Member Handbook

Total Choice Plan

For active employees and non-Medicare retirees

Wellpoint

Commonwealth of Massachusetts
Group Insurance Commission

Series 1

Effective July 1, 2026

1082199MAMENWLP Rev. 09/25

Welcome

Total Choice plan members

Effective July 1, 2026–June 30, 2027

Wellpoint

You are covered under the Wellpoint Total Choice plan

Total Choice offers 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 in the New England area. The subscriber (the main person insured on your health plan) can live anywhere in New England, or even internationally. Dependents (members of the subscriber's family, like a child or spouse, who are eligible for benefits under this health plan) can live anywhere.

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**.

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 Total Choice.

This plan meets state minimum coverage standards

In Massachusetts, you must have health insurance with a certain level of benefits. This level of benefits is called **Minimum Creditable Coverage**.

This applies to the Minimum Creditable Coverage standards effective **January 1, 2026**. Check your health plan materials each year to make sure your coverage meets the latest standards.

If you have questions about this policy, call the Commonwealth Health Insurance Connector at **877-MA-ENROLL**. You can also visit betterhealthconnector.com/about/policy-center for more information.

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

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 Wellpoint about what they charge for healthcare services.

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

What is a Preferred provider?

In this handbook, care providers who have an agreement with your plan are called **Preferred care providers**. They're also called contracted or in-network care providers. You may see them referred to this way on wellpointmass.com.

For medical services

- **Preferred care providers** are doctors, hospitals, or other healthcare providers that have an agreement to provide covered services at lower out-of-pocket costs to members. They are also known as in-network or contracted providers, and you may see these terms used on wellpointmass.com.

  Outside of Massachusetts, be sure to use Preferred care providers — Nonpreferred care providers can bill you for the difference between what Wellpoint pays and the allowed amount. Within Massachusetts, all medical care providers are considered Preferred.

- **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 from Nonpreferred care providers.

Table 1. Location of care cost differences

Location of care	Care provider type	Member cost difference
In Massachusetts	Preferred care providers* (all providers are considered in network)	No cost difference
Outside Massachusetts	Preferred care providers (all providers are considered in network)	No cost difference

For behavioral health services

- **Preferred (or in-network or contracted) behavioral health care providers** have an agreement with your health plan to provide covered services at lower out-of-pocket costs to members. Preferred behavioral health care providers have agreed to accept your plan's allowed amount as payment in full, and they won't balance bill you.
- **Nonpreferred (or out-of-network or noncontracted) behavioral health care providers** are those that do not have an agreement with your plan. 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.

* Does not include services such as DME, enteral therapy, home health care, and home infusion. For how those benefits apply please review details in the member handbook.

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: **833-663-4176**/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

CVS Caremark

Contact 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: info.caremark.com/oe/gic

Employee Assistance Program*

Optum

Contact Optum for questions about Employee Assistance Program (EAP) benefits, like:

- Addiction recovery support
- Crisis support
- Personal empowerment tools
- Financial well-being support

Optum Customer Service:

- Phone: **844-263-1982** (toll-free)
- Website: supportfinder.optum.com/mass4you (Use access code Mass4You.)

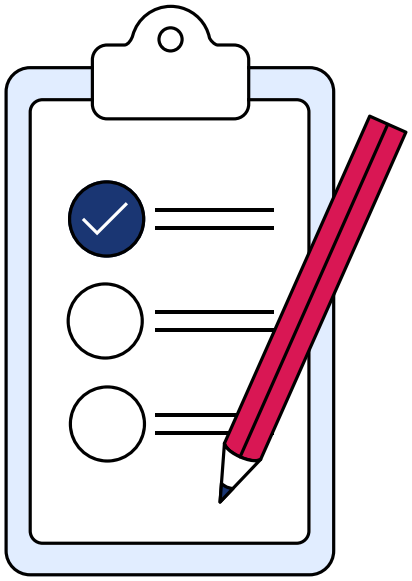
* Available to state and municipal employees who are eligible for GIC coverage, and their dependents.

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

Table of Contents

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 833-663-4176.

Wellpoint

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 CVS Caremark.

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**.

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 Preferred care providers and suppliers** — to get the best benefit, use a Preferred care provider or supplier for this service or product.

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.

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 AARP, MassHealth, or TRICARE
- 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 AARP, MassHealth, or TRICARE
- 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. CVS Caremark will send it. Call CVS Caremark 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

Choose Preferred providers for behavioral health care services and medical supplies. These suppliers and care providers accept Wellpoint's payment as payment in full and won't bill you for the rest. Services and equipment from Preferred care providers and suppliers are 100% covered. Your plan covers Nonpreferred care providers and suppliers at 80%, so you'll owe 20% coinsurance. Find Preferred care providers and suppliers at wellpointmass.com, where they may be called **in-network care providers** or **suppliers**.

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 $20 copay at walk-in clinics, like urgent care centers and retail health clinics. At a hospital emergency room, your copay is $100.

Use independent ambulatory surgery centers for eye or gastrointestinal (GI) surgery. You pay a lower copay when you have these services at a nonhospital facility.

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.

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.

Insurance pays a set amount for each service

For every covered service, insurance plans set an amount they will pay. This is called the **allowed amount**.

Let's say the allowed amount for tetanus serum is $80. Even if your doctor charges $100, insurance will pay no more than $80 — the allowed 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 who have contracted with your plan accept the allowed amount as payment in full. Nonpreferred care providers don't. 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
Deductible	A set dollar amount you pay for healthcare services before your plan starts paying
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 deductible, copays, and coinsurance.

How member costs work

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 deductible (if it applies), and lastly we subtract 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.

Your deductible

A deductible is a set amount you pay for certain services before your plan starts sharing the cost. Your deductible starts at the beginning of each plan year — July 1, for your plan.

The deductible applies to some — but not all — covered services. For example, you owe your deductible for inpatient care but not for occupational therapy. Inpatient care is **subject to the deductible**, but occupational therapy is not.

Sometimes it takes more than one claim to meet (fully pay) your deductible. Once you meet the deductible, you won't owe any more deductible until the next plan year starts.

You have one deductible for medical and behavioral health services.

Important! You have a separate prescription drug deductible. It is described in Chapter 12 of this handbook.

Table 4. How much is my deductible?

Deductible	Amount
For an individual	$500 (each plan year)
For a family	$1,000 for the entire family, each plan year ($500 for any one person in the family)

How an individual deductible works

An **individual deductible** is the amount that one person must pay before their plan starts to share the cost.

Example:

In the month of:	Your medical services cost:	You pay:	Your plan pays:	Deductible remaining:
July	$375	$375	$0	$125
August	$100	$100	$0	$25
September	$97	$25	$72	$0

How a family deductible works

If you have dependents covered under your plan, you also have a **family deductible**. Each person has a $500 deductible, but the maximum you'll pay is $1,000 for everyone on your plan.

Example:

In the month of:	Medical costs by family member	Year-to-date amount paid toward $500 individual deductible	Year-to-date amount paid toward $1,000 family deductible	Family deductible amount remaining
July	Parent: $0 Child 1: $250 Child 2: $250	Parent: $0 Child 1: $250 Child 2: $250	$500	$500
August	Parent: $175 Child 1: $0 Child 2: $103	Parent: $175 Child 1: $250 Child 2: $353	$778	$222
September	Parent: $97 Child 1: $125 Child 2: $0	Parent: $272 Child 1: $375 Child 2: $353	$1,000	$0

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. Copays can work in two ways:

- **Per visit:** Pay a copay each time you have a medical service. Doctor visits, emergency room (ER) trips, and some outpatient services have per-visit copays.
- **Quarterly:** Pay a copay for each type of service only once each calendar quarter, even if you have that type of service again during the same quarter.

How quarterly copays work

Two types of services have quarterly copays:

- **Inpatient admissions:** Pay a quarterly copay when you're admitted to a hospital for medical or behavioral health care.

- **Outpatient surgeries:** Pay a quarterly copay when you have outpatient surgery at a hospital or non-hospital-owned facility.

Each calendar quarter, you only need to pay your copay the first time you have each type of service. If you happen to be hospitalized or have outpatient surgery twice in 30 days, you won't owe a second copay, even if the dates fall in two different quarters. But if the dates fall in two different plan years — in June and July, for example — you owe both copays. The calendar quarters are July–September, October–December, January–March, and April–June.

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.

Important! Although some specialists may also provide primary care, they are still considered specialists. This means you will pay the specialist copay whether you see the doctor for a primary care or specialty care visit.

Inpatient hospital admissions

You owe a quarterly inpatient copay when you're admitted to a hospital for medical or behavioral health care. Once you've paid an inpatient copay (for either kind of care), you won't owe another for the rest of the calendar quarter.

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 and you owe a quarterly inpatient copay instead.

Outpatient surgery

You owe a quarterly copay when you have surgery at a hospital or a non-hospital-owned facility like an ambulatory surgery center. Once you've paid an outpatient surgery copay, you won't owe another for the rest of the calendar quarter.

Note: Non-hospital-owned facilities are those that perform outpatient medical services but aren't owned or operated by a hospital. Many ambulatory surgery centers and urgent care centers are non-hospital-owned facilities.

Other outpatient medical services

You owe a copay at each visit for:

- Cardiac rehabilitation programs.
- Chiropractic services.
- High-tech imaging like an MRI, CT scan, or PET scan. You owe just one high-tech imaging copay per day, no matter how many scans you get.
- Occupational therapy.
- Physical therapy.
- Routine eye exams.
- Speech therapy.

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%. You owe 20% coinsurance.

Out-of-pocket (OOP) maximum

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

Table 5. Your OOP maximums

Out-of-pocket maximum	Amount
For an individual	$5,000 each plan year
For a family	$10,000 for the entire family each plan year ($5,000 for any one person in the family)

These costs count toward your OOP maximum for medical, behavioral health, and prescription drug services:

- Deductibles
- Copays
- Coinsurance

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

- 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.

Allowed amounts

The allowed amount for a covered service is the maximum Wellpoint pays. Preferred care providers agree to accept the allowed amount for each service as payment in full.

Nonpreferred care providers do not have an agreement with Wellpoint about the amount they can bill for services. Care provider charges are usually much higher than allowed amounts, and Nonpreferred care providers can bill you for the difference.

Questions?

Contact Member Services at **833-663-4176** 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 **833-663-4176**. 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.

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 **833-663-4176**.

Table 6. Preapproval reviewers

Medical and behavioral health reviewers	Services
Wellpoint • **800-442-9300/**TTY: **711** (toll-free) • wellpoint.com/mass/providers/preapprovals	Behavioral health services and some medical services
Carelon Medical Benefits Management • **866-766-0247** (toll-free) • providerportal.com	Bilevel positive airway pressure (BPAP) and continuous positive airway pressure (CPAP) equipment; some cardiology procedures; high-tech imaging; genetic testing; musculoskeletal services; oncology drugs; radiation therapy; sleep studies

Specialty pharmacy reviewers
CVS Caremark • **800-237-2767** (toll-free) • Check the "Prescription benefits" section for more information.
CarelonRx • **833-293-0659** (toll-free) • Start a request for prior authorization (preapproval) at covermymeds.health/prior-authorization-forms

Not sure who to call?

CVS Caremark handles most pharmacy reviews. Call Customer Care at **877-876-7214** and they'll transfer you to CarelonRx if needed.

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 **833-663-4176**.

⚠ Examples of medical services that need preapproval

- Ambulance services (nonemergency)
- Cardiology services:
  - Arterial duplex
  - Diagnostic cardiac catheterization
  - Diagnostic coronary angiography
  - Percutaneous coronary intervention (PCI)
  - Physiologic study arterial
  - Resting transthoracic echocardiography
  - Stress echocardiography
  - Transesophageal echocardiography
- Cleft palate and cleft lip services
- Colonography (virtual colonoscopy)
- Durable medical equipment (DME)
  - For equipment costing more than $1,000
  - Doesn't apply to oxygen and oxygen equipment
- Enteral and oral therapy
- Gender affirmation (reassignment) surgery
- Genetic testing
- High-tech imaging
  - CT or CTA scan
  - MRI or MRA scan
  - Nuclear cardiology
  - PET scans
  - SPECT scans

- **Home healthcare**
- **Hospice care**
- **Hyperbaric oxygen therapy**
- **Inpatient hospital admissions:**
  - Hospital at home
  - Inpatient hospital stay
  - Inpatient readmission
- **Musculoskeletal services:**
  - Interventional pain management
  - Joint surgery
  - Spine surgery
- **Oncology services:**
  - Chemotherapy supportive drugs
- **Prosthetics and orthotics**
- **Radiation therapy:**
  - Brachytherapy
  - CyberKnife®
  - Intensity-modulated radiation therapy (IMRT)
  - Proton beam
  - Traditional radiation
- **Rehabilitation services:**
  - Occupational therapy
  - Physical therapy
  - Speech therapy
- **Skilled nursing facility admissions**
- **Sleep services:**
  - BPAP and CPAP equipment
  - Sleep studies
- **Surgeries (selected)**
- **Transplants:**
  - Doesn't apply to cornea transplants
- **Varicose vein treatment:**
  - Includes sclerotherapy

Specialty drugs

These are prescription medications used to treat complex conditions like cancer, rheumatoid arthritis, and multiple sclerosis. Specialty drugs are often costly and might require special handling (like refrigeration during shipping) and administration (such as injection or infusion).

- A site-of-service review may be included in the preapproval review process.
- Some nononcology specialty drugs that are not for cancer may need preapproval through your prescription drug plan. Check Chapter 12 of this handbook.

Preapprovals for behavioral health services

Care providers can contact Wellpoint 24 hours a day, seven days a week, for preapproval of behavioral health services. Below are behavioral health services that need preapproval.

Table 7. Inpatient services for mental health treatment

☑ Service	With Preferred care providers	With Nonpreferred care providers
• Acute residential treatment • Transitional care units (TCUs)	Needs preapproval	Needs preapproval
• Community-based acute treatment (CBAT) • Inpatient psychiatric services	• **In Massachusetts:** Notify Wellpoint within 72 hours • **Outside Massachusetts:** Needs preapproval	• **In Massachusetts:** N/A • **Outside Massachusetts:** Needs preapproval
Crisis stabilization units (CSUs)	Preapproval needed for stays over 5 days	Preapproval needed for stays over 5 days

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 (adults and adolescents)

☑ Service	With Preferred care providers	With Nonpreferred care providers
• 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)	• **In Massachusetts:** Notify Wellpoint within 48 hours • **Outside Massachusetts:** Needs preapproval	• **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.

Table 9. Outpatient services

☑ Service	With Preferred care providers	With Nonpreferred care providers
• Acupuncture withdrawal management • Community support programs (CSPs) • Day treatment	N/A	Needs preapproval
• Applied Behavior Analysis (ABA) • Dialectical behavioral therapy (DBT) • Family stabilization teams (FSTs) • Family support and training • In-home behavioral services • Intensive care coordination • Partial hospitalization programs for mental health conditions (PHPs) • Psychiatric visiting nurse services • Therapeutic mentoring services • Transcranial magnetic stimulation (TMS)	Needs preapproval	Needs preapproval
Partial hospitalization programs (PHPs) for mental health conditions (ASAM level 2.5)*	• **In Massachusetts:** Notify Wellpoint within 48 hours • **Outside Massachusetts:** Needs preapproval	• **DPH-licensed care providers in Massachusetts:** Notify Wellpoint within 48 hours • **All other Nonpreferred care providers:** Needs preapproval
• Intensive outpatient programs (IOPs) • Structured outpatient addiction programs (SOAPs)	• Notify Wellpoint within 48 hours	• **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 833-663-4176.

Wellpoint

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	Deductible
⚠ Applied Behavior Analysis (ABA)	• Preferred care providers — $20 copay • Nonpreferred care providers — deductible and 20% coinsurance
Bereavement counseling	Deductible and 20% coinsurance (your plan will pay up to $1,500 for a family in a plan year)
Cardiac rehab programs	$20 copay
Chemotherapy	Deductible
Chiropractic care	$20 copay (limited to 20 visits in a plan year)
☑ Diabetic supplies	• Preferred suppliers — deductible • Nonpreferred — deductible and 20% coinsurance
Dialysis	Deductible
Doctor visits	• Primary care provider (PCP) visit — $20 copay • Specialist visits — $45 copay • Virtual care (telehealth) — $20 copay
Doctors — other services	• At an emergency room — deductible • For inpatient hospital care — deductible (you also have a $275 quarterly copay for the hospital stay) • For outpatient hospital care — $45 copay (You may need to meet your deductible for some services. If you're having surgery, you have a $250 quarterly outpatient surgery copay too.)
Drug screening (lab tests)	Deductible
⚠ ☑ Durable medical equipment (DME)	• Preferred suppliers — deductible • Nonpreferred — deductible and 20% coinsurance
Early intervention programs	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
Emergency room visits	$100 copay and deductible
Eye exams (routine)	$45 copay (limited to one exam every 24 months)
Eyeglasses and contact lenses	Deductible (limited to the first lenses within six months of eye injury or cataract surgery)
Family planning services	No member costs
Fitness reimbursement	Your plan will reimburse (pay back) up to $100 for an individual and $200 for a family in a plan year
Hearing aids	• 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	No member costs (but you may owe a copay for the office visit)
⚠ High-tech imaging (like MRIs or CT scans)	• Emergency room — deductible • Inpatient hospital — deductible • Outpatient hospital and non-hospital-owned facilities — $100 copay each day and deductible
⚠ ☑ Home healthcare	• Preferred suppliers — deductible • Nonpreferred suppliers — deductible and 20% coinsurance
☑ Home infusion therapy	• Preferred suppliers — deductible • Nonpreferred suppliers — deductible and 20% coinsurance
⚠ Hospice care	Deductible
Immunizations (vaccines)	No member costs (but you may owe a copay for the office visit)
⚠ Inpatient medical care	• At a hospital or rehab facility in a semiprivate room — $275 quarterly copay and deductible • At a hospital or rehab facility in a medically necessary private room – First 90 days — $275 quarterly copay and deductible – After 90 days — You pay the dollar difference between a semiprivate room and a private room

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
⚠ Inpatient behavioral health care	• Hospital or facility charges – Preferred — $275 quarterly copay and deductible – Nonpreferred — deductible and 20% coinsurance • Professional services from care providers – Preferred — no member costs – Nonpreferred — deductible and 20% coinsurance
Lab services	Deductible
Medical services not listed elsewhere	Deductible and 20% coinsurance
Medication-assisted treatment (MAT)	No member costs
Mobile Crisis Intervention (MCI)	No member costs
Nutritional counseling	No member costs
⚠ Occupational therapy	• With an autism diagnosis — $20 copay • With a Down syndrome diagnosis — $20 copay • All other occupational therapy — $20 copay (needs preapproval after 30 visits)
⚠ Outpatient behavioral health services	• Preferred care provider — $20 copay • Nonpreferred care provider — deductible and 20% coinsurance
Outpatient hospital services not listed elsewhere	Deductible
☑ Oxygen	• Preferred suppliers — deductible • Nonpreferred suppliers — deductible and 20% coinsurance
Personal Emergency Response Systems (PERS)	• Installation — deductible and 20% coinsurance (your plan will pay up to $50 in a plan year) • Rental — deductible and 20% coinsurance (your plan will pay up to $40 each month)
⚠ Physical therapy	• With an autism diagnosis — $20 copay • With a Down syndrome diagnosis — $20 copay • All other diagnoses — $20 copay (needs preapproval after 30 visits)

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
Prescription drugs	CVS Caremark administers your benefits for prescription drugs. Benefits are described in Chapter 12. Call CVS Caremark at **877-876-7214** for more information.
Preventive care	No member costs. Check Table 13.
Prosthetics and orthotics	Deductible
⚠ Radiation therapy	Deductible
Radiology (like X-rays and ultrasounds)	• Emergency room — deductible • Inpatient hospital — deductible • Outpatient hospital and non-hospital-owned facilities — deductible
Retail health clinic visits	$20 copay
⚠ Skilled nursing and long-term care facilities	Deductible and 20% coinsurance (your plan will cover up to 100 days in a plan year)
⚠ Speech therapy	$20 copay
Substance use disorder assessment or referral	No member costs
⚠ Surgery — inpatient at a hospital	Deductible and inpatient copay
⚠ Surgery — outpatient	• At a hospital — $250 quarterly copay and deductible • Eye and gastrointestinal (GI) surgery at non-hospital-owned facilities — $150 quarterly copay and deductible • All other outpatient surgeries at non-hospital-owned facilities — $250 quarterly copay and deductible • At a doctor's office — deductible (you also may owe a copay for the office visit)
Therapy or counseling (outpatient)	• Preferred care provider — $20 copay • Nonpreferred care provider — deductible and 20% coinsurance
Tobacco cessation counseling	No member costs
⚠ Transplants	• At a Quality Center or Designated Hospital for transplants — $275 quarterly copay and deductible • At other hospitals — $275 quarterly copay, deductible, and 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
Urgent care center visits	$20 copay
Virtual care (telehealth)	$20 copay
Virtual care (telehealth) — behavioral health	• Preferred care provider — $20 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 **833-663-4176**.

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

Service	Member costs	Preapproval needed
Shot (injection)	Deductible	No
Allergy serum	Deductible and 20% coinsurance	No
Office visit	• With a primary care provider (PCP) — $20 copay • With a specialist — $45 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.
- ⚠ **Nonemergency ambulance transportation needs preapproval.**

⊗ **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.
- Nonemergency ground ambulance is covered when there's no other safe way to move you.

Your plan doesn't cover:

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

Service	Member costs	Preapproval needed
Emergency transportation	• Ground ambulance — deductible • Air ambulance — deductible • Water ambulance — deductible	No
⚠ Nonemergency transportation	Ground ambulance only — deductible	Yes

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	Deductible	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	$20 copay	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	$20 copay	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 plan 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	$20 copay (limited to 20 visits in a plan year)	No
X-rays taken by your chiropractor	Deductible	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.

⚠ **These services need preapproval.** For help with preapproval, call Wellpoint Member Services at **833-663-4176**.

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)	Yes

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.

⚠ **These services need preapproval.** For help with preapproval, call Wellpoint Member Services at **833-663-4176**.

⊗ 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).

Diabetes prevention program reimbursement

Your plan will pay you back up to $500 if you complete at least 20 sessions of an approved diabetes prevention program.

Choose a diabetes prevention program in Massachusetts: mass.gov/info-details/diabetes-prevention-programs-in-massachusetts

Outside of Massachusetts, choose a program offered by the YMCA: ymca.org/what-we-do/healthy-living/fitness/diabetes-prevention

To be reimbursed, send proof that you've completed at least 20 sessions of a diabetes prevention program approved by the Massachusetts Department of Public Health or offered through the YMCA in other states. Here's how:

1. Go to wellpointmass.com.
2. Under **Health plans**, choose your plan name.
3. Go down to **Member forms**.
4. Choose **Diabetes Prevention Program Reimbursement** to download the form.
5. Follow the directions to fill out the form and send it in.

Restrictions

- You must complete at least 20 sessions to be reimbursed.
- Each member can only be reimbursed once for a diabetes prevention program.

Service	Member costs	Preapproval needed
Diabetes prevention program	Your plan will reimburse up to $500 per member (one time only)	No

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.
- Preapproval is needed for any item costing more than $1,000.
- 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.

⚠ **Items costing more than $1,000 need preapproval.** For help with preapproval, call Wellpoint Member Services at **833-663-4176**.

☑ After you meet your deductible, your plan pays 100% of the allowed amount for items you get from Preferred suppliers. Items from Nonpreferred suppliers are covered at 80%, even when they are out of stock from Preferred suppliers. Find Preferred suppliers at wellpointmass.com.

Service	Member costs	Preapproval needed
Diabetic supplies and equipment from Preferred suppliers	Deductible	Yes, for items costing more than $1,000
Diabetic supplies and equipment from Nonpreferred suppliers	Deductible, then 20% coinsurance. Your plan pays 80% of the allowed amount.	Yes, for items costing more than $1,000

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	Deductible	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 with a PCP	$20 copay	No
Office visits with a specialist	$45 copay	No
Virtual care (telehealth)	$20 copay	No
Doctor services at an **emergency room**	Deductible (you also have a $100 copay for the emergency room visit)	No
Doctor services for **inpatient hospital care**	Deductible (you also have a $275 quarterly copay for the hospital stay)	Yes, preapproval needed for inpatient medical care
Doctor services for **outpatient hospital care**	$45 copay (You may need to meet your deductible for some services. If you're having surgery, you may have a $250 quarterly outpatient surgery copay too.)	Yes, preapproval needed for outpatient surgery
Services not listed elsewhere	Deductible	See listings for specific services, or call Wellpoint Member Services at **833-663-4176**.

Drug screening (lab tests)

Lab tests for drug screening, such as blood and urine tests, are covered when a doctor orders them.

Restrictions

- Drug screening tests must be performed by hospitals, medical labs, and other medical care providers.
- Your plan does not cover drug screening needed for nonmedical reasons, like:
  - Drug testing for your job, school, camp, sports, travel, insurance, marriage, adoption, or housing (like sober living)
  - Court-ordered drug testing (except where laws require your plan to cover it)
  - Drug testing to keep or get any type of license

Service	Member costs	Preapproval needed
Lab tests for drug screening	Deductible	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

- 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, 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 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.

⚠ **BPAP and CPAP equipment need preapproval.** After the equipment rental (rent-to-own) period is over, supplies need preapproval each year.

⚠ **DME items costing more than $1,000 (to rent or to buy) need preapproval**, except for oxygen and oxygen equipment.

Need help with preapproval?

For help with preapproval, call Wellpoint Member Services at **833-663-4176**.

☑ After you meet your deductible, your plan pays 100% of the allowed amount for items you get from Preferred suppliers. Items from Nonpreferred suppliers are covered at 80%, even when they are out of stock from Preferred suppliers. Find Preferred care providers and suppliers at wellpointmass.com.

Service	Member costs	Preapproval needed
☑ Breast pumps	• Preferred suppliers — no member costs • Nonpreferred suppliers — deductible, then 20% coinsurance	Yes, for items costing more than $1,000
⚠ ☑ BPAP and CPAP equipment	• Preferred supplier — deductible • Nonpreferred suppliers — deductible, then 20% coinsurance	Yes, for items costing more than $1,000
⚠ ☑ All other DME	• Preferred suppliers — deductible • Nonpreferred suppliers — deductible, then 20% coinsurance	Yes, for items costing more than $1,000

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

Restrictions

- Early intervention services must be provided by licensed or certified healthcare 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	No

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	$100 copay and deductible (emergency room copay is waived if you're admitted to the hospital)	No, but call Wellpoint Member Services if you're admitted to the hospital
Nonemergency care from hospital emergency room	$100 emergency room copay, then each service is covered under its own benefit	No
Urgent care center visits	$20 copay, then each service is covered under its own benefit	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.** For help with preapproval, call Wellpoint Member Services at **833-663-4176**.

☑ After you meet your deductible, your plan pays 100% of the allowed amount for enteral and oral formulas from Preferred suppliers. Items from Nonpreferred suppliers are covered at 80%, even when they are out of stock from Preferred suppliers. Find Preferred care providers and suppliers at wellpointmass.com.

⊗ Restrictions

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
⚠☑ Enteral and oral therapy	• Preferred suppliers — deductible • Nonpreferred suppliers — deductible, then 20% coinsurance	Yes

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)	$45 copay	No
Eye care office visits (when needed for your health)	$45 copay	No
Vision therapy	$20 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/ lenses in the first six months after an eye injury or cataract surgery)	Deductible	No

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 an individual medical plan and $200 for a family medical plan for costs related to fitness activities.

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:

- Your fitness membership or subscription must be for at least four months in a plan year.
- You must be a Wellpoint member for the entire four months of your fitness membership or subscription.
- You can request reimbursement once per plan year, anytime after November 1.
- Wait until you have paid the whole amount you want the plan to reimburse (up to $100 for an individual plan and $200 for a family plan) before you submit the request.
- Complete the Fitness Reimbursement form from wellpointmass.com.
- Submit the form and proof of payment to: Wellpoint Fitness Reimbursement, PO Box 4095, Woburn, MA 01888. You can also send us your paperwork through your secure Wellpoint member account or fax it to 978-474-5162.

⊗ 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.

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	• With a PCP — $20 copay • With a specialist — $45 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 (learn more in Chapter 5).

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 **833-663-4176**.

Gender affirmation services need preapproval. For help with preapproval, call Wellpoint Member Services at **833-663-4176**.

Restrictions

- Fertility storage (storage for sperm or eggs) is not covered after 12 months.
- 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	• With a PCP — $20 copay • With a specialist — $45 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	No member costs (you may owe a copay for the office visit)	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.

High-tech imaging needs preapproval. For help with preapproval, call Wellpoint Member Services at **833-663-4176**.

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)	Deductible	No
High-tech imaging at the hospital (outpatient) and at non-hospital-owned facilities	$100 daily copay and deductible	Yes

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.** For help with preapproval, call Wellpoint Member Services at **833-663-4176**.

☑ After you meet your deductible, your plan pays 100% of the allowed amount for covered care (services and items) from Preferred care providers and suppliers. 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.

⊗ 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
⚠☑ Home healthcare	• Preferred care providers and suppliers — deductible • Nonpreferred care providers and suppliers — deductible and 20% coinsurance	No

Home infusion therapy

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

⚠ **Infused drugs** (except those for treating cancer) **need preapproval.** Learn more about your prescription drug plan benefits and coverage in Chapter 12 of this handbook.

☑ After you meet your deductible, your plan pays 100% of the allowed amount for home infusion therapy from Preferred pharmacies. Care from Nonpreferred pharmacies is covered at 80% of the allowed amount. Your deductible applies to both types of pharmacies. Find Preferred providers and suppliers at wellpointmass.com.

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
⚠☑ Home infusion therapy	• Preferred pharmacies — deductible • Nonpreferred pharmacies — deductible and 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

⚠ **Hospice care needs preapproval.** We encourage you to call Wellpoint when hospice services are recommended. We'll connect you with our team of clinical advocates, who offer support and services to members dealing with complex health issues. Learn more abut how clinical advocates can help in Chapter 10.

⚠ **Bereavement counseling needs preapproval.**

Service	Member costs	Preapproval needed
⚠ Hospice care	Deductible	Yes
⚠ Bereavement counseling	• Deductible and 20% coinsurance • Your plan will pay up to $1,500 for the family in a plan year	Yes

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.

⚠ **Genetic testing, including preimplantation genetic testing (PGT), needs preapproval**. For help with preapproval, call Wellpoint Member Services at 833-663-4176.

⊗ **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.
- Your plan will only cover facility fees for licensed hospitals or ambulatory surgery centers.

Inpatient medical care (hospital admissions)

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 three to five 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

- The limit of 100 days per plan year is the total of all inpatient days at skilled nursing facilities and long-term care facilities, even if they took place at more than one facility and/or across more than one admission.
- 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)	$275 quarterly copay and deductible	No
⚠ **Inpatient medical care** at a hospital or rehab facility (medically necessary private room)	• **First 90 days** — deductible • **After 90 days** — you pay the dollar difference between a semiprivate room and a private room	No
⚠ **Inpatient medical care** at a skilled nursing or long-term care facility	Deductible and 20% coinsurance (limited to 100 days in a plan year)	No

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 833-663-4176.

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 **833-663-4176**.

- 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)

Your plan covers diagnostic lab work when ordered by your care provider to diagnose or monitor a health condition.

Service	Member costs	Preapproval needed
Diagnostic lab work	Deductible	No
Preventive lab work	No member costs when done according to the preventive care schedule (find out more in Chapter 6)	No

Long-term care facilities

Your plan covers 100 days of inpatient care at long-term care and skilled nursing facilities each plan 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.

⚠ **Maternity hospital admissions longer than 48 hours for vaginal delivery or 96 hours for Caesarian delivery need preapproval.**

⊗ **Restrictions**

Usually the inpatient hospital care copay applies to the mother's delivery as well as the baby's nursery stay. If 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. Newborn babies are temporarily enrolled in the plan for three days if you have an individual plan or 30 days for a family plan. For coverage beyond what's listed, the subscriber must contact their employer's benefits coordinator to add the baby as a dependent.

Service	Member costs	Preapproval needed
Amniocentesis	Deductible	No
Breastfeeding counseling	No member costs	No
Depression screening	No member costs	No
Home healthcare	• Preferred care providers — deductible • Nonpreferred care providers — deductible and 20% consurance	Yes
Inpatient medical care	$275 quarterly inpatient hospital care copay and deductible	Yes
Lactation consultants	• In hospital — covered under inpatient medical care benefit (above) • All other settings — no member costs	No
Ultrasounds	Deductible	No

Medical care outside the U.S.

Your plan covers medically necessary 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.

- **Emergency care** anywhere in the world is covered at 100% of the charges, after deductible and copay amounts (if any).
- **Elective services** are all covered nonemergency services.

Wellpoint reimburses non-U.S. services at 100% of the charges, after any deductible and copay amounts that apply. The claim is paid based on the exchange rate on the date of service, as found on 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 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)	Deductible and 20% coinsurance	For specific questions, contact Wellpoint Member Services at **833-663-4176**

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	• Preferred care providers — $20 copay • Nonpreferred care providers — deductible and 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

⚠ **Occupational therapy needs preapproval after 30 visits**, except with an autism or Down syndrome diagnosis.

⊗ **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** with an autism or Down syndrome diagnosis	$20 copay	No
⚠ **All other occupational therapy**	$20 copay	Yes, preapproval needed after 30 visits

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)	Deductible	No

Oxygen

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

☑ After you meet your deductible, your plan pays 100% of the allowed amount for items you get from Preferred suppliers. Items from Nonpreferred suppliers are covered at 80%, even when they are out of stock from Preferred suppliers. Find Preferred care providers and suppliers at wellpointmass.com.

⊗ Restrictions

Oxygen equipment needed for airplane or other travel is not covered.

Service	Member costs	Preapproval needed
☑ Oxygen therapy and supplies	• Preferred suppliers — deductible • Nonpreferred suppliers — deductible and 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 are covered under your behavioral health benefit (learn more in Chapter 5).

PANDAS and PANS

Your plan covers treatment for sudden-onset neurological and behavioral conditions in children, like Pediatric Acute-Onset Neuropsychiatric Syndrome (PANS) and Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS), which is a type of PANS. Along with other treatments, your plan covers intravenous immunoglobulin (IVIG) therapy. Depending on the treatment, some services may need preapproval.

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	Deductible and 20% coinsurance (your plan will pay up to $50 for installation in a plan year)	No
PERS rental	Deductible and 20% coinsurance (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

⚠ **Physical therapy needs preapproval after 30 visits**, except with an autism or Down syndrome diagnosis.

⊗ 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 with an autism or Down syndrome diagnosis	$20 copay	No
All other physical therapy	$20 copay	Yes, preapproval needed after 30 visits

Prescription drugs

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

⚠ **Some specialty drugs need preapproval.** Specialty drugs are high-cost prescription medications used to treat complex conditions like cancer, rheumatoid arthritis, and multiple sclerosis. Some are injected, infused, or inhaled, or they may need other special handling like refrigeration during shipping.

Some specialty drugs that need preapproval are covered by your Wellpoint health plan, and some are covered under your prescription drug plan. In Chapter 12, you'll find a list of the nononcology specialty drugs that need preapproval from your prescription drug plan.

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% of the allowed amount.
- 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.

⚠ Prosthetics and orthotics need preapproval.

⊗ 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
Prosthetics and orthotics (including mastectomy bras)	Deductible	Yes

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	Deductible	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).

⚠ **Radiation therapy needs preapproval.**

Service	Member costs	Preapproval needed
⚠ Radiation therapy	Deductible	Yes

Radiology (diagnostic imaging)

Radiology, also called **diagnostic imaging**, helps doctors diagnose medical conditions using images of the body. Your plan covers general radiology services, including X-rays and ultrasounds. Benefits for advanced imaging tests, like MRIs, CT scans, and PET scans, are listed under "high-tech imaging" earlier in this section.

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

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.

⚠ **Sleep studies need preapproval.**

Service	Member costs	Preapproval needed
⚠ Sleep studies	Deductible	Yes

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

⚠ **Speech therapy services need preapproval.**

⊗ **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	$20 copay	Yes

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 may need preapproval.**

Hip and knee replacement program

Wellpoint has a program that coordinates all the medical services — pre- and post-surgery — that need to be involved in a hip or knee replacement. Some member costs, like copays and coinsurance, might be reduced or even waived if you participate in the program. To learn more, call Wellpoint Member Services at **833-663-4176**.

⊗ **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
⚠ Inpatient surgery — facility charges	$275 quarterly copay and deductible	Yes
⚠ Inpatient or outpatient surgery — surgeon fees	Deductible	Yes

Service	Member costs	Preapproval needed
⚠ Outpatient surgery — at a hospital	$250 quarterly copay and deductible	Yes
⚠ Outpatient surgery — at a non-hospital-owned facility	• Eye and GI surgery — $150 quarterly copay and deductible • All other outpatient surgery — $250 quarterly copay and deductible	Yes
⚠ Outpatient surgery — at a doctor's office	Deductible (you may also owe a copay for the office visit)	Yes

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 plan 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 plan 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 one of Wellpoint's Quality Centers or Designated Hospitals 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

⚠ **Transplants need preapproval, except for corneal transplants.**

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)

Quality Centers and Designated Hospitals for transplants

Wellpoint has selected certain hospitals as Quality Centers or Designated Hospitals for organ transplants based on experience, specialized programs, reputation, and quality of care.

☑ Your plan pays 100% for transplants at Quality Centers and Designated Hospitals after your copay and deductible. Transplants at other hospitals are covered at 80% after copay and deductible. Find Quality Centers and Designated Hospitals at wellpointmass.com.

Service	Member costs	Preapproval needed
⚠ **Organ transplants** at Quality Centers or Designated Hospitals for transplants	$275 quarterly copay and deductible	Yes, except for corneal transplants
⚠ **Organ transplants** at other hospitals	$275 quarterly copay, deductible, and 20% coinsurance. Your plan pays 80% of the allowed amount.	Yes, except for corneal transplants

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/urgent care" entry earlier in this section 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	Deductible (limited to one each plan 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.

⚠ **Applied Behavior Analysis needs preapproval.** For help with preapproval, call Wellpoint Member Services at **833-663-4176**.

⊗ **Restrictions**

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

Service	Member costs	Preapproval needed
⚠ ☑ Applied Behavior Analysis	• With Preferred care providers — $20 copay • With Nonpreferred care providers — deductible and 20% coinsurance	Yes

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.

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 **833-663-4176** 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.

☑ After you meet your deductible, your plan pays 100% of the allowed amount for care and items you get from Preferred providers. Items from Nonpreferred providers are covered at 80%, even when they are out of stock from Preferred providers. Find Preferred providers at wellpointmass.com.

⚠ **Inpatient behavioral health services may need preapproval.** For help with preapproval, call Wellpoint Member Services at **833-663-4176**.

⊗ 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
⚠☑ Inpatient care facility charges	• With Preferred providers — $275 quarterly copay and deductible • With Nonpreferred providers — deductible and 20% coinsurance	Yes
⚠☑ Inpatient care professional services	• With Preferred care providers — no member costs • With Nonpreferred care providers — deductible and 20% coinsurance	Yes

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
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

Inpatient services	Description
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

***** 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.

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.

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 (OTP)** 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, or you'll pay 20% coinsurance after you meet your deductible	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.

☑ After you meet your deductible, your plan pays 100% of the allowed amount for care and items you get from Preferred care providers. Care from Nonpreferred care providers is covered at 80%. Find Preferred care providers at wellpointmass.com.

⚠ **Outpatient behavioral health services may need preapproval.** For help with preapproval, call Wellpoint Member Services at **833-663-4176**.

⊗ 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

Service	Member costs	Preapproval needed
⚠☑ Outpatient services	• With Preferred care providers — $20 copay • With Nonpreferred care providers — deductible and 20% coinsurance	Yes, for some services

Table 12. Behavioral health outpatient services covered under this benefit

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
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
Family support and training	Peer support to help caregivers access services and navigate care for a child with serious emotional disturbance
In-home behavioral services	Specialized behavior management therapy and monitoring provided at home for youth
Intensive care coordination	The coordination of services when multiple services and systems are involved
Intensive outpatient programs (IOPs) • 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

Outpatient service	Description
Medication management	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. 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.
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) • 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
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
Therapeutic mentoring services	One-on-one support, coaching, and skill-building for youth to address daily living, social, and communication needs
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	Yes

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.

☑ After your $20 copay, your plan pays 100% of the allowed amount for care and items you get from Preferred care providers. Care from Nonpreferred providers is covered at 80%. Find Preferred care providers at wellpointmass.com.

⊗ **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.

Service	Member costs	Preapproval needed
Therapy	• With Preferred care providers — $20 copay • With Nonpreferred care providers — 20% coinsurance after you meet your deductible	No

Virtual care (telehealth)

The plan covers counseling and medication management services that take place by telephone, mobile device, or computer using audio and video.

Service	Member costs	Preapproval needed
Virtual care or telehealth	• With Preferred care providers — $20 copay (you don't owe a copay for the first three visits) • With Nonpreferred care providers — 20% coinsurance after you meet your deductible	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 healthcare 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	Every 2 years for women 40 and older
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 (⚠ preapproval needed for virtual colonoscopies)	Yes	Yes	As recommended by care provider
CT lung cancer scan for adults who have smoked	Yes	Yes	As recommended by care provider
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

Preventive service	Males	Females	Recommendations
Fluoride supplements	Yes	Yes	Starting at the age of primary tooth eruption, up to age 5
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: • 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	• 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	As recommended by care provider
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

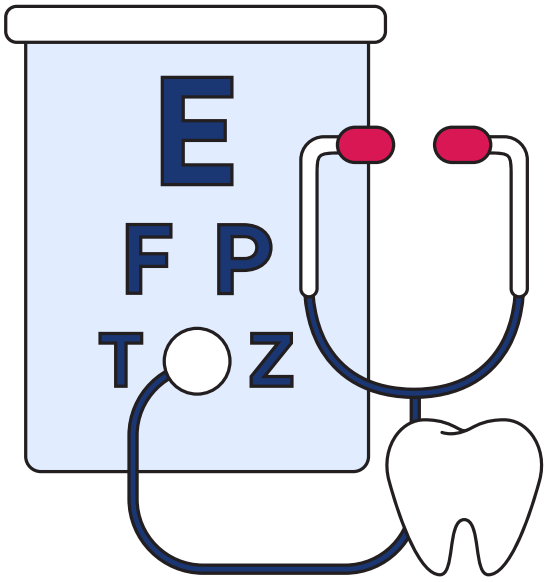
Questions about immunizations?

The Centers for Disease Control and Prevention lists which vaccines a person should have based on their age at cdc.gov/vaccines/imz-schedules.

- 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 833-663-4176.

Wellpoint

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	• 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 covered when there's no other safe way to move you. • 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 nonhospital beds, orthopedic mattresses, or weighted blankets.
Behavioral health services	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. 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). Other noncovered behavioral health services include: • 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.
Convenience items	No coverage for convenience items used during a hospital stay, such as telephones, television, computers, and beauty or barber services.
Cosmetic services	No coverage for cosmetic procedures or services except for: • Treatment for HIV-associated lipodystrophy • The initial surgical procedure to correct appearance that has been damaged by an accidental injury Cosmetic services are not covered even if they are intended to improve 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.
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 and need preapproval.
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)	Only medically necessary equipment is covered. 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
E	
Ear molds	Not covered except when needed for hearing aids for members age 21 and under.
Enteral and oral therapy	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. Baby formula is not covered by your medical plan. Call CVS Caremark at **877-876-7214** to find out if it's covered by your prescription drug plan.
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	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: • 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	• 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	No coverage for any treatment that is not medically necessary. The only exceptions to this requirement are: • 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)	No coverage for nutritional supplements administered by mouth, including: • 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, corrective shoes, heating pads, hot water bottles, incontinence supplies, lift or riser chairs, nonhospital 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, Rolfing 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	No coverage for nonacute residential treatment. Examples of such treatment include: • Clinically managed low-intensity residential services • Clinically managed population-specific, high-intensity residential services • Recovery residences • Sober homes

Service	What is not covered or has limited coverage
Respite care	Limited to a total of five days each plan 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	No coverage for shoes, including special shoes to fit orthotics or to wear after foot surgery, except for: • 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 deductible or your out-of-pocket maximum. Member costs like the deductible and your out-of-pocket maximum only apply to covered services.

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: • Treat severe illnesses, diseases, and trauma • Provide surgery recovery with 24-hour intensive medical and nursing care
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.

Why this matters

A facility owned by a hospital often bills as the hospital, even if the facility is located somewhere else. This means your claim will be processed as a hospital service, which can result in higher costs you may not expect.

Example:

Service	Independent ambulatory surgery center	Facility owned by and bills as a hospital
Eye or gastrointestinal (GI) surgery	$150	$250

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.

Preferred suppliers

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 (and your deductible, if it applies).

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.

Preferred care providers

Preferred care providers are care provders — 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 plan year.

How to find care providers

You can find care providers at 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.

How do I submit a prescription drug claim?

Prescription drug claims must be submitted to CVS Caremark, 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.

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 CVS Caremark, 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 the 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.

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

Dependent	Enrollment window	Additional documentation
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?

Active state and municipal employees: Contact your GIC coordinator at mass.gov/service-details/find-your-gic-benefit-coordinator.

Retirees: 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. This means you'll enroll before July 1 during GIC's annual enrollment period.

For spouses and dependents

Coverage begins for your spouse and/or dependents once the GIC determines they're eligible and after your own coverage has started.

For 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?

Active state and municipal employees: Contact your GIC coordinator at mass.gov/service-details/find-your-gic-benefit-coordinator.

Retirees: 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.

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.

Details about COBRA continuation coveargе and other health coverage alternatives can be found in Appendix D.

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 trusteed 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

If Wellpoint is your primary plan, it pays benefits as if no other plans exist. A secondary plan may reduce its benefits if payments are made by Wellpoint.

If another plan is primary and Wellpoint is secondary, Wellpoint calculates its benefit payments by:

1. Determining your covered expenses. They don't consider the primary plan's benefits when first determining your covered expenses.
2. Subtracting those covered expenses from the primary plan's benefits — benefits that were paid by the other plan or the reasonable cash value of benefits — and paying the difference.

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.

Special provisions for those 65 or older and eligible for Medicare

Active employees and their dependents age 65 or older who have medical coverage under Wellpoint may continue that coverage, even if they're able to enroll or are enrolled in Medicare.

Medical coverage primary to Medicare for the disabled

Employees or dependents under age 65 who are covered under Wellpoint and entitled to Medicare disability, for reasons other than end-stage renal disease (ESRD), may continue their coverage under Wellpoint, even if they're able to enroll or are enrolled in Medicare.

Health coverage primary to Medicare for those with end-stage renal disease

For those with ESRD and coverage under Wellpoint, Wellpoint will be primary to Medicare during the Medicare ESRD waiting and coordination periods.

Kidney disease that can't be reversed, is permanent, and requires a regular course of dialysis or a transplant to maintain life is considered ESRD.

- The **Medicare ESRD waiting period** is generally the first three months after starting dialysis. This means you're not entitled to Medicare until after the three-month waiting period. This waiting period can be waived or shortened if you participate in a self-dialysis training program or are scheduled for an early kidney transplant.

- The **Medicare ESRD coordination period** is 30 months long and occurs after the ESRD waiting period. The coordination period begins on the date that Medicare became effective or would have become effective on the basis of ESRD.

During the 30-month period, Wellpoint is the primary payer and Medicare is the secondary payer for COB. After 30 months, Medicare becomes the primary payer and Wellpoint becomes the secondary payer. At that point, you must change health plans. Contact the GIC through the GIC member portal at mygiclink.my.site.com or by mail:

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.

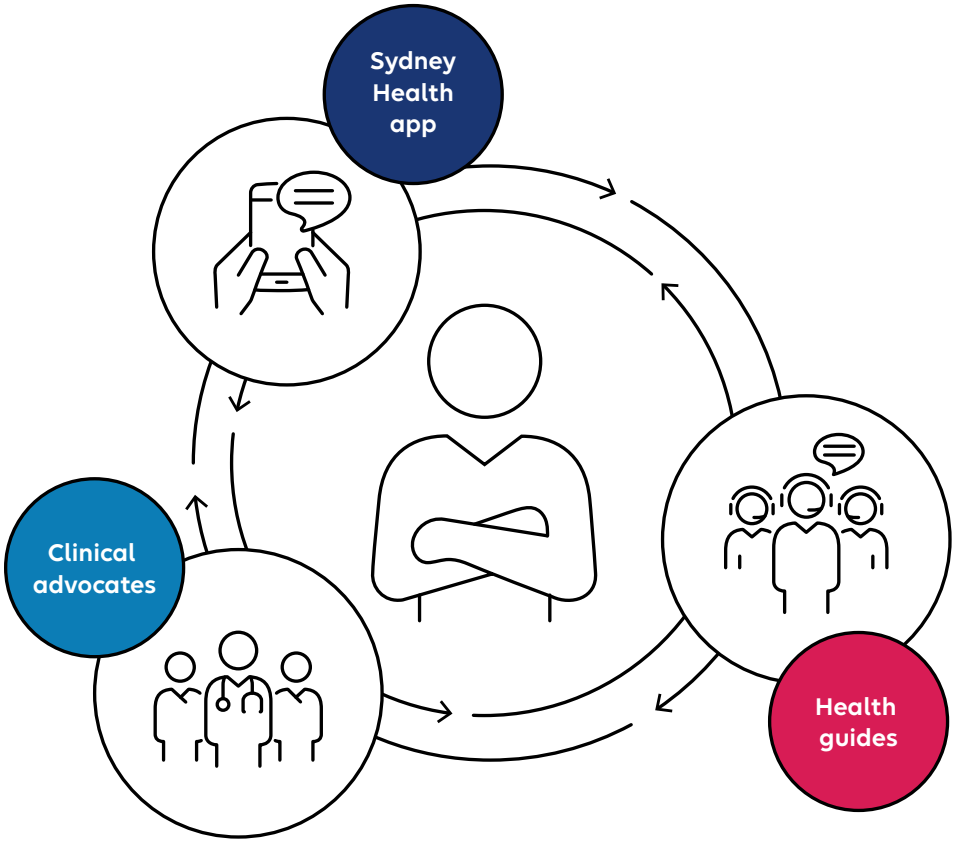
Chapter 10: Other plan resources

The Whole Health, Whole You program

Wellpoint's Whole Health, Whole You program gives you access to supportive healthcare professionals and digital resources that give you more personal service and a better healthcare experience.

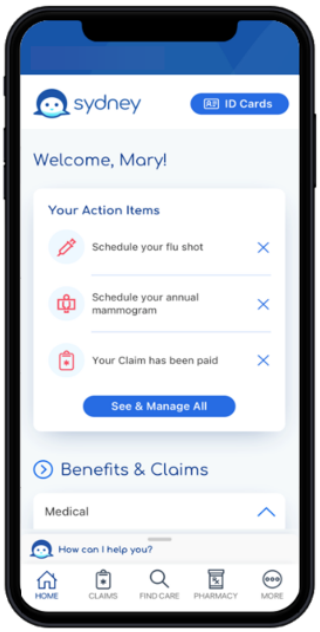
The program is made up of:

- **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.
- **Health guides**, who provide you with one-on-one support and answer your healthcare questions.
- **Clinical advocates, including nurse case managers**, who work one-on-one with you and your family to help you work on personal health goals and manage complex or chronic health conditions.



These three resources work together to provide you personal, thorough support for anything related to your plan and care.

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.

Wellpoint Health Guides

Wellpoint Health Guides can answer questions and help you:

- Learn more about your Wellpoint health coverage, benefits, and claims
- Find out if a service is covered and compare costs
- Keep up with follow-up appointments or preventive care, like an annual physical
- Find care providers and schedule appointments
- Connect with benefits and programs that fit your needs, like cancer and behavioral health support

How to reach a health guide

Call **833-663-4176**/TTY: **711** (toll-free), Monday through Thursday, 7:30 a.m. to 6 p.m., and Fridays until 5 p.m.

Use the Live Chat feature of the Sydney Health app. Go to sydneyhealth.com to download the app.

Send a message from the Wellpoint member portal at mass.gov/mygiclink-member-benefits-portal anytime.

Wellpoint Clinical Advocates

Wellpoint's team of clinical advocates, made up of healthcare professionals like registered nurses, doctors, counselors, and health coaches, work together to help you and your family meet health goals and manage various health matters and chronic conditions.

Nurse case managers

When you first connect with your case manager, they will find out what type of care and support you need. They'll connect you with other specialized care providers on the team if you need more support.

A nurse case manager can help you:

- Get answers and care for health matters that affect you and your family
- Understand how to best use your benefits
- Get advice from other care providers on the clinical advocates team, such as health coaches, dietitians, and pharmacists
- Find out how to access other medical and wellness services
- Set and reach health goals, like losing weight or quitting smoking
- Arrange care if you need surgery or a medical procedure

Your nurse case manager will always be the main contact for you and your family when you would like help with a health matter.

Sometimes a nurse case manager may reach out to you before you contact them if they think there may be a healthcare matter they could help you with.

While you're not required to participate, working with clinical advocates can be very helpful in improving your health. This service is also included as part of your benefits at no added cost.

Help with complex health issues

More serious or challenging health matters usually require many types of expertise. This is true whether you have an ongoing condition like diabetes or an urgent situation like a stroke or cancer.

That's why Wellpoint's clinical advocates team includes healthcare professionals with expertise in a variety of areas who work together to support and assist you every step of the way.

They can help you:

- Understand your diagnosis and treatment options
- Coordinate services when many care providers are involved
- Coordinate services before, during, and after a hospital stay
- Guide family discussions about healthcare planning
- Work with your doctors to support your present and future healthcare needs
- Work with behavioral health providers to coordinate care and benefits if you need both medical and behavioral health services
- Find out about education, wellness, self-help, and prevention programs to help manage chronic conditions
- Set up a care plan to help ease the shift from hospital to home
- Explore other funding and resources if you have ongoing needs but plan benefits are limited

Behavioral health support services

Behavioral Health Case Management

Behavioral Health Case Management, made up of experienced and licensed nurses, social workers, and mental health experts, is a program to help you or a family member with your mental health or substance use needs. The goal of the program is to help you be your best and get the most out of treatment. The program is included as part of your health plan at no extra cost, and you don't have to join if you choose not to.

Case managers:

- Help organize care among your doctors, nurses, and social workers
- Give you information on community, mental health, and substance use programs and which ones may work best for you
- Help you create a plan for taking your medications and follow instructions from your doctor, nurse, or social worker
- Keep your primary care doctor and psychiatrist updated on your progress, with your permission

Case managers can help if you:

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

To find out more about Behavioral Health Case Management, call Wellpoint Member Services at **833-663-4176** and ask to speak with a nurse care manager.

Recovery coaching

Recovery coaching is a support service that helps people with mental health or substance use challenges work toward better health. Recovery coaches partner with you to set goals, stay motivated, and overcome barriers.

Recovery coaches are not licensed clinicians, though they are specifically trained to work alongside your treatment team to support your progress.

How recovery coaching helps

A recovery coach can help you:

- Set and work toward personal recovery goals
- Build coping and relapse prevention skills
- Stay engaged with treatment and appointments
- Connect to community resources for housing, employment, or peer support
- Navigate the healthcare system

How to access recovery coaching

You may be able to access recovery coaching through:

- A referral from your provider
- Self-referral
- Your care manager (if assigned)
- Member Services

To find out more, call Wellpoint Member Services at **833-663-4176**.

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.

About the wellpointmass.com website

You can find additional information and resources at 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.

Comparing costs at different Massachusetts facilities

Different medical facilities can charge different prices for the exact same test or procedure. Wellpoint's transparency tool lets you compare your costs for common procedures at Massachusetts hospitals and other facilities.

Access the cost comparison tool through Find Care at wellpointmass.com. If you haven't already registered for your Wellpoint account, check the section above for instructions on how to do so.

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 **833-663-4176**.
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 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 healthcare 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 plan 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 non-hospital 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.
- **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 "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 CVS Caremark at 877-876-7214.

Administered by

CVS caremark®

Chapter 12: Prescription benefits

GIC's pharmacy benefit and your pharmacy plan

GIC's prescription drug benefits are administered through CVS Caremark.

CVS Caremark is the pharmacy benefit manager for your prescription drug benefit plan. The CVS Caremark pharmacy network includes major chain pharmacies nationwide, many independent pharmacies, a mail order pharmacy and a specialty drug pharmacy.

If you have any questions about your prescription drug benefits, contact CVS Caremark Member Services toll free at **877-876-7214** (option 2). Additional resources — including your plan summary, drug cost lookup, and pharmacy locator — are available at info.caremark.com/oe/gic. Register or sign in to your account on caremark.com or the CVS Caremark mobile app to manage your prescriptions.

About your plan

Prescription medications are covered by the plan only if they have been approved by the U.S. Food and Drug Administration (FDA). In addition, except for the over-the-counter versions of preventive drugs, medications are covered only if a prescription is needed for their dispensing. Diabetes supplies and insulin are also covered by the plan.

Copayments and deductible

One of the ways your plan maintains coverage of quality, cost-effective medications is a multi-tier copayment pharmacy benefit: Tier 1 (mostly generic drugs), Tier 2 (preferred drugs), Tier 3 (non-preferred drugs), or drugs that require no copayments. The following shows your deductible and copayment based on the type of prescription you fill and where you get it filled.

Table 19. Deductible for prescription drugs

The prescription drug deductible applies to each plan year (July 1 – June 30).

Deductible type	Deductible amount
Individual	$100
Family	$200

No more than $100 per person will be applied to the family deductible. Multiple family members can satisfy the family deductible.

Table 20. 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
Other • Orally administered anti-cancer drugs • ACA Preventive drugs*	$0 member cost (deductible does not apply)	$0 member cost (deductible does not apply)

*Refer to the "Preventive Drugs" section below for detailed information, or visit info.caremark.com/oe/gic for more information.

Table 21. Copays for specialty drugs

Drug type	Specialty drugs must be filled only through CVS Specialty, a specialty pharmacy. Please call CVS Specialty toll free at 800-237-2767.
Specialty drugs	$0 copay after Prudent Rx enrollment. Specialty medications may be dispensed up to a 30-day supply, some exceptions may apply.
Orally administered anti-cancer specialty drugs	$0 per 30-day supply

Important! Effective July 1, 2026, you are automatically enrolled in PrudentRx. **If you decide to opt out, you will be responsible for the full 30% coinsurance.** All eligible members must call PrudentRx at 1-800-578-4403 to register for any manufacturer copay assistance program available for your specialty medication as some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications. **If you do not call PrudentRx, PrudentRx will make outreach to you.** The deductible applies regardless of enrollment in PrudentRx. See CVS Specialty section for more information on Prudent Rx. Medications excluded from the Prudent Rx Program will take on standard plan copays based on tier as listed above.

Table 22. 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

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

Payments for a brand drug when there is an exact generic equivalent and for drugs not covered by the plan do not count toward the out-of-pocket limit.

Table 23. Out-of-pocket limits

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

No more than $5,000 per person will be applied to the family out-of-pocket limit. Multiple family members can satisfy the family out-of-pocket-limit.

How to use the plan

After you first enroll in the plan, CVS Caremark will send you a welcome packet and CVS Caremark Prescription Card(s). Your Prescription Card(s) will be mailed to you with ID cards for you and your dependents (if any).

Show your new Prescription Card to your pharmacy so they can correctly process your prescription drug benefits.

You may register at caremark.com beginning on your effective date. As a registered user, you can check drug costs, order mail order refills, and review your prescription drug history. You can access this site 24 hours a day. You may also check this information via the CVS Caremark mobile app.

Filling your prescription

You may fill your prescriptions for non-specialty drugs at any participating retail pharmacy, or through mail order from CVS Caremark.

Prescriptions for specialty drugs must be filled as described in the CVS Specialty subsection.

To obtain benefits at a retail pharmacy, you must fill your prescription at a participating pharmacy using your CVS Caremark Prescription Card, except for the limited circumstances detailed in the "Claim Forms" subsection.

Insurers must implement a continuation of care policy for new members, providing a 30-day fill of existing prescriptions.

Filling your prescriptions at a participating retail pharmacy

The retail pharmacy is your most convenient option when you are filling a prescription for a short-term prescription that you need immediately (for example, antibiotics for strep throat or painkillers for an injury). Simply present your CVS Caremark Prescription Card to your pharmacist, along with your written prescription (if applicable), and pay the required copayment.

Prescriptions filled at a non-participating retail pharmacy are not covered.

You can find the nearest participating retail pharmacy anytime online after registering at caremark.com or by calling toll free at **877-876-7214** (option 2).

If you do not have your Prescription Card, the pharmacist can also verify eligibility by contacting the CVS Caremark Pharmacy Help Desk at **800-365-6331**. Members can also access their pharmacy ID card information via the CVS Caremark mobile app.

Maintenance medications — up to 30 days

After you fill two 30-day supplies of a maintenance medication at a retail pharmacy, you will receive a letter from CVS Caremark explaining how you may convert your prescription to a 90-day supply to be filled either through mail order or at a CVS Pharmacy.

You will receive coverage for additional fills of that medication only if you convert your prescription to a 90-day supply to be filled either through mail order or at a CVS Pharmacy.

CVS Caremark will assist you in transitioning your maintenance prescription to either mail order or a CVS Pharmacy location.

Maintenance medications — up to 90 days

Filling 90-day Prescriptions through mail order or at a CVS Pharmacy.

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

You have the choice and convenience of filling maintenance prescriptions for up to a 90-day supply at the mail order copayment or at a CVS Pharmacy. This means fewer refills and fewer visits to your pharmacy, as well as lower copayments.

The CVS Mail Service Pharmacy is a convenient option for prescription drugs that you take on a regular basis for 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.

Using the CVS Caremark Mail Order Pharmacy:

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/MailService and we will contact your doctor for you. Or you can ask your doctor to send a new prescription to CVS Caremark Mail Service Pharmacy.

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

CVS Specialty

CVS Specialty is a full-service specialty pharmacy that provides personalized care to each patient and serves a wide range of patient populations, including those with hemophilia, hepatitis, cancer, multiple sclerosis and rheumatoid arthritis.

You must fill your specialty medications with CVS Specialty. This means that your prescriptions can be sent to your home, doctor's office or to a CVS Retail Pharmacy.

Specialty medications may be filled only at a maximum of a 30-day supply; some exceptions may apply. Many specialty medications are subject to a clinical review by CVS Caremark to ensure the medications are being prescribed appropriately.

CVS Specialty offers a complete range of services and specialty drugs. Your specialty drugs are quickly delivered to any approved location, at no additional charge. We ship to all fifty states using one of our preferred expedited carriers. We can also ship to a variety of alternate addresses, including physician's offices or to another family member's address. We do not ship to P.O. Boxes.

You have toll-free access to expert clinical staff who are available to answer all your specialty drug questions. CVS Specialty will provide you with ongoing refill reminders before you run out of your medications.

To begin receiving your specialty drugs through CVS Specialty, call toll free at **800-237-2767**. Hours of operation: 7:30am – 9pm EST M-F; 9am – 4pm EST on Saturday; closed on Sunday.

CVS Specialty offers:

- **Patient Counseling** — Convenient access to pharmacists and nurses who are specialty medication experts
- **Patient Education** — Educational materials
- **Convenient Delivery** — Coordinated delivery to your home, your doctor's office, or other approved location
- **Refill Reminders** — Ongoing refill reminders from CVS Caremark.
- **Language Assistance** — Language-interpreting services are provided for non-English speaking patients

PrudentRx Solution for specialty medications

The PrudentRx Solution assists by helping you enroll in manufacturer copay assistance programs. Medications on the PrudentRx Program Drug List are included in the program and will be subject to a 30% co-insurance, after satisfaction of any applicable deductible. However, if a member is participating in the PrudentRx Solution, the member will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Solution, **after satisfaction of any applicable deductible**. Even if there is no copay assistance available.

What is copay assistance?

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications — in particular, specialty medications. The PrudentRx Solution will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible medications, thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with HIPAA.

How can I enroll in PrudentRx?

Effective July 1, 2026, members currently taking Specialty medications will be automatically enrolled in PrudentRx. PrudentRx will also be reaching out by mail and phone to help get you registered ahead of the new plan year.

If you are newly taking an applicable Specialty medication after July 1, 2026, CVS Specialty will help you onboard with PrudentRx so you can utilize the program right away.

Important! **All eligible members must call PrudentRx at 800-578-4403 to register for any manufacturer copay assistance program available for your specialty medication** as some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications. **If you do not call PrudentRx, PrudentRx will make outreach to you.**

If you choose to opt out of the PrudentRx Solution, you must call **800-578-4403**.

Eligible members who fail to enroll in an available manufacturer copay assistance program or who opt out of the PrudentRx Solution will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx Solution.

The PrudentRx Program Drug List may be updated periodically. If you take a specialty medication that **is not on the PrudentRx Program Drug List**, these medications will have the standard plan copays. Copay assistance can still be used but will be separate from the PrudentRx program and may require your input in coordination with the pharmacy.

Payments made on your behalf, including amounts paid by a manufacturer's copay assistance program, for medications covered under the PrudentRx Solution will not count toward your plan deductible or out-of-pocket maximum (if any), unless otherwise required by law. Also, payments made by you for a medication that does not qualify as an "essential health benefit" under the Affordable Care Act (ACA), will not count toward your deductible or ACA out-of-pocket maximum (if any), unless otherwise required by law. A list of specialty medications that are not considered to be "essential health benefits" under the Affordable Care Act is available. An exception process is available for determining whether a medication that is not an "essential health benefit" under the Affordable Care Act is medically necessary for a particular individual.

Claims reimbursement

Retail purchases out of the country, or purchases at a participating retail pharmacy without the use of your CVS Caremark Prescription Card, are covered as follows:

Table 24. Reimbursement eligibility

Type of claim	Claims incurred **within 30 days** of the member's eligibility effective date	Claims incurred **more than 30 days** after the member's eligibility effective date
Purchases at a participating (in-network) pharmacy without a CVS Caremark Prescription Card	Claims will be covered at full cost, less the applicable copayment	Claims will be reimbursed at a discounted cost, less the applicable copayment

Claim Reimbursement forms are available to registered users on caremark.com or by calling **877-876-7214** (option 2). If you are not registered, you can download a copy of the paper claim reimbursement form via the Help Center at caremark.com/pharmacy/benefits/public/help-center by clicking **Reimbursement Claims**.

Other plan provisions

Table 25. ACA preventive drugs

Coverage will be provided for the following drugs:

Drug	Generic, brand name, or over-the-counter (OTC)
Aspirin	Generic OTC 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 versions of contraceptive drugs and devices, and OTC contraceptive products. Brand products are covered at no cost until a generic becomes available. OTC requires prescription for claims processing. Per state statute, some oral contraceptives can be dispensed up to a 3-month supply for the first fill and up to a 12-month supply for subsequent fills with no member cost share.
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.
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.

To begin receiving your specialty drugs through CVS Specialty, call toll free at **800-237-2767**. Hours of operation: 7:30am – 9pm EST M-F; 9am – 4pm EST on Saturday; closed on Sunday.

Table 26. 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
Diabetes	Preferred brand-name insulins capped at $25 for a 30-day supply
Asthma	Generic albuterol sulfate HFA is $0 cost; preferred brands capped at $25 per 30-day supply
High cholesterol	Generic atorvastatin is $0 cost; preferred brands capped at $25 for a 30-day supply
Coronary artery disease	Generic amlodipine besylate and metoprolol succinate are $0 cost; preferred brands capped at $25 for a 30-day supply

Please visit info.caremark.com/oe/gic for the most current Formulary drug list.

Expansion of coverage for substance abuse disorder treatments

Generic and brand drugs used to treat opioid use disorder, such as buprenorphine-naloxone and Naltrexone as well as 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. There are many brand-name drugs, such as Lipitor®, Ambien® and Fosamax®, for which exact generic equivalents are available. If you fill a prescription for a brand-name medication for which there is an exact generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand-name drug and the generic drug, plus the generic copayment. This amount does not count toward the out-of-pocket limit. Exceptions to this provision may apply to certain brand-name preventive drugs. Contact CVS Caremark for more information.

Prescription drugs with over-the-counter (OTC) equivalents

Some prescription drugs have over-the-counter (OTC) equivalent products available. These OTC products have strengths, active chemical ingredients, routes of administration and dosage forms identical to the prescription drug products.

Your plan does not provide benefits for prescription drugs with OTC equivalents. This provision is not applicable to preventive 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 ensures that you are receiving the right drug for the treatment of a specific condition, in quantities approved by the FDA. For select drugs, prior authorization also includes a medical necessity review that ensures the use of less expensive first-line formulary prescription drugs before the plan will pay for more expensive prescription drugs. First-line formulary prescription drugs are safe and effective medications used for the treatment of medical conditions or diseases.

If a drug that you take requires prior authorization, your physician will need to contact CVS Caremark to see if the prescription meets the plan's conditions for coverage. If you are prescribed a drug that requires prior authorization, your physician should call CVS Caremark at **800-294-5979**.

Table 27. Current examples of drugs requiring prior authorization for specific conditions

Drug class	Products requiring prior authorization
Topical acne products	Aklief®, Arazlo®, Tazorac® (tazarotene) 0.05% and 0.1% cream, gel; Fabior 0.1% foam, (Retin-A®, Retin-A Micro®; Avita®; Atralin™ gel: other generic topical tretinoin products) and Clindamycin Phosphate 1.2% and Tretinoin 0.025% gel (Ziana®; Veltin™), Winlevi®
Testosterone — topical	Androderm [testosterone patch], AndroGel [testosterone gel], Fortesta [testosterone gel], Natesto [testosterone nasal gel], testosterone solution, Testim [testosterone gel], Vogelxo [testosterone gel]
Testosterone — injectable	Aveed®, Depo-Testosterone® [testosterone cypionate injection, generics], testosterone enanthate injection, Xyosted® [testosterone enanthate injection, generics], Testopel® [testosterone pellet]
Compounded — select medications	A compounded medication is one that is made by combining, mixing or altering ingredients, in response to a prescription, to create a customized medication that is not otherwise commercially available.
Diabetes GLP-1 agonists	Adlyxin®, Byetta®, Bydureon® BCise, Mounjaro®, Ozempic®, Rybelsus®, Trulicity®, Victoza® (liraglutide)

Drug class	Products requiring prior authorization
Nutritional supplements	Nonprescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.
Pain	Fentanyl transmucosal drugs (Actiq®, Fentora®, Subsys®), Lidoderm®, ZTlido, opioid analgesics
Weight management	Adipex (phentermine), Benzphetamine, naltrexone-bupropion; Diethylpropion Phendimetrazine, Lomaira (phentermine), generic phentermine, Orlistat, Qsymia®
Weight Management GLP-1	Wegovy®, Saxenda®, Zepbound® (covered with FDA approved supplemental indication only)
Dry eyes	Cequa®, Restasis®, Vevye®, Xiidra®

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

Current example of top drug classes that may require prior authorization for medical necessity

- 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 for medical necessity** to ensure formulary alternative(s) within the class have been tried. If you are a registered user on caremark.com, refer to the Performance Drug List (Standard Control with Advanced Control Specialty Formulary) or call CVS Caremark toll free at **877-876-7214** (option 2) for more information.

Quantity dispensing limits

To promote member safety and 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 quantity of the drug that you may receive at one time.

Quantity per dispensing limits is based on the following:

- 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:

Examples of drugs with quantity limits currently include: insomnia agents (e.g., zolpidem), pain medications, asthma/COPD inhalers, anxiety medications (e.g., alprazolam, lorazepam, clonazepam, diazepam), antiviral medications, erectile dysfunction medications (e.g., tadalafil, sildenafil) continuous glucose monitor sensors, steroid/antihistamine nasal sprays, diabetic test strips, antinausea medications (e.g., ondansetron), migraine medications (e.g., sumatriptan), brand and generic topical products, including topical corticosteroids (e.g., desonide, hydrocortisone, triamcinolone, mometasone), topical antifungals, topical acne products (e.g., clindamycin, erythromycin), rosacea agents (e.g., metronidazole) and lidocaine products.

Drug utilization review program

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

- Adverse drug-to-drug interaction with another drug purchased through the plan
- Duplicate prescriptions
- Inappropriate dosage and quantity; or
- Too-early refill of a prescription

If any of the above conditions exist, medical necessity must be determined before the prescription drug can be filled.

Exclusions

Benefits exclude:

- Dental preparations (e.g., 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 the age of eighteen
- Injectable allergens
- Cosmetic drugs — including hair loss drugs, anti-wrinkle creams, hair removal creams and others
- 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, or a drug that must be infused into a space other than the blood, by or under the direction of health care professionals and recommended to be administered under sedation or supervision
- Drugs not suitable for coverage under a pharmacy/outpatient prescription drug benefit, as determined by Caremark
- Select medicaldDevices and artificial saliva products
- Prescription digital therapeutics, 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 non-medical substances
- Scar products
- Miscellaneous topical analgesics (containing ingredients in strengths typically used in OTC analgesics) and convenience kits (containing two or more products to be used separately)
- Prescription multivitamins (other than pediatric and prenatal multivitamins)

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

Definitions

Table 28. Glossary of terms for your prescription drug plan

A

Acute drugs: Drugs prescribed for a short-term illness or condition, expected to clear up in a short amount of time. They are usually not taken for more than thirty days, and additional refills are typically not included.

B

- **Biosimilars**: Biosimilars are FDA-approved biologic medications made to be highly similar to original biologics. They go through rigorous evaluation to ensure they have no clinically meaningful differences from the original biologics, and they are as safe and effective. Biosimilars provide the same treatment benefits and have the same risks. Both biologics and biosimilars are approved by the FDA and are currently available to treat conditions like Crohn's disease, ulcerative colitis, rheumatoid arthritis, ankylosing spondylitis, multiple sclerosis, certain cancers, diabetes and more. FDA-approved Biosimilars are now available for Humira (examples include Hyrimoz and adalimumab-adaz), which are highly similar and have no clinically meaningful differences than the original biologic (Humira). Additional information on Biosimilars is available within the Patient Biosimilars Resource Center on CVSSpecialty.com.
- **Brand-name drug:** The brand name is the trade name under which the product is advertised and sold, and during a period of patent protection, it can only be produced by one manufacturer. Once a patent expires, other companies may manufacture a generic equivalent, providing they follow stringent FDA regulations for safety.

C

- **Compounded medication:** A compounded medication is one that is made by combining, mixing or altering ingredients, in response to a prescription, to create a customized medication that is not otherwise commercially available. At least one of the ingredients must be a medication that can only be dispensed with a written prescription.
- **Controlled drug:** Prescription medications that are designated as a Controlled Drug under the Controlled Substances Act (CSA). These include prescription drugs associated with potential for dependency or abuse.
- **Copay:** A copayment is the amount that members pay for covered prescriptions. If the plan's contracted cost for a medication is less than the applicable copayment, the member pays only the lesser amount..

D

- **Deductible:** A deductible is the dollar amount you must pay during a plan year before the copayments for covered prescriptions apply.

- **Diabetes supplies:** Diabetic supplies include needles, syringes, test strips, lancets and blood glucose monitors.

F

- **FDA:** The U.S. Food and Drug Administration, which approves medications for safety and effectiveness.
- **Formulary:** A formulary is a list of recommended prescription medications that is created, reviewed and continually updated by a team of physicians and pharmacists. The CVS Caremark Performance Drug List (Standard Control with Advanced Control Specialty Formulary) contains a wide range of generic and preferred brand-name products that have been approved by the FDA. The formulary applies to medications that are dispensed in either the retail pharmacy or mail-order settings. The formulary is developed and maintained by CVS Caremark. Formulary designations may change as new clinical information becomes available.

G

Generic drugs: Generic versions of brand medications contain the same active ingredients as their brand counterparts, thus offering the same clinical value. The FDA requires generic drugs to be just as strong, pure and stable as brand-name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements assure that generic drugs are as safe and effective as brand-name drugs.

M

Maintenance drug: A maintenance drug is a medication taken on a regular basis for conditions such as asthma, diabetes, high blood pressure or high cholesterol. They are often filled in 90-day supplies.

N

Nonpreferred drug: A non-preferred drug is a medication that usually has an alternative, therapeutically equivalent drug available on the formulary.

O

- **Out-of-pocket limit:** The out-of-pocket limit is the most you could pay in copayments during the year for prescription drugs that are covered by CVS Caremark. Once you reach this limit, you will have no more copayments for covered drugs. Payments for a brand drug when there is an exact generic equivalent and for drugs not covered by the plan do not count toward the out-of-pocket limit.
- **Over-the-counter (OTC) drugs:** Over-the-counter drugs are medications that do not require a prescription. Your plan does not provide benefits for OTC drugs, except for preventive drugs (all of which are covered only if dispensed with a written prescription)..

P

- **Participating pharmacy:** A participating pharmacy is a pharmacy in the CVS Caremark Nationwide network. All major pharmacy chains and most independently owned pharmacies participate.
- **Preferred drug:** A preferred brand-name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a group of physicians and pharmacists and has been selected by CVS Caremark for formulary inclusion based on its proven clinical and cost effectiveness.
- **Prescription drug:** A prescription drug means any and all drugs that, under federal law, are required, prior to being dispensed or delivered, to be labeled with the statement "Caution: Federal Law prohibits dispensing without prescription," or a drug that is required by any applicable federal or state law or regulation to be dispensed pursuant only to a prescription drug order.
- **Preventive drugs:** Preventive drugs consist primarily of drugs recommended for coverage by the U.S. Preventive Services Task Force, and as specified by the federal Patient Protection and Affordable Care Act (ACA).
- **Prior authorization:** Prior authorization means determination that a drug is appropriate for treatment of a specific condition. It may also mean determination of medical necessity. It is required before prescriptions for certain drugs will be paid for by the plan.

S

- **Special medical formulas or food products:** Special medical formulas or food products means nonprescription enteral formulas for home use for which a physician has issued a written order, and that are medically necessary for the treatment of malabsorption caused by 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 non-specialty prior authorization number at **866-814-5506**.

- **Specialty drugs:** Specialty drugs are usually injectable and non-injectable biotech or biological drugs used to treat rare and/or complex conditions with one or more of several key characteristics, including:
  - Potential for frequent dosing adjustments and intensive clinical monitoring
  - Need for intensive patient training and compliance for effective treatment
  - Limited or exclusive product distribution
  - 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 CVS Caremark® standard protocols based on federal laws and regulations. Time frames and processes may vary based on client requirements or state regulations.

CVS Caremark may be delegated to perform prior authorizations (PA), exceptions or appeals on behalf of our clients. CVS Caremark and the client will enter a mutually agreed-upon written contract, which defines the requirements for processing PAs, exceptions and/or appeals on the client's behalf. The client provides CVS Caremark with a copy of its Summary Plan Description, including the Prescription Benefit section that describes the prescription benefits to plan members. Employees of CVS Caremark may not participate in a PA, exceptions or appeals review if there is a personal, professional or financial conflict of interest with the claimant.

CVS Caremark may, depending on the client's plan, conduct two types of reviews: Clinical and Non-Clinical Reviews.

- An **initial clinical review** is an initial review of a request for a drug covered by the terms of the Plan when clinically appropriate, including but not limited to PA, step therapy, formulary exceptions and quantity limit exceptions. CVS Caremark will conduct an Initial Clinical Review utilizing the rules, guidelines, protocols, or criteria for coverage adopted by or provided by the Plan and as set forth in the Plan Design Document (PDD).
- An **initial non-clinical review** is an initial review of a request for a drug not covered by the terms of the Plan, including the PDD, the preferred drug lists, formulary or other plan benefits selected by the client. An Initial Non-Clinical Review does not involve an assessment of whether the requested drug is medically necessary.

Initial clinical reviews prior authorization program

PA is available as a stand-alone service to clients. It may also be provided in conjunction with quantity limits or step therapy protocols when a member fails to meet the requirements for these programs. Prescription claims are processed at the point of sale by the adjudication system to determine if the claim is subject to a PA. If the claim is subject to a PA, a reject message will display informing the dispensing pharmacy to have the prescribing practitioner contact the CVS Caremark PA Department.

A PA may be initiated by phone call, fax, electronic request or in writing to CVS Caremark by a member's prescribing physician or his/her representative. A member or pharmacist may initiate a PA by calling the PA department, who will reach out to the prescribing physician to obtain the necessary information, or they will be instructed to have the member's physician or designated representative contact CVS Caremark directly. Phone calls received during regular business hours will be routed directly to the CVS Caremark PA team.

If the call is received outside of business hours, the caller will be prompted to call back during regular business hours if it is a non-urgent request. If the request is urgent, the automated system will advise the caller to hold for the answering service. The service will then contact the PA department for the on-call pharmacist to process the request within the allowable time frame.

Once CVS Caremark has received a request, the PA department will check to determine if a new PA is still required and will review the member's PA history for duplicate or pending requests.

The PA request is evaluated using client-approved criteria. A decision will be made solely on the clinical information available at the time of the review.

PAs are processed within the following time frames:

- **Urgent requests** from the member's physician are processed within 72 hours from receipt of the request. However, the CVS Caremark standard is to complete the review within 24 hours from receipt of all necessary information.
- **Non-urgent requests** are processed within 15 days from receipt of the request. However, the CVS Caremark standard is to complete the review within 72 hours from receipt of all necessary information.

If the information provided is incomplete, and if time permits based on state or federal regulations, the PA department will request the additional information from the physician's office. Once the physician's office provides CVS Caremark with the required information, the original PA is reviewed to decide. If the required information is not provided, the PA will be denied.

If the PA is approved, the technician enters the documentation and applicable overrides into the CVS Caremark authorization system. A test claim is processed to ensure the claim will pay when the member fills the prescription at the pharmacy. Approval letters are generated and faxed to the physician and mailed to the member.

If the PA does not meet the criteria requirements as required by the plan or state rules, the appropriate clinical reviewer will deny the PA request. Denial letters are generated and faxed to the physician and mailed to the member. Denial letters include directions on how to appeal the denial.

CVS Caremark PA activity reporting is available, if requested by the client.

Exceptions program

A standard exceptions program is available to support client requests to make exceptions to certain aspects of a client's plan design. Exception requests will only be considered if, and to the extent that, a plan allows exceptions. Exceptions are available for covered and non-covered medications. For the latest list of available exceptions, refer to the Clinical Plan Management (CPM) form.

Examples of **exceptions for covered drugs** include but are not limited to the following:

- Brand penalty: Request to allow a member to waive the dispense as written (DAW) penalty for a brand-name medication
- Contraceptive zero copay (Health Care Reform): Request to allow a member to receive a contraceptive product for a zero-dollar member cost share
- Preventive services zero copay (Health Care Reform): Request to allow a member to receive a preventive service product (excluding contraceptives) for a zero-dollar member cost share

Examples of **exceptions for non-covered drugs** include but are not limited to the following:

- Formulary exceptions: Request to allow a member to have formulary coverage for a drug currently not covered by the CVS Caremark formulary

Exception requests may be initiated by contacting Customer Care or submitting a request in writing to the Exceptions department. If the request is initiated by phone, an exceptions fax form or electronic PA (ePA) request will be sent to the physician's office.

The exception fax form or ePA is completed by the member's physician and returned to the Exceptions department. A letter of medical necessity from the physician is also acceptable for exceptions reviews. The exceptions request is reviewed against the supporting criteria.

If the exception is approved, the technician enters the documentation and applicable overrides into the CVS Caremark authorization system. A test claim is processed to ensure the claim will pay when the member fills the prescription at the pharmacy. Approval letters are generated and faxed to the physician and mailed to the member.

If the exception does not meet the criteria requirements as required by the plan or state rules, the appropriate clinical reviewer will deny the exceptions request. Denial letters are generated and faxed to the physician and mailed to the member. Denial letters include directions on how to appeal the denial.

Exceptions are processed within the following time frames:

- **Urgent requests** from the member's physician are processed within 72 hours from receipt of the request. However, the CVS Caremark standard is to complete the review within 24 hours from receipt of all necessary information.
- **Non-urgent requests** are processed within 15 days from receipt of the request. However, the CVS Caremark standard is to complete the review within 72 hours from receipt of all necessary information.

Initial non-clinical reviews

An initial non-clinical review is a request for coverage of medications or benefits that are not subject to a PA or an exception but are not covered by the Plan. Examples include, but are not limited to, non-covered medications, diabetes supplies and medical devices. A decision is based solely on the terms of the Plan, including the PDD, the preferred drug lists, formulary or other plan benefits selected by the client. An Initial Non-Clinical Review does not involve a clinical review or an assessment of whether the requested drug is medically necessary.

Appeals program

Once a member or member's representative is notified that a claim is wholly or partially denied (an adverse determination), he or she has the right to appeal. Appeals may be based on an adverse benefit determination from an initial clinical review or an adverse non-clinical determination from an initial non-clinical review. Appeal requests must be submitted to the Appeals department by fax, mail or phone within 180 days after receiving an adverse determination notification. Urgent appeals may be submitted by phone or in writing. Non-urgent appeals may be submitted in writing by fax or mail:

Members can call the PA or CVS Caremark Customer Care line **877-876-7214** (option 2) and can be transferred to the appeals team to work on an urgent appeal over the phone. The preferred method for receiving an appeal is via fax.

- Non-specialty PA:
  - Fax: 888-836-0730
  - Phone number: **800-294-5979**
- Specialty PA:
  - Fax: 866-249-6155
  - Phone number: **866-814-5506**
- Non-specialty appeals:
  Prescription Claim Appeals MC 109
  CVS Caremark
  P.O. Box 52084
  Phoenix, AZ 85072
  Fax 866-443-1172
- Specialty Appeals:
  CVS Caremark
  Specialty Appeals Department
  800 Biermann Court
  Mount Prospect, IL 60056
  Fax 855-230-5548

Appeal process

The appeal process can be initiated with a letter of medical necessity via fax or mail written by the doctor stating why the medication should be considered for coverage or additional coverage. The letter of medical necessity should include:

- Patient's date of birth and ID number
- Name of requested drug
- State of why the appeal should be approved or the physician's disagreement with the denial reason
- Reason the medication is medically necessary
- Any office chart, labs, or other clinical notes

The doctor can call to request an urgent appeal and will be transferred to 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 documenting are reviewed and completed, including a notification to the member and physician, within the following timelines:

- Urgent pre-service appeal: 72 hours
- Non-urgent pre-service 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

First-level appeals are reviewed against predetermined medical criteria relevant to the drug or benefit being requested. This includes the consideration of relevant and supporting documentation submitted by the member or the member's authorized representative. Supporting documentation may include a letter written by the practitioner in support of the appeal, a copy of the denial letter sent by CVS Caremark, a copy of the member's payment receipt, medical records, etc. The appeal will be reviewed by an appropriately qualified reviewer. If the denial is upheld by the appeal, a denial notification will be sent to the member with instructions on how to request a second-level Medical Necessity review.

If a member's appeal is urgent, CVS Caremark will perform both the first-level and second-level review as a combined appeal review within the designated time frames. If the first-level request is approved, no further review is needed, and a notice of approval will be sent to the member. If the first-level review cannot be approved, a second-level Medical Necessity review will be initiated

automatically. The member will receive notice of the determination at the conclusion of the Medical Necessity review. The two levels are combined to meet the designated urgent appeal time frame.

Second-level medical necessity appeals

If the first-level appeal denial is upheld, the member or the member's authorized representative may choose to pursue a second-level appeal. The second-level appeal consists of a review to determine if the requested drug or benefit is medically necessary. These requests are reviewed either by an appropriately qualified reviewer or a sub-delegated medical necessity review organization (MNRO). If a member's appeal is urgent, CVS Caremark will perform the second-level review within the designated urgent appeal time frame.

For appeals reviewed by the MNRO, the following will occur:

- CVS Caremark will forward applicable medical records, PA and appeals documentation, plan language and specific criteria to the MNRO.
- The independent physician reviewer selected by the MNRO to conduct the review will evaluate the provided documentation received with the case. If the physician reviewer determines additional information is necessary or potentially useful in the review, the physician reviewer may contact the member's physician to request such information.
- The independent physician reviewer will review current medical literature and available medical records and any additional information obtained from the prescribing physician. The independent physician reviewer will write an independent rationale in support of his or her final decision.
- The letter containing the rationale will be forwarded to CVS Caremark for communication to the member or the member's representative.

Review of adverse non-clinical determinations

CVS Caremark provides a single-level appeal for non-clinical appeals. Upon receipt of a non-clinical appeal, CVS Caremark will review the member's 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 non-clinical appeal will not involve an assessment of whether the requested drug or benefit is medically necessary.

Appeal determination process

Appeals and associated documentation are stamped with the date and time of receipt. Reviews are conducted within the applicable time frames previously mentioned in this document. The appeal determination is rendered, and pertinent information is entered into the database. The determination is then communicated in writing to the member or the member's representative.

Communications are written in a manner to be understood by the member or the member's representative. Communications include:

- The specific reason(s) for the determination
- A reference to pertinent Plan provision on which the determination was based
- A notice that the member can submit a written request for the following at no cost: copies of all documents, records and other information relevant to the claim
- A copy of the specific rule, guideline, protocol or other similar criterion that was relied upon in making the determination, if applicable; or a statement that such rule, guideline, protocol or other similar criterion will be provided free of charge upon written request
- An explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the member's medical circumstances, if the Adverse Benefit Determination or Appeal of Adverse Benefit Determination is based on a Medical Necessity; or a statement that such explanation will be provided free of charge upon written request
- A statement of the member's right to bring action under (Employee Retirement Income Security Act) ERISA Section 502(a), if applicable
- A description of the available internal appeals processes and external review process, if available
- Information regarding the applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist individuals with internal claims and appeals and external review

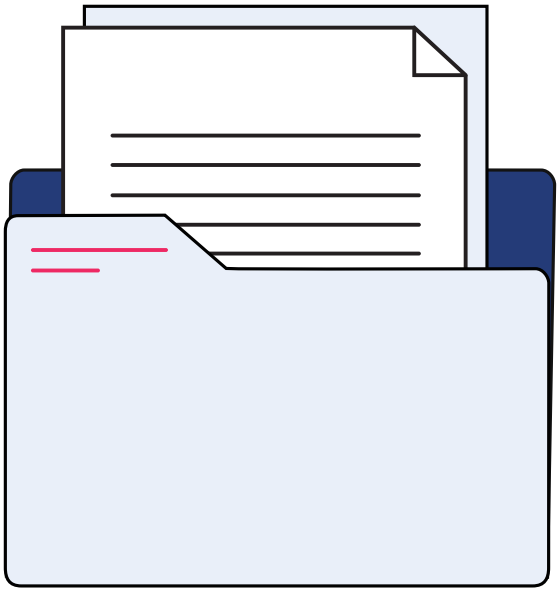
If you have questions or need help submitting an appeal, please call customer care for assistance at **877-876-7214** (option 2).

Confidentiality

All member and client appeal documentation are handled in a confidential manner and in accordance with applicable statutes and regulations to protect the member's identity and his or her prescription history. To maintain confidentiality of member information, all appeal information becomes a part of a permanent case file.

Appendices

Notices and reference information



Wellpoint

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, 2026

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 plans performance.
  - Arrange for legal and auditing services including fraud and abuse protection
- Pay for your health services: We can use and disclose your health information as we pay for your health services, administrative fees for health care and determining eligibility for health benefits.
- Provide you with information on health-related programs or product: 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 health care 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.

Substance Use Disorder Patient Records

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

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

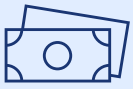
This section explains your rights and some of our responsibilities to help you. You have the right to:

- **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 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 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 Total Choice 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 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.
- 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 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 its 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.

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 1-**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 or call **866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your state for further information on eligibility.

Table 29. 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: 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/child-health-plan-plus
  - 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**
  - Health Insurance Premium Payment Program website: in.gov/fssa/hip
  - Medicaid website: in.gov/medicaid
  - Family and Social Services Administration phone: **800-403-0864**
  - Member Services phone: **800-457-4584**
- **Iowa — Medicaid and CHIP (Hawki)**
  - Medicaid website: hhs.iowa.gov/medicaid
  - Medicaid phone: **800-338-8366**
  - Hawki website: hhs.iowa.gov/medicaid/plans-programs/hawki
  - 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
  - KI-HIPP phone: **855-459-6328** (option 1)
  - Email: kihipp.program@ky.gov
  - KCHIP website: kynect.ky.gov
  - Medicaid services phone: **877-524-4718** (option 2)
  - Kentucky Medicaid website: chfs.ky.gov/agencies/dms
- **Louisiana — Medicaid**
  - Medicaid website: ldh.la.gov/healthy-louisiana
  - Medicaid customer service phone: **888-342-6207**
  - Medicaid email: healthy@la.gov
  - Health Insurance Premium Program (LaHIPP) website: ldh.la.gov/lahipp
    - LaHIPP phone: **877-697-6703**
    - LaHIPP email: La.HIPP@la.gov
    - LaHIPP fax: 888-716-9787
    - LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
- **Maine — Medicaid**
  - Enrollment website: mymaineconnection.gov/benefits/s/?language=en_US
  - Phone: **800-442-6003** TTY: Maine relay **711**
  - Private Health Insurance Premium website: 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: mn.gov/dhs/health-care-coverage
  - Phone: **800-657-3672**
- **Missouri — Medicaid**
  - Website: mydss.mo.gov/mhd/healthcare
  - Phone: **573-751-2005**
- **Montana — Medicaid**
  - Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
  - Phone: **800-694-3084**
  - Email: HHSHIPPProgram@mt.gov
- **Nebraska — Medicaid**
  - Website: dhhs.ne.gov/pages/accessnebraska.aspx
  - 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**
  - HIPP program (toll-free): **800-852-3345**, ext. 5218
  - Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
- **New Jersey — Medicaid and CHIP**
  - Medicaid website: nj.gov/humanservices/dmahs
  - Phone: **800-356-1561**
  - CHIP Premium Assistance phone: **609-631-2392**

  - CHIP website: njfamilycare.org/index.html
  - CHIP phone: **800-701-0710** (TTY: **711**)
- **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: insureoklahoma.org
  - Phone: **888-365-3742**
- **Oregon — Medicaid and CHIP**
  - Website: healthcare.oregon.gov/Pages/index.aspx
  - Phone: **800-699-9075**
- **Pennsylvania — Medicaid and CHIP**
  - Website: pa.gov/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp
  - Phone: **800-692-7462**
  - CHIP website: pa.gov/agencies/dhs/resources/chip
  - 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: **888-828-0059**
- **Texas — Medicaid**
  - Website: hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
  - Phone: **800-440-0493**
- **Utah — Medicaid and CHIP**
  - Utah's Premium Partnership for Health Insurance (UPP) website: medicaid.utah.gov/upp
  - Email: upp@utah.gov
  - Phone: **888-222-2542**
  - Adult Expansion website: medicaid.utah.gov/expansion
  - Utah Medicaid Buyout Program website: medicaid.utah.gov/buyout-program
  - CHIP website: chip.utah.gov
- **Vermont — Medicaid**
  - Website: dvha.vermont.gov/members/medicaid/hipp-program
  - Phone: **800-250-8427**
- **Virginia — Medicaid and CHIP**
  - 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: **800-432-5924**
- **Washington — Medicaid**
  - Website: hca.wa.gov
  - Phone: **800-562-3022**

- **West Virginia — Medicaid and CHIP**
  - 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, 2026, or for more information on special enrollment rights, contact either:

- U.S. Department of Labor Employee Benefits Security Administration: visit dol.gov/agencies/ebsa or call **866-444-EBSA (3272)**.
- U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services: visit cms.hhs.gov or call **877-267-2323**, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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 **833-663-4176** 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). 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.

Appendix C: Your right to appeal

This appendix describes how Wellpoint handles member appeals in accordance with federal regulations.

For purposes of these appeal provisions, "claim for benefits" means a request for benefits under the Plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the plan for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- You will be provided with a written notice of the denial or rescission; and
- You are entitled to a full and fair review of the denial or rescission.

A rescission is a retroactive termination of coverage as a result of fraud or an intentional misrepresentation of material fact. A cancellation or discontinuance of coverage is not a rescission if the cancellation has a prospective effect or if the cancellation is due to a failure to timely pay required premiums or contributions toward the cost of coverage.

The procedure Wellpoint follows satisfies the requirements for a full and fair review under applicable federal regulations.

Notice of adverse benefit determination

If your claim is denied, Wellpoint's notice of the adverse benefit determination (denial) will include the following, when applicable:

- Information sufficient to identify the claim involved;
- The specific reasons for the denial;
- A reference to the plan provisions on which Wellpoint's determination is based;
- A description of any additional material or information needed to reconsider your claim;
- An explanation of why the additional material or information is needed;
- A description of the plan's review procedures and the time limits that apply to them;
- Information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination, and about your right to request a copy of it free of charge;
- Information about your right to a discussion of the claims denial decision;

- Information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, and about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

For claims involving urgent/concurrent care:

- Wellpoint's notice will also include a description of the applicable urgent/concurrent review process; and
- Wellpoint may notify you or your authorized representative within 24 hours orally and then furnish a written notification.

Appeals

You have the right to appeal an adverse benefit determination. You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. Wellpoint's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

Wellpoint shall offer an appeals process and an external review process. In cases involving eligibility for coverage, you may only appeal; there is no external review. The time frame allowed for Wellpoint to complete its review is dependent upon the type of review involved (e.g., pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care

You may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including Wellpoint's decision, can be exchanged by telephone, fax, or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact Wellpoint at the number shown on your Wellpoint ID card and provide at least the following information:

- The identity of the claimant;
- The dates of the medical service;
- The specific medical condition or symptom;
- The provider's name;
- The service or supply for which approval of benefits was sought; and
- Any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals

All other requests for appeals should be submitted in writing by the member or the member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g., urgent care). You or your authorized representative must submit a request for review to:

Wellpoint
P.O. Box 2933
Woburn, MA 01888

Upon request, Wellpoint will provide reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- Was relied on in making the benefit determination; or
- Was submitted, considered, or produced in the course of making the benefit determination; or
- Demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly situated claimants; or
- Is a statement of the plan's policy or guidance about the treatment or benefit relative to your diagnosis.

Wellpoint will also provide you with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination based on a new or additional rationale, Wellpoint will provide you with the rationale.

How your appeal will be decided

When Wellpoint considers your appeal, it will not rely upon the initial benefit determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a healthcare professional who has the appropriate training and experience in the medical field involved in making the judgment. This healthcare professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the outcome of the appeal

If you appeal a claim involving urgent/concurrent care

Wellpoint will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim

Wellpoint will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a post-service claim

Wellpoint will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

Appeal denial

If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from Wellpoint will include all pertinent information set forth in "Notice of adverse benefit determination" earlier in this section.

External review

If the outcome of the appeal is adverse to you, you may be eligible for an independent external review pursuant to federal law.

Unless you are filing an expedited external review, you must first file an appeal with Wellpoint before you can pursue an external review. You must submit your request for external review to Wellpoint within four months of the notice of Wellpoint's adverse determination of your appeal.

A request for an external review must be in writing unless Wellpoint determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for your appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an expedited external review without filing an appeal or while simultaneously pursuing an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including Wellpoint's decision, can be exchanged by telephone, fax, or other similar method.

To proceed with an expedited external review, you or your authorized representative must contact Wellpoint at the number shown on your Wellpoint ID card and provide at least the following information:

- The identity of the claimant;
- The dates of the medical service;
- The specific medical condition or symptom;
- The provider's name;
- The service or supply for which approval of benefits was sought; and
- Any reasons why the appeal should be processed on a more expedited basis.

All other requests for external review should be submitted in writing unless Wellpoint determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Wellpoint
P.O. Box 4077
Woburn, MA 01888

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek external review will not affect your rights to any other benefits under this healthcare plan. The external review decision is final and binding on all parties except for any relief available through applicable state laws.

Requirement to file an appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's appeals process before filing a lawsuit or taking other legal action of any kind against the Plan.

Important! We reserve the right to modify the policies, procedures and time frames in this section upon further clarification from the Department of Health and Human Services and the Department of Labor.

Appendix D: COBRA continuation coverage election notice

Important information — COBRA continuation coverage and other health coverage alternatives

This notice has important information about your right to continue your GIC health care coverage (the Plan), as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace at HealthCare.gov or call **800-318-2596**. **In Massachusetts, please view potential coverage options at MA Health Connector (mahealthconnector.org). You may be able to get coverage through the Health Insurance Marketplace or at the MA Health Connector that cost less than COBRA continuation coverage.** Please read the information in this notice very carefully before you make your decision. If you choose to elect COBRA continuation coverage, you should use the election form provided later in this notice. **You must complete the enclosed Election Form and return it to the GIC by no later than 60 days after the date of this notice. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage.**

Why am I getting this notice?

You're receiving this notice because your coverage under the Plan either has or will end due to one of the following qualifying life events:

1. End of employment
2. Reduction of employment hours
3. Death of employee/retiree
4. Divorce or legal separation
5. Loss of dependent child status

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there is a qualifying event that would result in a loss of coverage under an employer's plan.

What's COBRA continuation coverage?

COBRA continuation coverage allows you to continue having the same coverage Plan that you had prior to the event that made you eligible for COBRA. Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

Who are the qualified beneficiaries and who is eligible for COBRA continuation coverage?

Each eligible person, known as a "qualified beneficiary" has an independent right to elect COBRA continuation coverage.

Qualified beneficiaries may include (1) the employee or former employee; (2) spouse or former spouse; (3) dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage; and (4) child(ren) who lose dependent child status. See below for specific situations of eligibility:

- **If you are an employee of the Commonwealth of Massachusetts and covered by the GIC's health care insurance program**, you are eligible to elect COBRA continuation coverage if:
  - You lost your coverage due to reduced employment hours; or
  - Your employment ends for reasons other than gross misconduct
- **If you are an employee's spouse covered by the GIC's health care insurance program**, you are eligible to elect COBRA continuation coverage if you lose coverage because:
  - Your spouse dies; or
  - Your spouse's employment with the Commonwealth of Massachusetts ends for reasons other than gross misconduct **or** coverage is lost due to reduced employment hours; or
  - You and your spouse divorce or legally separate.
- **If you are a dependent child(ren) of an employee covered by the GIC's health care insurance**, you are eligible to elect COBRA continuation coverage if you lose coverage because:
  - The employee-parent dies; or
  - The employee-parent's employment with the Commonwealth of Massachusetts ends for reasons other than gross misconduct **or** coverage is lost due to reduced employment hours; or
  - Your parents' divorce or legally separate; or
  - You lose your dependent child status under GIC eligibility rules or other applicable law.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Medicare, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." These options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and make the best decision for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible. Another example might be that moving to a new coverage option may have lower premiums and/or out of pocket costs than COBRA continuation coverage.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

If I elect COBRA continuation coverage, when will my coverage begin and how long will the coverage last?

By law, COBRA continuation coverage must begin on the day immediately after your group health care coverage ends. If your group coverage ends due to employment termination or reduction in employment hours, COBRA continuation coverage may last for up to 18 months. If it ends due to any other qualifying event listed above, you may maintain COBRA continuation coverage for up to 36 months.

Continuation coverage may end early in certain circumstances, like failure to pay premiums, fraud, or the individual becomes covered under another group health plan.

Can I extend the length of COBRA continuation coverage?

If you elect continuation coverage, you may be able to extend the length of continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs. You must notify the GIC of a disability or a second qualifying event within 60 days to preserve any right to extend the period of continuation coverage for which you may be eligible (see the "Your Responsibilities" section, below, for more details on notification timing). If you don't provide notice of a disability or second qualifying event within the 60 days, you will lose your right to extend continuation coverage.

It is your responsibility to know what life events provide for COBRA coverage extensions and when the 60 day notice period begins and ends. If you miss notifying the GIC, you will lose your right to extend continuation coverage.

For more information about extending the length of COBRA continuation coverage visit dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/an-employees-guide-to-health-benefits-under-cobra.pdf.

How much does COBRA continuation coverage cost?

COBRA continuation coverage costs are provided in the Monthly COBRA Rates chart, further below in this notice.

Other coverage options may cost less. If you choose to elect continuation coverage, do not send any payment with the Election Form. Additional information about payment will be provided to you after the election form is received by the Plan. Important information about paying your premium can be found at the end of this notice.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid (healthcare.gov/medicaid-chip/getting-medicaid-chip) or the Children's Health Insurance Program (CHIP) (healthcare.gov/medicaid-chip/childrens-health-insurance-program). You can access the Marketplace for your state at HealthCare.gov. The Massachusetts specific Marketplace is the MA Health Connector (mahealthconnector.org).

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though — if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage once your election period ends.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage or during that other group health plan's open enrollment window.

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the initial enrollment period for Medicare Part A or B, you have an 8-month special enrollment period[1] to sign up, beginning on the earlier of

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

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

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

For more information visit medicare.gov/medicare-and-you.

[1] medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start. These rules are different for people with End Stage Renal Disease (ESRD).

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

- **Premiums:** COBRA coverage costs 102% of total plan premiums (if your COBRA is extended, you may be charge 150% of total plan premiums). Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- **Provider networks:** If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- **Drug formularies:** If you're currently taking medication, a change in your health coverage may affect your costs for medication — and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- **Severance payments:** If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at **866-444-3272** to discuss your options.
- **Service areas:** Some plans limit their benefits to specific service or coverage areas — so if you move to another area of the country, you may not be able to use your benefits. You should examine plan service or coverage areas or other similar limitations.
- **Other cost-sharing:** In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments. Additionally, any payments made toward your previous plan's deductible(s) will not count if you enroll in a new plan instead of COBRA coverage.

How and when do I pay for COBRA continuation coverage?

If you elect COBRA continuation coverage, you must make your first payment within 45 days after the date you elect it. If you do not make this first payment in full withing that 45 window, you will lose all COBRA continuation coverage rights. Do not submit payment with your application. You will be billed for your COBRA payments once you complete and return the application.

Your first payment must cover the cost of COBRA coverage from the time your employer-sponsored plan coverage ends through the time you make the first payment. Services cannot be covered until the GIC receives and processes the first payment. You are responsible for ensuring that the amount of your first payment is enough to cover this entire period. After you make your payment, you will be required to pay for COBRA coverage for every subsequent month of coverage. These periodic

payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment. **You are responsible for paying the coverage even if you do not receive a monthly statement**. Payments should be sent to the GIC's address on the bill, made through the member portal at mygiclink.my.site.com or may be paid through our online payment system mass.gov/info-details/gic-member-payments.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA continuation coverage.**

For more information

This notice doesn't fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description, plan handbook, or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact the GIC at P.O. Box 556, Randolph, MA 02368 or call the Public Information Unit at **617-727-2310**.

For more information about your COBRA rights, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at dol.gov/ebsa or call their toll-free number at **866-444-3272**. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your and your family's rights, keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy of any notices you send to the Plan Administrator.

Your responsibilities

- You must inform the GIC of any address changes to preserve your COBRA rights.
- You must elect COBRA within 60 days from the date you would lose coverage due to the life events described in this notice. If you do not elect COBRA continuation coverage within 60 days, your group health care insurance will end and you will lose all rights to COBRA coverage.
- You must make the first payment for COBRA continuation coverage within 45 days after you elect COBRA. The first payment must be for the full amount of premiums starting the day after your employ-sponsored coverage ends, through when you send in your first payment. Failure to pay the full amount within the 45 days will result in a loss of COBRA coverage rights.

- You must pay the subsequent monthly costs for COBRA continuation coverage in full by the end of the 30-day grace period after the due date on every bill. If you do not make the payment within the 30-day grace period, COBRA continuation coverage will end after the last paid coverage period.
- You must inform the GIC within 60 days of the later of either (1) the date of any of the following or (2) the date on which coverage would be lost because of any of the following events:
  - Insured employee's job terminates or their hours are reduced;
  - Insured employee dies;
  - Insured employee becomes legally separated or divorced;
  - Insured employee or their former spouse remarries;
  - A covered child ceases to be a dependent under GIC eligibility rules;
  - The Social Security Administration determines that the employee or covered family member is disabled; or
  - The Social Security Administration determines that the employee or covered family member is no longer disabled.

Table 30. Monthly insurance rates Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage

Premium rates effective starting July 1, 2026

Name of health Plan	Individual coverage full cost COBRA rate	Family coverage full cost COBRA rate
Harvard Pilgrim Access America	1,537.70	3,432.57
Wellpoint Total Choice	1,859.30	4,136.89
Wellpoint PLUS	1,181.35	2,826.70
Harvard Pilgrim Explorer	1,313.78	3,258.89
Mass General Brigham Health Plan Complete	1,255.97	3,334.70
Harvard Pilgrim Quality	983.50	2,508.56
Wellpoint Community Choice	919.50	2,295.59
Health New England	917.98	2,208.05

GIC COBRA APPLICATION

Name of Applicant: _____

Preferred Email:

Home Address: _____

Preferred Phone: _____Social Security Number: _____

Date of Coverage Termination (if known):_____

(*Check one*): I am the ___Insured ____Insured's Dependent (spouse, child)*

(***If dependent***) Name of Insured: _____

Insured's Social Security Number: _____

Applicant Signature_____Date: _____

all dependents* **must *complete information below in order to process application*

IF YOU ARE A DEPENDENT APPLYING FOR COVERAGE, PLEASE CHECK ALL THAT APPLY:

___I am a former spouse of a state/municipal insured who
- ___ died on_____
- ___ remarried on_____
- ___ left state/municipal service on_____
- ___ I remarried on_____

___ I am a surviving spouse of a deceased state/municipal insured, and remarried on_____

___ I am a dependent of a state/municipal insured and
- ___ my parent (the state/municipal insured) died on_____
- ___ my parent (the state/muni insured) left state/muni service on _____(*if known*)
- ___ my parents legally separated or became divorced on_____
- ___ I am age 19 to 26 and am not a dependent child as defined under federal healthcare reform
- ___ I am age 26 or over and am not a full-time student

___I am a_____spouse or_____dependent of a state/municipal insured and the Social Security Administration determined that I am ___ disabled or_____no longer disabled as of_____

Mail completed form to: GIC, P.O. Box 556, Randolph, MA 02368
DO NOT SEND CASH OR CHECK TO THIS P.O. BOX

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。若您是視障人士，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 ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես զանգահարեք 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 برقم يك سوى لنا عم .جانًام غتكلساعدة بم ىلحصول علا ي فق حلا كلا
بلنَّك طكمبصر؟ بلا فـيعضـ ت هل أنَّ .قويهلا قبطاق ىلوجود عملا لأعضاءا قمخد
.ستنَّدملا ان هذم ال أخرىكأش

Japanese
お客様の言語で無償サポートを受けることができます。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 fòma 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 ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਬਸ ਆਪਣy 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 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.

Wellpoint | Commonwealth of Massachusetts Group Insurance Commission

P.O. Box 4095, Woburn, MA 01888 | 833-663-4176 | wellpointmass.com

Claims are administered by Wellpoint Life and Health Insurance Company.