide)
Nutritional supplements	<p>Nonprescription tube-feeding formulas ordered by a doctor for patients to use at home. These are medically necessary when patients can’t eat or maintain enough nutrition by eating, which can be 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>
Pain	<ul style="list-style-type: none"> • Fentanyl Transmucosal Drugs (Actiq®, Fentora®, Subsys®) • Lidoderm® • Ztlido • Opioid analgesics

Drug class	Products requiring prior authorization
Weight management	<ul style="list-style-type: none"> • Adipex (phentermine) • Benzphetamine • Contrave (bupropion; naltrexone) • Diethylpropion Phendimetrazine • Lomaira (phentermine) • Generic phentermine • Xenical (orlistat) • Qsymia • Saxenda • Wegovy
Dry eyes	<ul style="list-style-type: none"> • Cequa® • Restasis® • Vevye® • Xildra®

This list is not all inclusive and is subject to change during the year. Call SilverScript toll-free at **877-876-7214** (option 2) to check if your drugs are included in the program.

Current examples of top drug classes that may require prior authorization

- Asthma or chronic obstructive pulmonary disease agents
- Autoimmune agents
- Dermatological agents
- Diabetic supplies
- Erectile dysfunction oral agents
- Erythropoiesis-stimulating agents
- Glaucoma
- Growth hormones
- Hepatitis C agents
- Insulins
- Nasal steroids
- Ophthalmic agents
- Opioid analgesics
- Osteoarthritis — hyaluronic acid derivatives
- Proton pump inhibitors (PPIs)

Select drugs within these classes require prior authorization to make sure they're medically necessary and that approved alternatives within the class have been tried. If you're a registered user on gic.silverscript.com, check the National Preferred Formulary or call SilverScript at **877-876-7214** (option 2) for more information.

Quantity dispensing limits

To keep you safe and promote the appropriate and cost-effective use of medications, your prescription plan includes a drug quantity management program. This means that for certain prescription drugs, there are limits on the amount of the drug that you may get at one time.

How the quantity limits for medications are decided:

- FDA-approved product labeling
- Common usage for episodic or intermittent treatment
- Nationally accepted clinical practice guidelines
- Peer-reviewed medical literature
- As otherwise determined by the plan

Examples of drugs with quantity limits currently include Cialis®, Imitrex®, and lidocaine ointment.

Drug utilization review program

Each prescription drug purchased through this plan is subject to utilization review. This is a process that reviews the prescribed drug to determine if any of the following conditions exist:

- Adverse (harmful) drug-to-drug interaction with another drug you're taking that was purchased through the plan.
- More than one prescription for the same medication.
- Inappropriate dosage and quantity.
- Too-early refill of a prescription.

If any of the above conditions exist, the plan will have to determine that it's medically necessary before the prescription drug can be filled.

Exclusions

Benefits exclude:

- Dental preparations (for example, topical fluoride, Arestin®), except for oral fluoride.
- Over-the-counter drugs, vitamins, or minerals (except for diabetic supplies and preventive drugs).
- Prescription homeopathic and miscellaneous natural products.
- Prescription products for cosmetic purposes, such as photo-aged skin products and skin depigmentation products.

- Medications in unit dose packaging.
- Impotence medications for members under age 18.
- Injectable allergens used to treat allergies.
- Cosmetic drugs, including anti-wrinkle and hair-removal creams and hair-loss drugs.
- Special medical formulas and medical food products, except as required by state law.
- Compounded medications — some exclusions apply. Examples include bulk powders, bulk chemicals, and proprietary bases used in compounded medications.
- Drugs administered intrathecally (delivered into the fluid surrounding the spinal cord) or a drug that's infused into a space other than the blood by or under the direction of care providers and recommended to be given under sedation or supervision.
- Drugs not suitable for coverage under a pharmacy or outpatient prescription drug benefit, as determined by SilverScript.
- Select medical devices and artificial saliva products.
- Prescription digital therapeutics, such as health programs delivered through smartphone apps, unless otherwise specified.
- Unapproved products that may be marketed contrary to the Federal Food, Drug and Cosmetic Act.
- Therapeutic devices or appliances, including support garments, ostomy supplies, durable medical equipment, and nonmedical substances.
- Scar products.
- Miscellaneous topical analgesics, also known as painkillers (containing ingredients in strengths typically used in OTC version) and convenience kits (containing two or more products to be used separately).
- Prescription multivitamins (other than pediatric and prenatal multivitamins).

Definitions

Table 26. Glossary of terms for your prescription drug plan

A

Acute drugs: Medications for short-term illnesses that are expected to clear up quickly. They are usually taken for less than 30 days and generally don't come with extra refills.

B

- **Biosimilars:** These are drugs very similar to existing biologic medications, approved by the FDA to ensure safety and effectiveness, and can be less expensive than the original biologic. They treat various conditions, such as rheumatoid arthritis, Crohn's disease, and diabetes, providing the

same benefits and risks as the original drugs. An example is Hyrimoz, an alternative to Humira, which treats certain autoimmune conditions.

- **Brand-name drug:** A medication advertised and sold under a trademarked name or company, usually protected by a patent. After the patent ends, other companies can make generic versions following strict FDA safety standards.

C

- **Compounded medication:** A drug customized by altering or mixing ingredients based on a specific prescription, creating a drug available for a specific person and not available commercially for everyone. At least one of the ingredients must be a doctor-prescribed medication.
- **Controlled drug:** Medications that have potential for abuse or dependency, as defined by the Controlled Substances Act.
- **Copay:** The cost you pay for prescription drugs covered by your plan. If the drug costs less than your copay amount, you pay the lower price.

D

- **Deductible:** The amount you pay each year before your prescription copays start and your health plan starts sharing the cost.
- **Diabetes supplies:** Needles, syringes, test strips, lancets, and blood sugar monitors used by people with diabetes.

F

- **FDA:** The U.S. Food and Drug Administration, which approves medications for safety and effectiveness.
- **Formulary:** A list of recommended prescription medications that are part of your drug plan, created and managed by SilverScript. The CVS Caremark National Preferred Formulary includes a range of generic and preferred brand-name drugs approved by the FDA and applies to drugs from pharmacies or mail order.

G

Generic drugs: These medications have the same active ingredients as brand names and are equally safe and effective. The FDA ensures they meet strict standards for strength, purity, and quality.

M

Maintenance drug: Medications taken regularly for chronic conditions, like asthma, high cholesterol, and high blood pressure, often filled in 90-day amounts.

N

Nonpreferred drug: A medication (not on the formulary) that usually has an equivalent option available on the formulary.

O

- **Out-of-pocket limit:** The maximum amount you pay for covered drugs in a year. After reaching this limit, you pay no more copays for covered medications, as they're covered at 100%. Reminder that payments you make for noncovered drugs and brand drugs that have generics available don't count toward this limit.
- **Over-the counter (OTC) drugs:** Medications available over the counter without a prescription. Usually not covered by your plan, except preventive ones if prescribed by a doctor.

P

- **Participating pharmacy:** A pharmacy in the CVS Caremark network, including major chains and many independent pharmacies.
- **Preferred drug:** A formulary drug recommended by doctors and pharmacists that is reviewed and chosen by SilverScript for its effectiveness and more affordable cost.
- **Prescription drug:** Any drug that must have a prescription to be legally dispensed under federal law. It must also be labeled with the statement: "Caution: Federal Law prohibits dispensing without prescription."
- **Preventive drugs:** Drugs recommended for coverage by the U.S. Preventive Services Task Force and covered by the ACA.
- **Prior authorization:** This is when the plan needs to review and approve a drug before the plan covers it, to make sure it's appropriate or medically necessary for treatment.

S

- **Special medical formulas or food products:** Enteral formulas (for tube feeding) ordered by a doctor for patients to use at home. These are medically necessary when patients can't eat or maintain enough nutrition by normal eating due to Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. These products require prior authorization to determine medical necessity.

To access the benefit for special medical formulas or food products, call the Group Insurance Commission at **617-727-2310**.

- **Specialty drugs:** Specialty drugs are usually injectable and noninjectable biotech or biological drugs used to treat rare and/or complex conditions. They have one or more of these key characteristics:
 - Needs frequent dosing adjustments and intensive clinical monitoring
 - Requires thorough patient training and compliance for treatment to be effective
 - Has limited or exclusive product distribution
 - Requires specialized product handling and/or administration requirements

Clinical operations prior authorizations, exceptions, and appeals programs

All time frames and processes contained in this document refer to SilverScript standard protocols based on federal laws and regulations. Timeframes and processes may vary based on client requirements or state regulations.

SilverScript can handle prior authorizations, exceptions, or appeals for clients if they both enter into and agree on a contract that details how these requests will be handled and processed.

- The client gives SilverScript a plan summary that includes details about prescription benefits for members.
- SilverScript employees won't review requests if they have a personal, professional, or financial conflict of interest with the claimant.
- Depending on the client's plan, reviews can be clinical or nonclinical.
 - **Initial clinical review:** Checks that a drug request has followed the plan's rules, such as prior authorization, step therapy, formulary exceptions, and limits. This is based on plan guidelines in the Plan Design Document (PDD).
 - **Initial nonclinical review:** Reviews requests for medications or benefits that aren't covered by the plan or subject to a prior authorization or an exception.

Initial clinical reviews prior authorization program

Prior authorization is available as a stand-alone service for clients, or they can combine it with programs like quantity limits or step therapy, if needed, for plan members.

When a prescription is submitted at the pharmacy, the system checks if it needs prior authorization. If it does:

- You, the pharmacist, or prescribing doctor (or their representative) must contact SilverScript by phone, fax, or electronic request or in writing to make the request.

- The prior authorization department, if first contacted by you or a pharmacist, will contact the prescribing doctor or ask you or the pharmacist to do so.
- Once it receives a request, the prior authorization department checks if a new review is needed. The decision is based on the clinical information they already have, following client-approved criteria.

If the call is received outside of business hours and not urgent, you or the caller will be prompted to call back during regular business hours. Nonurgent requests are processed within 15 days, but typically within 72 hours of receiving all the information.

If the request is urgent and made outside of business hours, the automated system will tell you or the caller to hold to speak to the after-hours answering service. They will contact the prior authorization department for the on-call pharmacist to process the request. Urgent requests are processed within 72 hours, but within 24 hours of receiving all the information.

After review, SilverScript will give one of these three responses to your prior authorization:

Missing information	Approved prior authorization	Denied prior authorization
If any required information is missing for the prior authorization request, SilverScript will ask the doctor for it. The request will be denied if the information isn't provided.	If the request is approved, the details are entered into the SilverScript system, and a test claim is processed to make sure the prescription will be covered. Approval letters are faxed to the doctor and mailed to the member.	If the request is denied, a reviewer will fax a letter to the doctor and mail one to the member with the reason and appeal instructions.

Clients can request prior authorization activity reports as needed from SilverScript.

Exceptions program

An exceptions program is in place to handle change requests to a client's plan. These changes are considered if the plan allows exceptions and may apply to both covered and noncovered medications. To find out what exceptions are available, refer to the Clinical Plan Management (CPM) form.

For covered drugs, examples include:

- **Brand penalty exception:** Allows you as the member to waive the “dispense as written” (DAW) penalty (which adds an additional charge) on a brand-name medication when a generic is available. This means you might still be able get the brand-name drug at no additional cost if you and/or your doctor can prove it's medically necessary through the prior authorization process.
- **Contraceptive zero copay exception (health care reform):** Allows you to get a contraceptive product at a \$0 member cost.
- **Preventive services zero copay exception (health care reform):** Allows you to get a preventive service product at \$0 member cost (excludes contraceptives).

For noncovered drugs, an example is a formulary exception. This provides coverage for a drug not included in the formulary.

To request an exception:

Contact Customer Care or submit a written request to the Exceptions department. If the request is made by phone, an exceptions fax form or electronic prior authorization request will be sent to the doctor. They will need to complete and return the form or may provide a letter of medical necessity. The request is then reviewed against the client's plan criteria.

- If approved, SilverScript will enter it into the system and submit a test claim to make sure the prescription will be covered. Approval letters are sent to both the doctor and the member.
- If denied, a clinical reviewer issues a denial letter with the reason why and appeal instructions. Denial letters are sent to the doctor and the member.

Requests are processed within the following time frames:

- **Urgent requests:** Within 72 hours, but typically completed within 24 hours once all information is received
- **Nonurgent requests:** Within 15 days, usually completed within 72 hours with all necessary information

As a member, you can call the SilverScript Customer Care line at **877-876-7214** (option 2) to be transferred to the appeals team, who will work an urgent appeal over the phone. The preferred method for sending an appeal is by fax.

Nonspecialty prior authorization requests and appeals

Fax: **888-836-0730**

Phone number: **800-294-5979**

Mailing address:

Prescription Claim Appeals MC 109
SilverScript
P.O. Box 52084
Phoenix, AZ 85072

Specialty prior authorization requests and appeals

Fax: **866-249-6155**

Phone number: **866-814-5506**

Mailing address:

SilverScript
Specialty Appeals Department
800 Biermann Court
Mount Prospect, IL 60056

Appeal process

You can start the appeal process by sending a letter of medical necessity by fax or mail. The letter needs to be written by the doctor stating why the medication should be considered for coverage or additional coverage.

The letter should include:

- Patient's date of birth and ID number
- Name of requested drug
- Why the appeal should be approved or the doctor's disagreement with the denial
- Reason the medication is medically necessary
- Any office chart, labs, or other clinical notes that support the appeal

The doctor can call to request an urgent appeal through the Appeal department.

If you have questions or need help submitting an appeal, please call Customer Care for assistance at **877-876-7214** (option 2). Once an appeal is received, the appeal and all supporting documentation are reviewed and completed. A notification will then be sent to you and your doctor within the following timelines:

- **Urgent preservice appeal:** 72 hours
- **Nonurgent preservice appeal:**
 - For plans with one level of appeal: 30 days
 - For plans with two levels of appeal: 15 days
- **Post-service appeal:** 30 days

Review of adverse benefit determinations

First-level clinical appeal

When you appeal a decision about a drug or benefit, it's first checked against set medical guidelines around the drug or benefit being requested. This review considers any documents you or your representative provide. This could include a letter from your doctor, the denial letter from CVS Caremark, your payment receipt, and medical records. A qualified reviewer will handle your appeal. If it's denied again, you'll get a letter explaining how to request a second-level Medical Necessity review.

If your appeal is urgent, SilverScript will do the first- and second-level appeals together within set time frames.

- If approved at the first level, no more reviews are needed, and you'll get an approval notice.
- If not approved, the second-level medical necessity review is started right away. You'll be notified once the second review is complete.

Second-level medical necessity appeals

If your first-level appeal is denied and upheld, you or your representative can ask for a second-level medical necessity review to check that a drug or benefit is medically necessary. A qualified reviewer or a separate medical necessity review organization handles this. If urgent, SilverScript fast-tracks the second review.

For appeals reviewed by the medical necessity review organization:

- SilverScript forwards your medical records, appeals documents, and other supporting items to the medical necessity review organization.
- An independent doctor reviews these documents. They might contact your doctor if more information is needed to help with the review.
- The independent doctor uses current medical literature and the additional documents they've received to make a decision, which will be put into a letter.
- The letter will be shared with SilverScript, who will then share it with you or your representative.

Review of adverse nonclinical determinations

SilverScript offers a single-level appeal option for nonclinical appeals. These are for medications or benefits that aren't covered by the plan or and don't have a prior authorization or an exception process. More information about nonclinical reviews is earlier in this chapter.

When SilverScript receives this kind of appeal, they'll review your request for a particular drug or benefit against the terms of the plan, including the preferred drug lists, formularies, or other defined plan benefits selected by the plan sponsor or in the PDD. A nonclinical appeal doesn't consider whether the requested drug or benefit is medically necessary.

Appeal determination process

1. Appeals and related documents are stamped with the date and time they're received.
2. Reviews are conducted within the time frames listed previously in this document.
3. The appeal decision (determination) is made and entered into the database. The written determination is sent to you or your representative.
4. Communications are written so they can be easily understood by you or your representative.

Communications include:

- The specific reason(s) for the determination
- The information and plan provision we based our decision on
- A notice that you can submit written request copies of all documents, records, and other information related to the claim at no cost

- A copy of the rule, guideline, or other information we used in our decision, if it applies, or a statement saying you can get the information at no cost by requesting it in writing
- A statement of your right to take legal action under the Employee Retirement Income Security Act (ERISA) Section 502(a), if it applies
- A description of our appeals processes and any external review process available
- Information about where you can get help with claims, appeals, and external reviews, such as the health insurance consumer assistance office and ombudsman (independent official) programs established in Section 2793 of the Public Health Service Act

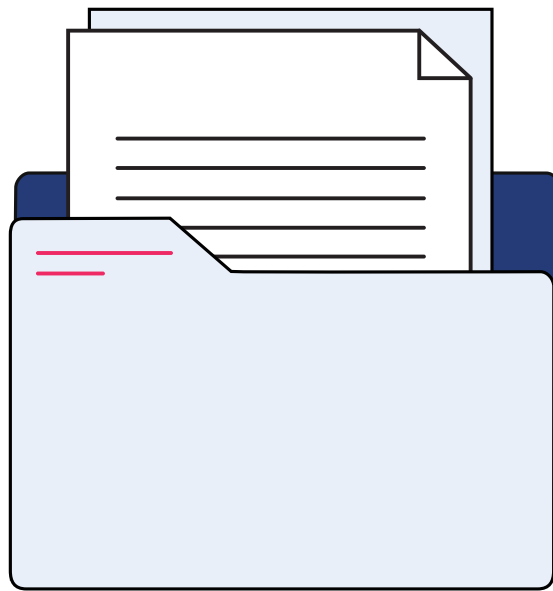
If you have questions or need help submitting an appeal, please call Customer Care at **877-876-7214** (option 2).

Confidentiality

All member and client appeal documents are handled in a confidential manner and follow applicable laws and regulations around your identity and prescription history. To maintain your confidentiality, all appeal information becomes a part of a permanent case file.

Appendices

Notices and reference information



Appendix A: GIC notices

Notice of Group Insurance Commission Privacy Practices

Important! 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 << **GIC should this be here? Should date be updated?**

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 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 plan’s 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, visit 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 the HHS website at [hhs.gov/ocr/privacy/hipaa/complaints](https://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 Medicare Extension 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 [ssa.gov](https://www.ssa.gov) **website was updated** 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 [medicare.gov](https://www.medicare.gov).
- Call your State Health Insurance Assistance Program (check 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 [ssa.gov](https://www.ssa.gov) or call **800-772-1213** (TTY: **800-325-0778**).



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 the VETS website at dol.gov/vets. An interactive online USERRA Advisor can be viewed at 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 [healthcare.gov](https://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 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 [askebsa.dol.gov](https://www.askebsa.dol.gov) or call **866-444-EBSA (3272)**.

Important! 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.



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.

GIC— Should these sections or dates be updated?

Table 27. Premium assistance resources by state

- **Alabama — Medicaid**
 - Website: myalhipp.com
 - Phone: **855-692-5447**
- **Alaska — Medicaid**

The AK Health Insurance Premium Payment Program

 - Website: myakhipp.com
 - Phone: **866-251-4861**
 - Email: CustomerService@MyAKHIPP.com
 - Medicaid eligibility: <https://health.alaska.gov/dpa/Pages/default.aspx>
- **Arkansas — Medicaid**
 - Website: myarhipp.com
 - Phone: **855-MyARHIPP (855-692-7447)**
- **California – Medicaid**

Health Insurance Premium Payment (HIPP) Program

 - Website: 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: healthfirstcolorado.com
 - Health First Colorado Member Contact Center: **800-221-3943** / State relay **711**
 - CHP+: hcpf.colorado.gov/chp
 - CHP+ Customer Service: **800-359-1991** / State relay **711**
 - Health Insurance Buy-In Program (HIBI): mycohibi.com
 - HIBI customer service: **855-692-6442**
- **Florida — Medicaid**
 - Website: flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
 - Phone: **877-357-3268**
- **Georgia — Medicaid**
 - GA HIPP website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
 - Phone: **678-564-1162**, press 1
 - GA CHIPRA website: 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: in.gov/fssa/hip
 - Phone: **877-438-4479**
 - All other Medicaid
 - Website: in.gov/medicaid
 - Phone: **800-457-4584**
- **Iowa — Medicaid and CHIP (Hawki)**
 - Medicaid website: dhs.iowa.gov/ime/members
 - Medicaid phone: **800-338-8366**
 - Hawki website: dhs.iowa.gov
 - Hawki phone: **800-257-8563**
 - HIPP website: hhs.iowa.gov/medicaid/plans-programs/fee-service/health-insurance-premium-payment-program
 - HIPP phone: **888-346-9562**

- **Kansas — Medicaid**
 - Website: kancare.ks.gov
 - Phone: **800-792-4884**
 - HIPP phone: **800-967-4660**
- **Kentucky — Medicaid**
 - Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) website: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
 - Phone: **855-459-6328**
 - Email: kihipp.program@ky.gov
 - KCHIP website: kynect.ky.gov
 - Phone: **877-524-4718**
 - Kentucky Medicaid website: chfs.ky.gov/agencies/dms/Pages/default.aspx
- **Louisiana — Medicaid**
 - Websites: medicaid.la.gov or ldh.la.gov/lahipp
 - Phone: **888-342-6207** (Medicaid hotline) or **855-618-5488** (LaHIPP)
- **Maine — Medicaid**
 - Enrollment website: www.mymaineconnection.gov/benefits/s/?language=en_US
 - Phone: **800-442-6003** TTY: Maine relay **711**
 - Private Health Insurance Premium webpage: maine.gov/dhhs/ofi/applications-forms
 - Phone: **800-977-6740** TTY: Maine relay **711**
- **Massachusetts — Medicaid and CHIP**
 - Website: 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: mydss.mo.gov/healthcare
 - Phone: **573-751-2005**
- **Montana — Medicaid**
 - Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
 - Phone: **800-694-3084**
 - Email: HSHIPPProgram@mt.gov
- **Nebraska — Medicaid**
 - Website: AccessNebraska.ne.gov
 - Phone: **855-632-7633**
 - Lincoln: **402-473-7000**
 - Omaha: **402-595-1178**
- **Nevada — Medicaid**
 - Medicaid website: nevadamedicaid.nv.gov
 - Medicaid phone: **800-992-0900**
- **New Hampshire — Medicaid**
 - Website: 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: nj.gov/humanservices/dmahs/clients/medicaid
 - Medicaid phone: **609-631-2392**
 - CHIP website: njfamilycare.org/index.html
 - CHIP phone: **800-701-0710**

- **New York — Medicaid**
 - Website: health.ny.gov/health_care/medicaid
 - Phone: **800-541-2831**
- **North Carolina — Medicaid**
 - Website: medicaid.ncdhhs.gov/
 - Phone: **919-855-4100**
- **North Dakota — Medicaid**
 - Website: hhs.nd.gov/healthcare
 - Phone: **800-755-2604**
- **Oklahoma — Medicaid and CHIP**
 - Website: oklahoma.gov/ohca/individuals.html
 - Phone: **888-365-3742**
- **Oregon — Medicaid**
 - Website: healthcare.oregon.gov/Pages/index.aspx
 - Phone: **800-699-9075**
- **Pennsylvania — Medicaid and CHIP**
 - Website: dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
 - Phone: **800-692-7462**
 - CHIP website: dhs.pa.gov/CHIP/Pages/CHIP.aspx
 - CHIP phone: **800-986-KIDS (5437)**
- **Rhode Island — Medicaid and CHIP**
 - Medicaid website: eohhs.ri.gov
 - Phone: **855-697-4347** or **401-462-0311** (Direct RIte Share Line)
- **South Carolina — Medicaid**
 - Website: scdhhs.gov
 - Phone: **888-549-0820**
- **South Dakota — Medicaid**
 - Website: dss.sd.gov
 - Phone: **800-597-1603**
- **Texas — Medicaid**
 - Website: hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
 - Phone: **800-440-0493**
- **Utah — Medicaid and CHIP**
 - Medicaid website: medicaid.utah.gov
 - CHIP website: dhhs.utah.gov
 - Phone: **866-608-9422**
- **Vermont — Medicaid**
 - Website: dvha.vermont.gov/members/medicaid/hipp-program
 - Phone: **800-250-8427**
- **Virginia — Medicaid and HIPP**
 - Medicaid website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
 - HIPP website: coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
 - Medicaid/CHIP phone: **855-242-8282**
- **Washington — Medicaid**
 - Website: hca.wa.gov
 - Phone: **800-562-3022**
- **West Virginia — Medicaid and HIPP**
 - Medicaid website: bms.wv.gov
 - HIPP website: mywvhipp.com
 - Medicaid phone: **304-558-1700**
 - CHIP toll-free phone: **855-MyWVHIPP (855-699-8447)**

- **Wisconsin — Medicaid and CHIP**

- Website: dhs.wisconsin.gov/badgercareplus/p-10095.htm
- Phone: **800-362-3002**

- **Wyoming — Medicaid**

- Website: 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**

- EBSA website: dol.gov/agencies/ebsa
- **866-444-EBSA (3272)**

- **U.S. Department of Health and Centers for Medicare & Medicaid Services**

- CMS website: cms.gov
- **877-267-2323**, Menu Option 4, Ext. 61565 (**OMB Control Number 1210-0137 (expires 1/31/2026)**) << **GIC is this necessary?**

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. Check 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. Check 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.

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 deductibles and 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.

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 about these benefits.

Massachusetts state clinical trial definition

Your plan covers patient care services that are provided as part of 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 nongovernmental 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.

Massachusetts state mandates

It is the intent of the plan to be compliant with Massachusetts state mandates that apply to the Group Insurance Commission.

Member rights and responsibilities (Carelon)

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 ([carelonbehavioralhealth.com](https://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, workers’ 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.

We're here for you — in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish

Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese

您有權免費獲得透過您使用的語言提供的幫助。請撥打您的 ID 卡片上的會員服務電話號碼。若您為視障人士，還可索取本文件的其他格式版本。

Vietnamese

Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

Korean

귀하는 자국어로 무료지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog

May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

Russian

Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

Armenian

Դուք իրավունք ունեւ ստանալ անվճար օգնությունն ձեր լեզվով: Պարզապէս գտնեալ հարկէ Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

Farsi

«شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید.» "دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید."

French

Vous pouvez obtenir gratuitement de l'aide dans votre langue. Il vous suffit d'appeler le numéro réservé aux membres qui figure sur votre carte d'identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d'autres formats.

Arabic

لاتصال برقمًا يك سويلا عم. جانًا م نمتك لساعدة بم لي حصول علا في ق حلا لفل بلنك طكمبصر؟ بلا فيعضدت هل أن. تويهاا ببطاقة لي لوجود عملا لأعضاء اتمخد ستن دملما ان هذمال آخرى كاشد.

Japanese

お客様の言語で無償サポートを受けることができません。IDカードに記載されているメンバーサービス番号までご連絡ください。

Haitian

Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòm tou.

Italian

Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

Polish

Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

Punjabi

ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫਤ ਮਦਦ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਬਸ ਆਪਣਾ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਸਿਰਵਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਤੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

TTY/TTD: 711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800-368-1019 (TDD: 1-800-537-7697) or visit <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.

In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare provider in your plan's network. If you receive care from a doctor or healthcare provider not in your plan's network, your share of the costs may be higher. You also may receive a bill for any charges not covered by your health plan.

Claims are administered by Wellpoint Life and Health Insurance Company.

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan.

LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan.

Carelon Behavioral Health, Inc. is a separate company providing behavioral health services on behalf of your health plan.

Carelon Health, Inc. is a separate company providing care management and palliative care services on behalf of your health plan..

Carelon Medical Benefits Management, Inc. is a separate company providing utilization review services on behalf of your health plan.

CarelonRx, Inc. is an independent company providing pharmacy benefit management services on behalf of your health plan.



P.O. Box 4095, Woburn, MA 01888 | 800-442-9300 | wellpointmass.com
Claims are administered by Wellpoint Life and Health Insurance Company.

