Wellpoint | Commonwealth of Massachusetts Group Insurance Commission

Series 1

Wellpoint

Total Choice

Member handbook for active employees and non-Medicare retirees

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Effective July 1, 2025

Wellpoint Total Choice Plan Member Handbook

For active employees and non-Medicare retirees

Effective July 1, 2025 – June 30, 2026

Disclosure when Plan Meets Minimum Standards

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

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

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

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

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

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

Interpreting and Translating Services

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

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

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

Whom to Contact

Questions about medical or behavioral health coverage

Wellpoint
P.O. Box 4095
Woburn, MA 01888

- **Member Services:**
  833-663-4176 / TTY: 711 (toll free)
  7:30 a.m. to 6:00 p.m. (M-Th)
  7:30 a.m. to 5:00 p.m. (F)
- **Email:** contact.ma@wellpoint.com
- **Website:** wellpoint.com/mass

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

For questions about:

- Benefits for a medical service or procedure
- Benefits for mental health or substance use disorder services
- Status of a medical or behavioral health claim
- Finding a doctor, hospital, or other health care provider
- These sections of this handbook:
  - Part 1: Getting Started (pages 11-28)
  - Part 2: Your Benefits and Coverage (pages 29-84)
  - Part 3: Using Your Plan (pages 86-138)

Questions about prescription drug coverage

CVS Caremark

- **Customer Service:**
  1-877-876-7214 (toll free)
- **Website:** www.caremark.com

For questions about:

- Benefits for a prescription drug
- Status of a prescription drug claim
- Where to get prescriptions filled
- Which drugs are covered
- This section of this handbook:
  - Part 4: Your Prescription Drug Benefits (pages 140-159)

Questions about Employee Assistance Program (EAP) benefits

Optum

- **Customer Service:**
  844-263-1982 (toll free)
- **Website:** www.liveandworkwell.com
  (Use access code: Mass4You)

For questions about your Employee Assistance Program (EAP) benefits

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

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Part 1:

Getting Started

Introducing Total Choice

For questions about any of the information in Part 1 of this handbook, please call Wellpoint Member Services at 833-663-4176.

Administered by

Wellpoint

Chapter 1: First things first

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

About this plan

This handbook is a guide to benefits for you and your dependents covered under the **Wellpoint Total Choice** plan.

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

Total Choice offers comprehensive coverage to subscribers who live anywhere in New England for many health services including hospital stays, surgery, emergency care, preventive care, outpatient services, and other medically necessary treatment. This plan covers services from any provider in the New England plan area. Subscribers can even live internationally. In addition, dependents can live anywhere, as long as the subscriber lives in New England. Keep in mind, however, that benefits can differ depending on the service and the provider, and that not all services are covered by the Plan.

About this handbook

Benefits described in this handbook

This handbook looks at features and coverage for these types of benefits:	
Medical services	These benefits are administered by Wellpoint
Behavioral health services	These benefits, which cover mental health and substance use disorder services, are administered by Wellpoint in partnership with **Carelon Behavioral Health**
Prescription drugs	These benefits are separately administered by **CVS Caremark**

Where to find information in this handbook

Part 1: Getting Started	**Pages 11-28**
▪ Overview information to help you get to know the health benefits administered by Wellpoint ▪ Features and advantages of the Total Choice plan ▪ How to get the most out of your Total Choice coverage ▪ How costs and billing work; what member costs are ▪ Information about preapproval reviews (preauthorization)	
Part 2: Your Benefits and Coverage	**Pages 29-85**
▪ Medical services covered under Total Choice ▪ Behavioral health services covered under Total Choice ▪ What your benefits are for preventive services	
Part 3: Using Your Plan	**Pages 86-138**
▪ How to understand and use the features of the Total Choice ▪ Exclusions and limits on what's covered ▪ Descriptions of the different kinds of healthcare providers ▪ Information about claims, claim reviews, and other health plan concepts	
Part 4: Your Prescription Drug Benefits	**Pages 140-159**
▪ General information about your prescription drug benefits (administered by CVS Caremark) ▪ What your coverage is for prescription drugs ▪ Exclusions and limits on your prescription drug benefits	
Part 5: Appendices	**Pages 161-181**
▪ Reference material and notices including GIC notices; state and federal mandates; member notices; and your appeal rights	

A note about terms and definitions

Definitions for many of the terms used in this handbook appear in Chapter 11 (pages 129-138). You should also keep in mind that:

- ❑ The formal name of your plan is **Wellpoint Total Choice**. In this handbook and other plan materials, we usually refer to it as **Total Choice**, the **Total Choice plan**, or **the Plan**.
- ❑ We often use the abbreviation **GIC** for the **Group Insurance Commission**.
- ❑ If you have dependents covered under your plan, text that refers to **you** also applies to your dependents.
- ❑ **Medical services (medical care)** are 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 1. What the handbook symbols mean

What the handbook symbols mean	
	**Important information** – This may have an impact on your benefits or costs.
	**No coverage, limited coverage, or benefit restriction** – A full list of Plan exclusions and limitations appears in Chapter 7.
	**May need preapproval review** – This service may need to be reviewed to determine if it is eligible for benefits. See Chapter 3.
	**Use contracted suppliers** – To get the best benefit, use a contracted supplier for this service or product. See page 103 to learn more.
	**Use Sydney Health** – You can do this through the Sydney Health app. See page 125.
	**Go to wellpoint.com/mass** – This information can be found at our website.

Do you have other health insurance?

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

Wellpoint needs this information to coordinate your benefits with other plans. To learn more about how this works, turn to "Coordinating benefits with other health plans (COB)" on pages 119-122.

 Find this and other forms at wellpoint.com/mass.

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

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

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

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

About your ID card

Every Total Choice member will get a Wellpoint ID card. Your ID card has useful information about your benefits, as well as important telephone numbers you and your healthcare providers may need.

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

 You can order replacement physical cards by logging in to your member portal at wellpoint.com/mass.

Your prescription drug card is separate. CVS Caremark will send your prescription drug cards separately. Call CVS Caremark at 1-877-876-7214 if you have questions about your prescription drug card.

Some services need preapproval

In this handbook, services marked with a **telephone** ☎ require preapproval (preauthorization) review to determine if the services are eligible for benefits. Your provider must notify Wellpoint if you're having a service that requires review. See Chapter 3 for information about how preapprovals work.

Getting the most out of Total Choice

For a description of the different kinds of providers and facilities mentioned in Table 2, see "Types of healthcare providers" on pages 100-104.

Table 2. How to get the most out of Total Choice

Tips on choosing providers		See pages
If you need care quickly, 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, you'll owe a $100 copay.	45-46, 102
Have eye and GI procedures at ambulatory surgery centers	There's a lower copay when you have eye or gastrointestinal (GI) surgery at an independent ambulatory surgery center (not run by a hospital).	67-68, 102
✓ **Use contracted suppliers**	Services and equipment from contracted suppliers are covered at 100%. Non-contracted suppliers are covered at 80%, so you'll owe 20% coinsurance. In this handbook, the **checkmark** ✓ indicates a contracted supplier benefit.	103
Use contracted behavioral health providers	You will not owe any coinsurance, and contracted providers won't balance bill you for charges over the Plan's allowed amounts.	100-101
Getting care outside of Massachusetts		**See pages**
Use contracted providers outside of Massachusetts	If you live or travel outside of Massachusetts, be sure to go to contracted providers for your health care. These providers have agreed to accept Wellpoint's payment as payment in full – they won't balance bill you.	23, 104
Make sure your out-of-state dependents use contracted providers, too	Covered dependents who live outside of Massachusetts should also use contracted providers when they need healthcare services.	23, 104
Other ways to keep your costs down		**See pages**
Check hospital costs with Find Care	Compare costs for common procedures with Massachusetts providers using Find Care at wellpoint.com/mass.	127
Avoid outpatient facilities that are owned by hospitals	Sometimes, outpatient facilities – like urgent care centers and ambulatory surgery centers – are owned by hospitals and may bill as hospitals. That can cost you more. If you're not sure, you should ask how your visit is billed.	101
Make sure you're using contracted providers	If you live outside of Massachusetts, make a habit of confirming that your providers are contracted. Provider status can change at any time.	23
Learn the difference between preventive and diagnostic care	When you have a preventive visit with your doctor, you could be billed if you have any services that are diagnostic instead of preventive. Get to know what your preventive benefits are – see Chapter 6.	82-85

Chapter 2: About costs and billing

The ABCs of medical bills

When you get a medical bill, it's often hard to understand what needs to be paid, and who needs to pay what. Here are some basics about medical billing that are worth knowing, and that may help everything make a bit more sense:

Medical services are almost never just one service.

You already know that health care is complicated, but nothing makes that more obvious than when the bill arrives. Let's say you go to the doctor for a tetanus shot – one simple service, right? Then when the bill comes, you see separate charges for the office visit with the doctor, the administration of the shot (the injection itself), and the tetanus serum (what's in the injection).

This is how medical billing works, and this is why you'll often see more than one charge on a medical bill.

Not all services are paid for (covered) by insurance.

Your insurance covers most services that are **medically necessary** – services that you need in order to take care of your health. There are some services that aren't covered; you have to pay for those yourself. Cosmetic services are one example of services that are usually not medically necessary and that insurance doesn't cover. Also, most insurance plans have a list of services that are **excluded** (never covered). You can find the list of services that are excluded or limited in Chapter 7.

Even when a service is covered, it doesn't mean that insurance will pay whatever the doctor charged.

Insurance covers up to the **allowed amount** for a service, which may not be the amount that's on the bill. An allowed amount is the most that your insurance will pay.

Let's say the allowed amount for the tetanus serum in your shot is $80. Even if the doctor charged $100 for the serum, insurance will pay no more than $80 – the allowed amount. Remember: 100% coverage means 100% of the allowed amount, *not* 100% of the bill.

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

Providers who have contracted with your health plan accept the allowed amount as complete payment. Non-contracted providers don't. Non-contracted providers can bill you for the difference between what they billed and what your health plan paid. This is called **balance** or **surprise billing**. See pages 23-24 for information about balance billing protection.

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

So, who pays what?

Your insurer pays the allowed amounts for your tetanus shot. You may also owe a fee, called a copay, at the doctor's office. When you pay something toward the healthcare services you get, that's known as **cost sharing**. The costs that you must pay yourself are your **member costs**.

The next several pages talk about the different member costs you pay toward your health care: **deductibles**, **copays** and **coinsurance**.

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

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

There are three kinds of member costs. These costs are separate and unrelated; they apply in different situations and to different services.

Types of member costs		See pages
Deductible	A set dollar amount you owe toward services each year before the Plan starts paying for those services.	19
Copays	A fixed amount you pay when you get certain healthcare services, like seeing your doctor for a sprained ankle.	20-22
Coinsurance	For some services, the Plan pays 80% and you pay the other 20%. The 20% that you owe is called coinsurance.	22

There is a limit on how much you could pay for these member costs. An **out-of-pocket maximum** caps how much you'll spend each plan year on the combination of deductible, copays, and coinsurance. See page 22 to learn about your out-of-pocket maximum.

What is a plan year? The **plan year** starts on July 1 each year and ends the following June 30th.

How member costs work

If you owe any member costs, we'll send you an *Explanation of Benefits* (EOB), which is a statement that shows how the claim has been paid and what member costs you owe.

When Wellpoint gets a claim for services that you or someone in your family had, we subtract any member costs you owe from the amount we pay to that provider. The copay, if there is one, gets subtracted first. Then the deductible – if it applies – is subtracted, and finally the coinsurance, if any.

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

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

About your deductible

A **deductible** is a set dollar amount you pay toward certain services each plan year before the Plan starts paying for those services. Your deductible starts at the beginning of each plan year (in other words, on July 1, when your plan coverage starts).

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.

Depending on how much a claim is for, it may take more than one claim before you have *satisfied* (fully paid) your deductible. Once you have paid all of this year's deductible, you won't owe any more deductible until the next plan year starts.

Your deductible applies to both medical and behavioral health services.

Important! A separate deductible applies to prescription drugs and is described in Part 4 of this handbook.

Table 3. How much is my deductible?

How much is my deductible?	
For an individual	**$500 for one person (each plan year)**
For a family	**$1,000 for the entire family (each plan year)** *For any one person in the family, the deductible is capped at $500*

How an individual deductible works

An **individual deductible** is the amount that one person must pay before the Plan starts to pay for any services the deductible applies to.

> **Example** – In July, you get services and pay $200 toward your deductible. You now have $300 of your deductible that you haven't paid yet. In August, you get more services. If this second bill is *more* than $300, you pay the $300 deductible you still owe, and the Plan pays the covered amount of the rest of the bill. But if the August bill is *less* than $300, you'll owe the rest of your deductible next time you have services that the deductible applies to.

How a family deductible works

If you have dependents who are covered under your plan, then you also have a **family deductible**. The family deductible is the maximum amount that you and your family could pay in a plan year. The most you'll owe for any one family member is $500, until the family as a whole reaches the $1,000 family limit.

> **Example** – In July, you and your two children get services and each of you pay $300 deductibles. This means you've paid $900 of your family deductible. In August, your spouse gets services and pays $100 deductible – the rest of your family deductible. Even though no one person has reached the $500 cap, you've paid the entire $1,000 family deductible. You won't have to pay any more deductible for anyone in your family for the rest of the plan year.

About copays

What's 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 go to your doctor for a sore throat, when you're admitted to a hospital, or when you have outpatient surgery. Copays can work in two ways:

- ❑ You pay a **per-visit copay** each time you have that service. Doctor visits, emergency room visits, and some outpatient services have per-visit copays.
- ❑ You pay a **quarterly copay** only once in a calendar quarter, even if you have that type of service again during the same quarter.

How quarterly copays work

There are two services that require quarterly copays:

- ❑ You owe a **quarterly inpatient copay** when you're admitted to a hospital for medical or behavioral health care.
- ❑ You owe a **quarterly outpatient surgery copay** when you have outpatient surgery at a hospital or non-hospital-owned facility.

You pay just one copay in a calendar quarter, even if you have that service again during the same quarter.

> **What is a calendar quarter?** The **calendar quarters** are July/August/September, October/November/December, January/February/March, and April/May/June.

In the case of the quarterly inpatient and outpatient copay, you won't owe another copay within 30 days, even if your services occur in two different calendar quarters. But you'll always owe a quarterly copay when a new plan year starts (on July 1), even if fewer than 30 days have passed since your last quarterly copay.

Which services have copays?

Provider visits (page 42)

You owe a per-visit copay each time you have an in-person or virtual care visit (telehealth) with a provider at a medical practice or clinic, including urgent care centers and retail clinics. The dollar amount of the copay varies by what type of facility you use and whether you see 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.

☞ **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 (page 56)

You owe a quarterly inpatient copay when you are admitted to a hospital for medical or behavioral health care. Once you have paid an inpatient copay (for either kind of care), you won't owe another inpatient copay for the rest of the calendar quarter. See above, "How quarterly copays work".

Emergency room (ER) visits (page 45)

You owe the ER copay each time you go to an emergency room at a hospital. If you get admitted to the hospital from the ER, this copay is waived and the quarterly inpatient copay will apply instead.

Outpatient surgery (page 67)

You owe a quarterly copay when you have outpatient surgery at a hospital or a non-hospital-owned facility such as an ambulatory surgery center. Once you have paid an outpatient surgery copay, you won't owe another outpatient surgery copay for the rest of the calendar quarter. See above, "How quarterly copays work".

> **What is a non-hospital-owned facility?** **Non-hospital-owned facilities** are facilities that perform outpatient medical services but that are not owned or operated by a hospital. Non-hospital-owned facilities include many ambulatory surgery centers and urgent care centers.

Other outpatient medical services

Medical services that require a copay at each visit include:

- ❑ Cardiac rehabilitation programs (page 35)
- ❑ Chiropractic services (page 36)
- ❑ High-tech imaging such as an MRI, CT scan, or PET scan (page 51). You owe just one high-tech imaging copay per day, no matter how many scans you get.
- ❑ Occupational therapy (page 60)

- ❑ Physical therapy (page 62)
- ❑ Routine eye exams (page 47)
- ❑ Speech therapy (page 66)

Outpatient behavioral health services (page 77)

You owe a per-visit copay for many behavioral health outpatient services when you use Carelon-contracted behavioral health providers. Although there are no copays when you use a non- contracted behavioral health provider, you'll owe 20% coinsurance, and you risk being balance billed. See pages 100-101 for information about behavioral health providers.

About coinsurance

Coinsurance is your share of the cost of a covered service when the service isn't covered at 100%. For example, if the Plan pays 80% of the allowed amount for a service, you are responsible for paying the other 20%.

About the out-of-pocket (OOP) maximum

There is a limit on the member costs you'll have to pay each year toward covered services. This limit is called the **out-of-pocket (OOP) maximum**. Once you reach this limit, the Plan pays 100% of the allowed amounts for services for the rest of the plan year.

Table 4. How much is the OOP maximum?

How much is the OOP maximum?	
For an individual	**$5,000 for one person (each plan year)**
For a family	**$10,000 for the entire family (each plan year)** *For any one person in the family, this maximum is $5,000*

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

- ❑ Deductibles
- ❑ Copays
- ❑ Coinsurance

The following costs ***do not*** count toward reaching your OOP maximum:

- ❑ Premiums
- ❑ Balance bills (charges over the Plan's allowed amounts) – See "Your rights and protections against surprise medical bills" below for information about balance billing protection
- ❑ Costs for health care that the Plan doesn't cover

About allowed amounts

Wellpoint negotiates with contracted providers to ensure members have access to services and to establish an allowed amount that Wellpoint and the provider have agreed to for that service in most cases.

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

We always recommend that members proactively call and work with the Plan to find a contracted provider to ensure they receive the best possible benefit. Wellpoint works hard to negotiate reimbursements with providers that are fair and reasonable for our members.

Your rights and protections against surprise medical bills

What is balance billing?

When you visit a doctor or other healthcare specialist, you may owe certain out-of-pocket costs, such as a copay, coinsurance, and/or a deductible. In certain cases, if you visit a non-contracted provider, you might owe additional charges.

These non-contracted doctors and facilities may be allowed to bill you for the difference between Wellpoint's allowed amount and the full amount charged for a service. This is called **balance billing**. Balance bills from non-contracted providers are not applied toward your out-of-pocket maximum.

Surprise billing is a balance bill that 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 contracted facility but are unexpectedly treated by a non-contracted doctor.

Your protections against surprise billing

You are protected from receiving surprise bills – balance bills that you don't expect – under the following circumstances:

- ❑ **Emergency services in Massachusetts and elsewhere** – Federal law prohibits all providers, whether contracted or non-contracted, from balance billing for medical or behavioral health emergency services.
- ❑ **Medical services in Massachusetts** – State law prohibits all medical providers in Massachusetts from balance billing Wellpoint members.
- ❑ **Medical services outside of Massachusetts** – You cannot be balance billed when you receive services at a Wellpoint-contracted facility. Although some providers (e.g., anesthesiologists) at a Wellpoint-contracted facility may be non-contracted, federal law prohibits those non-contracted providers from balance billing you.

- ❑ **Behavioral health services in Massachusetts and elsewhere** – You won't be balance billed when you use behavioral health providers who are contracted with Carelon Behavioral Health. Non-contracted behavioral health providers may balance bill you; however, the federal protections against surprise billing apply to behavioral health providers as well as to medical providers.

As this list of protections shows, you risk getting balance billed if you knowingly use a non-contracted provider. In that case, the balance bill is your own responsibility to pay, and the bill does not count toward your out-of-pocket maximum. We urge members to always verify a provider's status as a contracted provider. Because providers' contract status can change during the plan year, it can be unwise to assume that your provider's status hasn't changed.

Important! You are ***never*** required to give up your protections against balance billing, and you are ***never*** required to receive care from non-contracted doctors or facilities.

What to do if you get a surprise bill

If you get a balance bill from any of the following providers, contact Wellpoint Member Services at 833-663-4176 for help. These providers are not allowed to balance bill Wellpoint members:

- ❑ Any provider of emergency medical or emergency behavioral health care
- ❑ Providers of ancillary services (such as anesthesiology) at contracted facilities
- ❑ Medical providers in Massachusetts
- ❑ Contracted suppliers
- ❑ Contracted medical providers outside of Massachusetts
- ❑ Contracted behavioral health providers both in and outside of Massachusetts

However, balance bills from other providers are your responsibility to pay. Since the Plan doesn't cover balance bills, and since they don't count toward your out-of-pocket maximum, balance bills can end up being very costly.

Chapter 3: Getting preapproval

What is preapproval?

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

In most cases, your doctor will provide Wellpoint with the information necessary to get services preapproved. But, occasionally, you may need to work with your doctor to arrange for preapproval. For example, if you use a non-contracted provider outside Massachusetts, you may need to ask that doctor to contact Wellpoint about preapproval.

If someone (you or your provider) doesn't get preapproval when it's required, your benefits may be reduced or not paid at all. If you need help with a preapproval, Wellpoint Member Services can contact your provider to make the arrangements.

What else should I know?

Here are a few other points about the preapproval process that may be helpful to know:

- ❑ Submitting a claim for a service does not meet the requirement for preapproval. Your provider must contact Wellpoint for preapproval before the service takes place.
- ❑ You don't need to get preapproval if you are outside the continental United States (the continental U.S. includes all states except Alaska and Hawaii).
- ❑ In this handbook, the telephone ☎ marks services that need to be preapproved.
- ❑ If you're not sure whether a service needs preapproval, ask your doctor to check the list 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**. Carelon Medical Benefits Management and CarelonRx are Wellpoint-affiliated companies that provide support for the preapproval process. Your provider will need to contact the appropriate reviewer for the service needing preapproval.

Reviewer / contact info
Wellpoint – Behavioral health services and some medical services ▪ 800-442-9300 TTY: 711 (toll free) ▪ wellpoint.com/mass/providers/preapprovals
Carelon Medical Benefits Management – BPAP/CPAP equipment; some cardiology procedures; high-tech imaging; genetic testing; musculoskeletal services; oncology drugs; radiation therapy; sleep studies ▪ 866-766-0247 (toll free) ▪ www.providerportal.com
CarelonRx – Specialty drugs ▪ 833-293-0659 (toll free) ▪ www.covermymeds.com/main/prior-authorization-forms/
CVS Caremark – Specialty drugs ▪ 800-237-2767 ▪ Please refer to Your Prescription Drug Benefits section for more information.

Preapprovals for medical services

Table 5 lists types of medical services that need to be preapproved. This is a representative list only and is subject to change. If you need help determining if a service needs preapproval, contact Wellpoint Member Services at 833-663-4176.

Table 5. Types of medical services needing preapproval

Types of medical services needing preapproval	
Ambulance services (non-emergency) **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/oral therapy** **Gender affirmation (reassignment) surgery** **Genetic testing** **High-tech imaging** ▪ CT/CTA scan ▪ MRI/MRA scan ▪ Nuclear cardiology ▪ PET scans ▪ SPECT scans **Home health care** **Hospice care** **Hyperbaric oxygen therapy** **Inpatient hospital admissions** ▪ Inpatient hospital stay ▪ Hospital at home ▪ Inpatient readmission	**Musculoskeletal services** ▪ Interventional pain management ▪ Joint surgery ▪ Spine surgery **Oncology services** ▪ Chemotherapy ▪ Supportive drugs **Prosthetics and orthotics** **Radiation therapy** ▪ Brachytherapy ▪ CyberKnife ▪ 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 ▪ Prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis, and multiple sclerosis. Specialty drugs are often high-cost and 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 non-oncology specialty drugs may need preapproval through your prescription drug plan. See Part 4 of this handbook.	

Preapprovals for behavioral health services

To request preapproval for a behavioral health service 24 hours a day, seven days a week, your provider should contact Wellpoint.

Table 6 lists types of behavioral health services that need preapproval. Note that the preapproval requirements may be different for contracted and non-contracted providers (see pages 99-100 for information about behavioral health providers).

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

Table 6. Types of behavioral health services needing preapproval

Behavioral health service	With contracted providers	With non-contracted providers
Inpatient services for mental health treatment		
▪ Acute residential treatment ▪ Transitional care units (TCU)	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 (CSU)	Needs preapproval for stays over 5 days	Needs preapproval for stays over 5 days
Inpatient services for substance use disorders (adults and adolescents)		
▪ 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 providers in Massachusetts:** Notify Wellpoint within 48 hours ▪ **All other non-contracted providers:** Needs preapproval
▪ Crisis stabilization units (CSU)	Needs preapproval for stays over 5 days	Needs preapproval for stays over 5 days

Behavioral health service	With contracted providers	With non-contracted providers
Outpatient services		
▪ Acupuncture withdrawal management ▪ Community support programs (CSP) ▪ Day treatment	N/A	Needs preapproval
▪ Applied Behavior Analysis (ABA) ▪ Dialectical behavioral therapy (DBT) ▪ Family stabilization teams (FST) ▪ Family support and training ▪ In-home behavioral services ▪ Intensive care coordination ▪ Mobile crisis intervention ▪ Partial hospitalization programs for mental health conditions (PHP) ▪ Psychiatric visiting nurse services ▪ Therapeutic mentoring services ▪ Transcranial magnetic stimulation (TMS)	Needs preapproval	Needs preapproval
▪ Partial hospitalization programs for substance use disorders (PHP) (ASAM level 2.5)	▪ **In Massachusetts:** Notify Wellpoint within 48 hours ▪ **Outside Massachusetts:** Needs preapproval	▪ **DPH-licensed providers in Massachusetts:** Notify Wellpoint within 48 hours ▪ **All other non-contracted providers:** Needs preapproval
▪ Intensive outpatient programs (IOP) ▪ Structured outpatient addictions programs (SOAP)	Notify Wellpoint within 48 hours	▪ **DPH-licensed providers in Massachusetts:** Notify Wellpoint within 48 hours ▪ **All other non-contracted providers:** Needs preapproval

Part 2:

Your Benefits and Coverage

Description of coverage for medical and behavioral health services

For questions about any of the information in Part 2 of this handbook, please call Wellpoint Member Services at 833-663-4176.

Administered by

Wellpoint

Chapter 4: Covered medical services

Summary of covered medical services

Table 7. Summary of costs for medical services

Important! To be covered, services must be medically necessary. Benefits are limited to the Plan's allowed amounts for the services (page 23).

Service	Member costs	See page
☎ **Ambulances**	Deductible	34
Bereavement counseling	Deductible and 20% coinsurance (limited to $1,500 for a family in a plan year)	53
Cardiac rehab programs	$20 copay	35
Chemotherapy	Deductible	36
Chiropractic care	$20 copay (limited to 20 visits in a plan year)	36
✓ **Diabetic supplies**	▪ **Contracted suppliers:** Deductible ▪ **Non-contracted:** Deductible and 20% coinsurance	41
Dialysis	Deductible	42
Doctor visits		42
▪ Primary care (PCP) visits	$20 copay	
▪ Specialist visits	$45 copay	
▪ Virtual care (telehealth)	$20 copay	
Doctors – other services		42
▪ At an emergency room	Deductible	
▪ For inpatient hospital care	Deductible	
▪ For outpatient hospital care	$45 copay	
Drug screening (lab tests)	Deductible	43
☎ ✓ **Durable medical equipment (DME)**	▪ **Contracted suppliers:** Deductible ▪ **Non-contracted:** Deductible and 20% coinsurance	43
Early intervention programs	No member costs	44
Emergency room visits	$100 copay and deductible	45

Important! To be covered, services must be medically necessary. Benefits are limited to the Plan's allowed amounts for the services (page 23).

Service	Member costs	See page
Eye exams (routine)	$45 copay (limited to one exam every 24 months)	47
Eyeglasses and contact lenses	Deductible (limited to the first lenses within six months of eye injury or cataract surgery)	48
Family planning services	No member costs	48
Fitness reimbursement	Reimbursed up to $100 for an individual and $200 for a family in a plan year	48
Hearing aids		50
▪ Age 21 and under	No member costs (limited to $2,000 for each impaired ear every 24 months)	
▪ Age 22 and over	No member costs (limited to $1,700 for each impaired ear every 24 months)	
Hearing exams	No member costs (but you may owe a copay for the office visit)	51
☎ **High-tech imaging (e.g., MRIs, CT scans)**		51
▪ Emergency room	Deductible	
▪ Inpatient hospital	Deductible	
▪ Outpatient hospital and non-hospital-owned facilities	$100 daily copay and deductible	
☎ ✓ **Home health care**	▪ **Contracted suppliers:** Deductible ▪ **Non-contracted:** Deductible and 20% coinsurance	52
✓ **Home infusion therapy**	▪ **Contracted suppliers:** Deductible ▪ **Non-contracted:** Deductible and 20% coinsurance	53
☎ **Hospice care**	Deductible	53
Immunizations (vaccines)	No member costs (but you may owe a copay for the office visit)	54
☎ **Inpatient medical care**		56
▪ At a hospital or rehab facility (semi-private room)	$275 quarterly copay and deductible	
▪ At a hospital or rehab facility (medically necessary private room)	▪ **First 90 days:** $275 quarterly copay and deductible ▪ **After 90 days:** Dollar difference between the semi-private room rate and the private room rate	
Lab services	Deductible	58
Medical services, if not listed elsewhere	Deductible and 20% coinsurance	59
Nutritional counseling	No member cost	95

Important! To be covered, services must be medically necessary. Benefits are limited to the Plan's allowed amounts for the services (page 23).

Service	Member costs	See page
Occupational therapy		60
▪ With an autism diagnosis	$20 copay	
▪ With a Down syndrome diagnosis	$20 copay	
▪ ☎ All other occupational therapy	$20 copay (preapproval required after 30 visits)	
Outpatient hospital services, if not listed elsewhere	Deductible	61
✓ **Oxygen**	▪ **Contracted suppliers:** Deductible ▪ **Non-contracted:** Deductible and 20% coinsurance	61
Personal Emergency Response Systems (PERS)		62
▪ Installation	Deductible and 20% coinsurance (limited to $50 in a plan year)	
▪ Rental	Deductible and 20% coinsurance (limited to $40 a month)	
Physical therapy		62
▪ With an autism diagnosis	$20 copay	
▪ With a Down syndrome diagnosis	$20 copay	
▪ ☎ All other physical therapy	$20 copay (preapproval required after 30 visits)	
Prescription drugs	Benefits are administered by CVS Caremark and are described in Part 4 (pages 139-157). Call CVS Caremark at 1-877-876-7214 for more information.	140
Preventive care *See Table 13 on page 81.*	No member costs	63
☎ **Prosthetics and orthotics**	Deductible	64
☎ **Radiation therapy**	Deductible	65
Radiology (e.g., X-rays, ultrasounds)		65
▪ Emergency room	Deductible	
▪ Inpatient hospital	Deductible	
▪ Outpatient hospital and non-hospital-owned facilities	Deductible	
Retail health clinic visits	$20 copay	45
☎ **Skilled nursing and long-term care facilities**	Deductible and 20% coinsurance (limited to 100 days in a plan year)	56

Important! To be covered, services must be medically necessary. Benefits are limited to the Plan's allowed amounts for the services (page 23).

Service	Member costs	See page
☎ **Speech therapy**	$20 copay	66
☎ **Surgery – inpatient hospital**	Deductible (you also have an inpatient copay)	67
☎ **Surgery – outpatient**		67
▪ At a hospital	$250 quarterly copay and deductible	
▪ Eye and GI surgery at non-hospital-owned facilities	$150 quarterly copay and deductible	
▪ All other outpatient surgery at non-hospital-owned facilities	$250 quarterly copay and deductible	
▪ At a doctor's office	Deductible (you may also owe a copay for the office visit)	
Tobacco cessation counseling	No member costs	68
☎ **Transplants**		69
▪ At a Quality Center or Designated Hospital for transplants	$275 quarterly copay and deductible	
▪ At other hospitals	$275 quarterly copay, deductible, and 20% coinsurance	
Urgent care center visits	$20 copay	45
Virtual care (telehealth)	$20 copay	42

Allergy shots

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

	Member costs
Shot (injection)	Deductible
Allergy serum	Deductible and 20% coinsurance
Office visit	▪ **With a PCP:** $20 copay ▪ **With a specialist:** $45 copay

Ambulances and transportation

Ambulance transportation is covered both in medical emergencies and in certain non-emergency situations. Some examples of emergencies are stroke, heart attack, difficulty breathing, and severe pain. Covered emergency medical transportation may be by ground, air, or water ambulance, depending on the emergency situation. Non-emergency transportation may be covered when medically necessary and is limited to ground transportation only.

	Member costs
Emergency transportation	Deductible
☎ **Non-emergency ground transportation**	Deductible

✕ **Restrictions:**

✕ All ambulance transportation must be medically necessary and must take you to the nearest appropriate hospital or facility.

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

☎ **Non-emergency ambulance transportation needs preapproval.**

Anesthesia

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

Member costs	
Anesthesia and its administration	Deductible

Restrictions:

- Other charges associated with ECT are covered under your behavioral health benefit (Chapter 5).
- There is no coverage for anesthesia used for a non-covered procedure.

Autism spectrum disorders

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

Medical services for autism spectrum disorders are covered like any other physical condition. Coverage is subject to all pertinent provisions of the Plan, including use of participating providers, preapproval reviews, benefit limitations, and provider payment methods. Medical services needed for diagnosis and treatment (such as occupational therapy) are covered as a medical benefit. Behavioral health services are covered as a behavioral health benefit (page 74).

Cardiac rehabilitation (rehab) programs

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

Member costs	
Cardiac rehab programs	$20 copay

A cardiac rehab program must:

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

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

Restrictions:

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

Chemotherapy

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

	Member costs
Outpatient	Deductible
Inpatient	Covered under the benefit for hospital admissions (page 56)

Chiropractic care

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

	Member costs
Chiropractic care	$20 copay (limited to 20 visits in a plan year)

Restrictions:

- Certain therapy services are not covered. These include, but are not limited to: acupuncture, aerobic exercise, craniosacral therapy, diathermy, infrared therapy, kinetic therapy, microwave therapy, paraffin treatment, Rolfing therapy, Shiatsu, sports conditioning, ultraviolet therapy, and weight training.
- X-rays performed by a chiropractor are subject to the X-ray benefit.
- Group chiropractic care is not covered.
- Services provided by a chiropractor are considered chiropractic care, not physical therapy.
- Massage therapy and services provided by a massage therapist or neuromuscular therapist are not covered.

Circumcision

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

	Member costs
Circumcision	Deductible

Cleft lip and cleft palate

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

Benefits include:

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

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

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

✕ Restrictions:

- This plan does not cover dental and orthodontic treatment covered by the member's dental plan.

☎ These services need preapproval.

Clinical trials (clinical research studies)

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

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

- ❑ The clinical trial is to study potential treatments for cancer.
- ❑ The clinical trial has been peer reviewed and approved by one of the following:
  - The United States National Institutes of Health (NIH)
  - A cooperative group or center of the NIH
  - A qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants
  - The United States Food and Drug Administration (FDA) pursuant to an investigational new drug exemption

- The United States Departments of Defense or Veterans Affairs
- With respect to Phase II, III and IV clinical trials only, a qualified institutional review board

❑ The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that experience.

❑ With respect to Phase I clinical trials, the facility must be an academic medical center (or an affiliated facility) at which the clinicians conducting the trial have staff privileges.

❑ The member meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial.

❑ The member has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards.

❑ The available clinical or pre-clinical data provide a reasonable expectation that the member's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial.

❑ The clinical trial does not unjustifiably duplicate existing studies.

❑ The clinical trial must have a therapeutic intent and must, to some extent, assume the effect of the intervention on the member.

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

❑ All services, including donor services, that are medically necessary for treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the Plan.

❑ The allowed cost, as determined by the Plan, of an investigational drug or device that has been approved for use in the clinical trial studying potential treatments for cancer to the extent it is not paid for by its manufacturer, distributor or provider, regardless of whether the FDA has approved the drug or device for use in treating your particular condition.

✕ Restrictions:

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

Chronic pain management

Charges associated with covered chronic pain management — such as laboratory, doctor, and surgery costs — are covered under the appropriate plan benefit. For example, chronic pain management coverage associated with physical therapy can be found under the benefit for physical therapy.

Opioid antagonists, such as Narcan, can reverse the effects of an opioid overdose. This medicine is covered at no cost to you and does not require a prior authorization. The benefit is administered by your plan's pharmacy vendor (CVS). For more information, please see the "Your Prescription Drug Benefits" section.

Dental services

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

- ❑ **Emergency treatment** from a dentist within 72 hours of an accidental injury to the mouth and sound natural teeth. Treatment must take place in an acute care setting (not a dentist's office) and is limited to trauma care, the reduction of pain and swelling, and any otherwise covered non-dental surgery and/or diagnostic X-rays.
- ❑ **Oral surgery for non-dental medical treatment** – such as procedures to treat a dislocated or broken jaw or facial bone, and the removal of benign or malignant tumors – is covered like any other surgery.
- ❑ **If you have a serious medical condition** (such as hemophilia or heart disease) that makes it necessary to have your dental care performed safely in a hospital, surgical day care unit, or ambulatory surgery center, only the following procedures are covered:
  - Extraction of seven or more teeth
  - Gingivectomies (including osseous surgery) of two or more gum quadrants
  - Excision of radicular cysts involving the roots of three or more teeth
  - Removal of one or more impacted teeth
- ❑ **Cleft lip or palate** (page 37) – The following services are covered specifically for the treatment of cleft lip or palate, if not otherwise covered by a dental plan:
  - Dental services
  - Orthodontic treatment
  - Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic or prosthetic treatment

Restrictions:

- There is no coverage for any services provided in a dentist's office.
- There is no coverage for dental rehabilitation or dental restoration.
- Facility fees, anesthesia and other charges related to non-covered dental services are not covered.
- Dentures, dental prosthetics and related surgery are not covered.

- Braces and other orthodontic treatment, including treatment done to prepare for surgery, are not covered.
- Treatment of temporomandibular joint (TMJ) disorder is limited to the initial diagnostic examination, initial testing and medically necessary surgery.

Diabetes care

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

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

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

Benefits are available in the following situations:

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

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

Diabetes prevention program reimbursement

You can get reimbursed for up to $500 when you complete at least 20 sessions of an approved diabetes prevention program. The Plan will reimburse you when you send us proof that you have completed a diabetes prevention program approved by the Massachusetts Department of Public Health or offered through the YMCA in other states.

Member costs	
Diabetes prevention program reimbursement	Costs are reimbursed up to $500 per member (one time only)

To be eligible for this reimbursement, you must complete a diabetes prevention program listed on the **www.mass.gov** website. For a list of programs in Massachusetts, go to:

www.mass.gov/service-details/dpp-programs-in-massachusetts

Outside of Massachusetts, look for a program at a nearby YMCA:

www.ymca.net/diabetes-prevention/locate-participating-y

Use the *Diabetes Prevention Program Reimbursement* form to submit your request for this reimbursement.

Download this form from wellpoint.com/mass.

✕ Restrictions:

- Reimbursement is available only once per member.
- You must complete at least 20 sessions of the program.

Diabetic supplies and equipment

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

	Member costs
✓ **Diabetic supplies**	▪ **Contracted suppliers:** Deductible ▪ **Non-contracted suppliers:** Deductible and 20% coinsurance

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

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

Diabetes drugs (such as insulin and prescribed oral agents) are covered under your prescription drug plan. In addition, if you buy diabetic supplies at a pharmacy, the supplies may also be covered under your prescription drug plan. See Part 4 of this handbook (pages 140-159).

✕ Restrictions:

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

☎ Preapproval is required for durable medical equipment costing more than $1,000.

✓ Use contracted suppliers (page 102) – Supplies from contracted suppliers are covered at 100% of the allowed amount. Supplies from non-contracted suppliers are covered at 80%, so you owe 20% coinsurance. Your deductible applies to both types of suppliers.

Find contracted suppliers at wellpoint.com/mass.

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

Dialysis

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

	Member costs
Dialysis	Deductible

Restrictions:

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

Doctor and other medical provider services

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

Office visits	Member costs
Primary care (PCP) visits	$20 copay
Specialist visits	$45 copay
Virtual care (telehealth)	$20 copay
Other provider services	**Member costs**
Emergency room care	Deductible
Inpatient hospital care	Deductible
Outpatient hospital care	$45 copay

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

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

Restrictions:

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

Drug screening (lab tests)

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

	Member costs
Lab tests for drug screening	Deductible

✕ Restrictions:

- Drug screening tests must be performed by a medical provider, such as a hospital or medical laboratory.
- There is no coverage for drug screening that is:
  - Required solely for the purposes of career, education, housing (e.g., sober living facilities), sports, camp, travel, employment, insurance, marriage, or adoption
  - Ordered by a court, except as required by law
  - Required to obtain or maintain a license of any type

Durable medical equipment (DME)

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

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

	Member costs
✓ **Breast pumps**	▪ **Contracted suppliers:** No member costs ▪ **Non-contracted suppliers:** Deductible and 20% coinsurance
☎ ✓ **All other DME**	▪ **Contracted suppliers:** Deductible ▪ **Non-contracted suppliers:** Deductible and 20% coinsurance

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

✕ Restrictions:

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

- Added, non-standard features or accessories (e.g., hand controls for driving, transit systems that secure wheelchairs in moving vehicles, wheelchair customizations)
- Items specifically designed to be used outdoors (e.g., special wheelchairs for beach access, equipment for use on rough terrain)
- Items that serve as backup by duplicating other equipment (e.g., a manual wheelchair as backup for a powered wheelchair)
- Equipment upgrades or replacements for items that function properly or that can be repaired

- There is no coverage for personal items that could be purchased without a prescription. This includes, but is not limited to, air conditioners, arch supports, bed pans, blood pressure cuffs, commodes, computer-assisted communications devices, corrective shoes, heating pads, hot water bottles, incontinence supplies, lift or riser chairs, non-hospital beds, orthopedic mattresses, shower chairs, telephones, televisions, thermal therapy devices and whirlpools.
- Compression stockings are covered up to a limit of four pairs within a 365-day period.
- The Plan will not cover any rental charges that exceed the purchase price of an item.

☎ **BPAP and CPAP equipment need preapproval** – After the equipment rental period (rent-to-own) is complete, supplies require preapproval annually.

☎ **Other DME needs preapproval if costing more than $1,000 (rental and/or purchase)** – This requirement doesn't apply to oxygen or oxygen equipment.

✓ **Use contracted suppliers** (page 102) – DME and related supplies from contracted suppliers are covered at 100% of the allowed amount. DME and related supplies from non-contracted suppliers are covered at 80%, so you owe 20% coinsurance. Your deductible applies to both types of suppliers.

Find contracted suppliers at wellpoint.com/mass.

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

Early intervention programs

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

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

	Member costs
Early intervention programs	No member costs

Emergency care / urgent care

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

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

	Member costs
Hospital emergency room	$100 copay and deductible (copay is waived if admitted)
Urgent care center visits	$20 copay
Retail health clinic visits	$20 copay
Medical practice visits	▪ **With a PCP:** $20 copay ▪ **With a specialist:** $45 copay

An **emergency** is when someone needs immediate help or they could experience:

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

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

Urgent care refers to services you get when your health is not in serious danger but you need medical attention right away. Some conditions you might seek urgent care for are listed in Table 8.

Table 8. Example conditions for urgent care

When you might want to get urgent care	
▪ Cough	▪ Minor allergic reactions
▪ Sore throat	▪ Bumps, cuts, and scrapes
▪ Minor fever, cold or flu	▪ Minor burn or rash
▪ Nausea, vomiting, or diarrhea	▪ Burning with urination
▪ Back pain	▪ Eye swelling, pain, redness or irritation
▪ Muscle strain or sprain	▪ Animal bites
▪ Ear or sinus pain	▪ Stitches
▪ Mild headache	▪ X-rays or lab tests

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

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

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

✕ Restrictions:

- Charges for non-emergency services received at an emergency room are covered under the appropriate plan benefit. For example, a non-emergency CT scan would be covered under the high-tech imaging benefit (described on page 51) rather than the emergency room benefit.

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

Enteral/oral therapy

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

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

	Member costs
☎ ✓ **Enteral/oral therapy**	▪ **Contracted suppliers:** Deductible ▪ **Non-contracted suppliers:** Deductible and 20% coinsurance

☎ Enteral/oral therapy needs preapproval.

✓ **Use contracted suppliers** (page 103) – Enteral/oral therapy from a contracted supplier is covered at 100% of the allowed amount. From non-contracted suppliers, enteral/oral therapy is covered at 80%, so you owe 20% coinsurance. Your deductible applies to both types of suppliers.

Find contracted suppliers at wellpoint.com/mass.

Eye care

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

	Member costs
Routine eye exams Refraction/glaucoma testing	$45 copay (limited to one exam every 24 months)
Eye care office visits When medically necessary	$45 copay
Vision therapy	$20 copay

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

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

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

✗ **Restrictions:**

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

Eyeglasses and contact lenses

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

	Member costs
Eyeglasses and contact lenses	Deductible (limited to first set within six months of eye injury or cataract surgery)

Restrictions:

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

Family planning

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

	Member costs
Family planning services	No member costs

Covered services include:

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

FDA-approved contraceptive drugs and devices are available through your prescription drug plan (see Part 4 of this handbook).

Fitness reimbursement

You can get reimbursed for up to $100 for an individual medical plan and $200 for a family medical plan on costs associated with participation in a fitness activity. This reimbursement is paid to the plan enrollee upon proof of payment.

	Member costs
Fitness reimbursement	Costs are reimbursed up to $100 for an individual medical plan and $200 for a family medical plan each plan year

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

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

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

Download this form from wellpoint.com/mass.

Restrictions:

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

Foot care (routine)

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

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

	Member costs
Routine foot care	▪ **With a PCP:** $20 copay ▪ **With a specialist:** $45 copay

Restrictions:

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

Gender affirmation (reassignment) services

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

Medical services needed for diagnosis and treatment are covered under your medical benefit. Behavioral health services are covered as a behavioral health benefit (see Chapter 5).

Covered services include:

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

For a list of specific covered services, contact Wellpoint Member Services at 833-663-4176.

✕ Restrictions:

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

☎ Gender affirmation (reassignment) services need preapproval.

Gynecology exams

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

	Member costs
Annual exam, with Pap smear	No member costs
Office visits	▪ **With a PCP:** $20 copay ▪ **With a specialist:** $45 copay

Hearing aids

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

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

✕ Restrictions:

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

Hearing exams

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

	Member costs
Hearing exams	No member costs (you may owe a copay for the office visit)
Hearing screenings for newborns	No member costs

✕ Restrictions:

- Services provided through schools are not covered.

High-tech imaging

High-tech imaging are tests such as MRIs, CT scans and PET scans that give a more comprehensive view of the human body than plain film X-rays. Many of these tests are also much more expensive than traditional X-rays.

	Member costs
Emergency room	Deductible
Inpatient hospital	Deductible
☎ Outpatient hospital and non-hospital-owned facilities	$100 daily copay and deductible

☎ High-tech imaging needs preapproval.

Home health care

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

Benefits for home health care are available when:

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

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

	Member costs
☎ ✓ **Home health care**	▪ **Contracted providers:** Deductible ▪ **Non-contracted providers:** Deductible and 20% coinsurance

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

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

✕ Restrictions:

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

☎ Home health care needs preapproval.

✓ Use contracted providers – Home health services from a Wellpoint contracted provider are covered at 100% of the allowed amount. From non-contracted providers, home health services are covered at 80%, so you owe 20% coinsurance. Your deductible applies to both types of providers.

Find a list of Wellpoint contracted providers at wellpoint.com/mass.

Home infusion therapy

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

	Member costs
✓ **Home infusion therapy**	▪ **Contracted suppliers:** Deductible ▪ **Non-contracted suppliers:** Deductible and 20% coinsurance

✕ Restrictions:

- Non-oncology infused drugs require prior review and are dispensed by the prescription drug plan (see Part 4 of this handbook).
- You must get subcutaneous and intramuscular drugs through your prescription drug plan.

✓ **Use contracted suppliers** (page 102) – Home infusion therapy from a contracted supplier is covered at 100% of the allowed amount. From non-contracted suppliers, home infusion therapy is covered at 80%, so you owe 20% coinsurance. Your deductible applies to both types of suppliers.

Find contracted suppliers at wellpoint.com/mass.

Hospice and end-of-life care

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

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

If you have a medical prognosis of greater than twelve months to live, but you have symptoms like severe pain or difficulty breathing, the Plan covers **palliative care** (page 61). Palliative care is focused on relieving pain or other symptoms of illness and improving the quality of life for patients and their families.

	Member costs
☎ **Hospice care**	Deductible
☎ **Bereavement counseling**	Deductible and 20% coinsurance (limited to $1,500 for the family in a plan year)

The Plan covers the following hospice services:

- ❑ Part-time, intermittent nursing care or home health aide services provided by or supervised by a registered nurse

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

✕ Restrictions:

- Respite care is limited to a total of five days.
- Bereavement counseling is limited to $1,500 per family. Additional counseling services are available under your behavioral health benefits (Chapter 5).
- No hospice benefits are payable for services not listed in this section, nor for any service furnished by a volunteer, or for which no charge is customarily made.

☎ **We encourage you to notify Wellpoint when hospice services are recommended** – When you contact Wellpoint, you'll be connected with Wellpoint's clinical team. The clinical team offers support and services to members dealing with complex healthcare issues. See pages 123-124 for more information about how the clinical team can help.

Immunizations (vaccines)

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

	Member costs
At a doctor's office	No member costs (you may owe a copay for the office visit)
At a travel clinic	No member costs
At a pharmacy	Covered under your prescription drug plan (pages 140-159)

✕ Restrictions:

- Unless you are pregnant, there is no coverage for blood tests (titers) to determine if you need an immunization. See **Immunization titers** on page 93.

Infertility treatment

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

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

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

The Plan provides benefits for the following procedures:

- ❑ In vitro fertilization and embryo placement (IVF-EP)
- ❑ Artificial insemination (AI), also known as intrauterine insemination (IUI)
  - Infertility diagnosis not required for this procedure
- ❑ Cryopreservation of eggs as a component of covered infertility treatment.
- ❑ Gamete intrafallopian transfer (GIFT)
- ❑ Intracytoplasmic sperm injection (ICSI) for the treatment of male factor infertility
- ❑ Natural ovulation intravaginal fertilization (NORIF)
- ❑ Preimplantation genetic testing (PGT)
- ❑ Sperm, egg and/or inseminated egg procurement and processing, from yourself or from a donor, to the extent that these costs are not covered by a donor's insurer, if any
- ❑ Zygote intrafallopian transfer (ZIFT)

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

✕ Restrictions:

- There is no coverage if the inability to conceive results from either voluntary sterilization or normal aging (menopause).
- Experimental infertility procedures are not covered.
- The Plan does not pay people to donate their eggs or sperm.
- Reversal of voluntary sterilization is not covered.

- Shipping costs, such as the cost of shipping eggs or sperm between clinics, are not covered.
- Procurement and processing of sperm, eggs, and/or inseminated eggs are covered only for the treatment of infertility.
- Infertility services provided as part of gender affirmation (reassignment) treatment (page 50) do not need to meet the definition of infertility described in this section.
- Storage fees for storing or banking sperm, eggs, and/or inseminated eggs are limited to a maximum of 12 months in storage.
- The Plan does not pay people to be surrogates (gestational carriers) for Wellpoint plan members, and there is no coverage for medical services, including in vitro fertilization, for a surrogate who is not a Wellpoint member.
- Facility fees are only covered at a licensed hospital or ambulatory surgery center.
- There is no coverage for infertility procedures that don't meet the above definition of infertility.

Inpatient medical care (hospital admissions)

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

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

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

At a hospital or rehab facility	Member costs
☎ **Inpatient medical care (semi-private room)**	$275 quarterly copay and deductible
☎ **Inpatient medical care (medically necessary private room)**	▪ **First 90 days:** $275 quarterly copay and deductible ▪ **After 90 days:** Dollar difference between the semi-private room rate and the private room rate
At a skilled nursing or long-term care facility	**Member costs**
☎ **Inpatient medical care**	Deductible and 20% coinsurance (limited to 100 days in a plan year)

Table 9 lists examples of the services and supplies covered under the benefit for inpatient care.

Table 9. Examples of covered inpatient services

Examples of covered inpatient services and supplies	
▪ Room and board	▪ Pre-admission testing
▪ Intensive care/coronary care	▪ Ancillary items and services, such as:
▪ Physician and nursing services	▫ Pasteurized donor human milk and/or donor human milk-derived products
▪ Surgery	▫ Infusions and transfusions
▪ Anesthesia, radiology and pathology	▫ Devices that are an integral part of a surgical procedure such as hip joints, skull plates and pacemakers
▪ Dialysis	▫ Drugs, medications, solutions, biological preparations, and supplies
▪ Physical, occupational and speech therapy	▫ Use of special rooms, like operating rooms
▪ Diagnostic tests, radiology and labs	▫ Use of special equipment
▪ Durable medical equipment	
▪ Medically necessary services and supplies charged by the hospital	

✕ Restrictions:

- The 100-day plan year limit 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 more than one admission.
- If a newborn is admitted to the hospital independently of the mother, it is considered a separate hospital admission and you will owe a separate inpatient copay.
- There is no coverage for custodial care. **Custodial care** is a level of care that is chiefly designed to assist with activities of daily living and cannot reasonably be expected to greatly restore health or bodily function.
- Private rooms are covered only if medically necessary.
- There is no coverage for private duty nursing.
- The Plan does not pay for donated blood.
- Convenience items such as telephone, radio and television are not covered.
- Services that are considered experimental or investigational are not covered.

- Devices that are not directly involved in the surgery, such as artificial limbs, artificial eyes or hearing aids may be covered under a different benefit, such as prosthetics.
- There is no coverage for charges for services that are not medically necessary.

☎ Notify Wellpoint about any inpatient stay.

Laboratory services (lab work)

Diagnostic lab work is covered when prescribed by a physician.

	Member costs
Diagnostic lab work	Deductible
Preventive lab work *(see Chapter 6)*	No member costs when done according to the preventive care schedule

Long-term care facilities

Long-term care facilities are specialized hospitals that treat patients who need further care for complex medical conditions but that no longer require the services of a traditional hospital. Services at long-term care facilities are covered under the benefit for inpatient care (pages 56-58).

Maternity services

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

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

✕ Restrictions:

- If a newborn is admitted to the hospital independently of the mother, it is considered a separate hospital admission and you will owe a separate inpatient copay.

☎ Maternity admissions need preapproval if the inpatient stay is longer than 2 days for vaginal delivery or 4 days for Caesarian.

Medical care outside the U.S.

The Plan covers medically necessary services you get outside of the United States. This includes medical help received on a cruise ship or other boat. Services are covered according to the provisions and limitations described in this handbook. Benefits may differ depending on the service and the provider, and not all services are covered by the Plan.

- ❑ **Emergency care** – The Plan covers emergency care anywhere in the world.
- ❑ **Elective services** – Elective services outside the U.S. are covered according to the provisions and limitations described in this handbook.

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

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

For more information on how to submit reimbursement for a foreign claim, including acceptable forms of proof of payment, refer to page 104. If your bill has information in a foreign language, please provide a translation, if possible.

Restrictions:

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

Medical services (if not listed elsewhere)

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

	Member costs
Covered medical services (if not listed elsewhere)	Deductible and 20% coinsurance

Neuropsychological (neuropsych) testing

Neuropsych testing is covered whether ordered for a medical condition or a behavioral health condition. See page 80 for coverage details.

Occupational therapy

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

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

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

Member costs	
Occupational therapy with an autism or Down syndrome diagnosis	$20 copay
☎ **All other occupational therapy**	$20 copay (preapproval required after 30 visits)

✕ Restrictions:

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

☎ Occupational therapy needs preapproval after 30 visits (except with an autism diagnosis).

Office visits

Office visits with primary care and specialty care providers are covered. See "Doctor and other medical provider services" on page 42 for coverage information.

Outpatient hospital services (if not listed elsewhere)

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

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

	Member costs
Outpatient hospital services (if not listed elsewhere)	Deductible

Oxygen

Oxygen and its administration are covered.

	Member costs
✓ **Oxygen**	▪ **Contracted suppliers:** Deductible ▪ **Non-contracted suppliers:** Deductible and 20% coinsurance

Restrictions:

- Oxygen equipment required for use on an airplane or other means of travel is not covered.

Use contracted suppliers (page 103) – Supplies from contracted suppliers are covered at 100% of the allowed amount. From non-contracted suppliers, supplies are covered at 80%, so you owe 20% coinsurance. Your deductible applies to both types of suppliers.

Find contracted suppliers at wellpoint.com/mass.

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

Palliative care

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

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

PANDAS and PANS

The Plan provides coverage for medically necessary treatment of Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-Onset Neuropsychiatric Syndrome (PANS), including the use of intravenous immunoglobulin therapy.

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

Personal Emergency Response Systems (PERS)

Installation and rental of a personal emergency response system (PERS) are covered.

	Member costs
PERS installation	Deductible and 20% coinsurance (limited to $50 in a plan year)
PERS rental	Deductible and 20% coinsurance (limited to $40 a month)

✕ Restrictions:

- There is no coverage for the purchase of a PERS unit.

Physical therapy

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

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

Physical therapy	Member costs
Physical therapy with an autism or Down syndrome diagnosis	$20 copay
☎ **All other physical therapy**	$20 copay (preapproval required after 30 visits)

Physical therapy must be:

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

✕ Restrictions:

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

☎ Physical therapy needs preapproval after 30 visits (except with an autism diagnosis).

Prescription drugs

Benefits for most prescription drugs are administered by CVS Caremark. See Part 4 of this handbook (pages 140-159) for benefits information.

☎ Certain specialty drugs need preapproval – Specialty drugs are prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis and multiple sclerosis. Specialty drugs are often high-cost and require special handling (like refrigeration during shipping) and administration (such as injection or infusion). Some specialty drugs are covered by Wellpoint and require preapproval.

Other specialty drugs are covered under your prescription drug plan. See Part 4 of this handbook for a list of (non-oncology) specialty drugs that require preapproval through your prescription drug plan.

Preventive care

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

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

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

	Member costs
Preventive care	No member costs

✕ Restrictions:

- Not all preventive healthcare services are recommended for everyone. You and your doctor should decide what care is appropriate for you.
- Claims must be submitted with the appropriate preventive diagnosis and procedure codes in order to be paid at 100%.
- Services to treat a diagnosed illness or condition may no longer be covered under the preventive benefit and may instead be billed as diagnostic.
- If you are treated for an existing illness, injury or condition during your preventive exam, you may have to pay member costs for those non-preventive services.

Prosthetics and orthotics

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

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

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

Prosthetics and orthotics	Member costs
☎ **Prosthetics and orthotics (including mastectomy bras)**	Deductible

✕ Restrictions:

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

☎ Prosthetics and orthotics need preapproval.

Pulmonary rehabilitation (rehab) programs

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

	Member costs
Pulmonary rehab programs	Deductible

A pulmonary rehab program must:

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

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

✕ Restrictions:

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

Radiation therapy

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

	Member costs
☎ **Radiation therapy**	Deductible

☎ Radiation therapy needs preapproval.

Radiology (diagnostic imaging)

Radiology, also called diagnostic imaging, is a covered service. General radiology services covered under this benefit include X-rays and ultrasounds. Benefits for high-tech (advanced) imaging are shown on page 51.

Radiology	Member costs
Emergency room	Deductible
Inpatient hospital	Deductible
Outpatient hospital and non-hospital-owned facilities	Deductible

Rehabilitation (rehab) hospitals

Rehabilitation (rehab) facilities are specialized hospitals that provide rehab services to restore basic functioning (such as walking or sitting upright) that was lost due to illness or injury. Services at rehab hospitals are covered under the benefit for inpatient care (pages 56-58).

Retail health clinics

Retail health clinics are clinics located in retail stores or pharmacies that offer basic medical services on a walk-in basis. See "Emergency care / urgent care" on pages 45-46 for coverage information.

Skilled nursing facilities

Skilled nursing facilities provide lower intensity rehab and medical services. Services at skilled nursing facilities are covered under the benefit for inpatient care (pages 56-58).

Sleep studies

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

	Member costs
☎ **Sleep studies**	Deductible

☎ **Sleep studies need preapproval.**

Speech therapy

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

	Member costs
☎ **Speech therapy**	$20 copay

Covered speech therapy services include:

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

✕ Restrictions:

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

☎ Speech therapy services need preapproval.

Surgery

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

☎ Inpatient surgery	Member costs
Facility charges	$275 quarterly copay and deductible
Surgeon fees	Deductible
☎ Outpatient surgery	**Member costs**
At a hospital	$250 quarterly copay and deductible
At a non-hospital-owned facility	▪ **Eye and GI (gastrointestinal) surgery:** $150 quarterly copay and deductible ▪ **All other outpatient surgery:** $250 quarterly copay and deductible
At a doctor's office	Deductible (you may also owe a copay for the office visit)

Reconstructive breast surgery for all stages of mastectomy are covered under this benefit. See page 172 for details.

✕ Restrictions:

- Coverage for reconstructive and restorative surgery – surgery intended to improve or restore bodily function or to correct a functional physical impairment that has been caused by either a congenital anomaly or a previous surgical procedure or disease – is limited to the following:
  - Correction of a functional physical impairment due to previous surgery or disease
  - Reconstruction of defects resulting from surgical removal of an organ or body part for the treatment of cancer. Such restoration must be within five years of the removal surgery.
  - Correction of a congenital birth defect that causes functional impairment for a minor dependent child
- Devices that are not directly involved in the surgery, such as artificial limbs, artificial eyes or hearing aids may be covered under a different benefit, such as prosthetics.
- Cosmetic services are not covered, with the exception of treatment for HIV-associated lipodystrophy and the initial surgical procedure to correct appearance that has been damaged by an accidental injury.

- Coverage for assistant surgeon services is limited, as follows:
  - The services of an assistant surgeon must be medically necessary.
  - The assistant surgeon must be a licensed provider (e.g., physician, physician assistant) acting within the scope of his or her license and trained in a surgical specialty related to the procedure.
  - The assistant surgeon serves as the first assistant surgeon to the primary surgeon during a surgical procedure.
  - Only one assistant surgeon is covered per procedure. Second and third assistants are not covered.
  - Interns, residents and fellows are not covered as assistant surgeons.

☎ Surgical services may need preapproval.

Hip and knee replacement program

Wellpoint has established a program for members needing hip or knee replacement surgery. The program is designed to better coordinate the many different medical services that hip and knee replacements require, including the surgery as well as post-surgical services. Certain member costs, such as copays and coinsurance, may be reduced or waived for members who participate.

To learn more about this program, call Wellpoint Member Services at 833-663-4176.

Tobacco cessation counseling

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

	Member costs
Tobacco cessation counseling	No member costs

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

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

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

💻 Download claim forms from wellpoint.com/mass.

Nicotine replacement products are available at no cost through the prescription drug plan, but you must have a prescription. See Part 4 of this handbook for details.

Transplants

Benefits are payable – subject to any deductible, copays, coinsurance and benefit limits – for necessary medical expenses incurred for the transplanting of a human organ. To get the highest benefit, see "Quality Centers and Designated Hospitals for transplants" below.

	Member costs
☎ **At a Quality Center or Designated Hospital for transplants**	$275 quarterly copay and deductible
☎ **At other hospitals**	$275 quarterly copay, deductible, and 20% coinsurance

A Wellpoint primary clinician is available to support you and your family before the transplant procedure and throughout the recovery period. The primary clinician will:

- ❑ Review your ongoing needs
- ❑ Help to coordinate services while you are awaiting a transplant
- ❑ Help you and your family optimize Plan benefits
- ❑ Maintain communication with the transplant team
- ❑ Facilitate transportation and housing arrangements, if needed
- ❑ Facilitate discharge planning alternatives
- ❑ Help to coordinate home care plans, if appropriate
- ❑ Explore alternative funding or other resources in cases where there is need but benefits under the Plan are limited

☎ **Transplants need preapproval** – This requirement doesn't apply to cornea transplants.

Human organ donor services

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

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

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

Quality Centers and Designated Hospitals for transplants

Wellpoint has designated certain hospitals as Quality Centers and Designated Hospitals for organ transplants. These hospitals were chosen for their specialized programs, experience, reputation and ability to provide high-quality transplant care. The purpose of this program is to facilitate the provision of timely, cost-effective, quality services to eligible members.

Transplants at Quality Centers and Designated Hospitals are covered at 100% after the copay and deductible. Transplants at other hospitals are covered at 80% after the copay and deductible. Although you have the freedom to choose any healthcare provider for these procedures, your coverage is highest when you use one of these Quality Centers or Designated Hospitals.

Go to wellpoint.com/mass for a list of designated hospitals in Massachusetts.

Travel clinics

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

	Member costs
Travel clinic visits	No member costs

Restrictions:

- Unless you are pregnant, there is no coverage for blood tests (titers) to determine if you need an immunization. See **Immunization titers** on page 93.

Urgent care

The Plan covers urgent care services. **Urgent care** refers to services you get when your health is not in serious danger but you need immediate medical attention. You can get urgent care services at various locations that offer walk-in medical care, but your member costs will vary. See "Emergency care / urgent care" on pages 45-46 to find out about the different types of providers that offer urgent care services.

Virtual care (telehealth)

Virtual care (also called **telehealth**) refers to provider visits that are conducted using electronic communication methods instead of in a face-to-face meeting. Both telephone calls and video communications with providers are considered virtual care. Virtual care is covered just like in-person, face-to-face visits.

Telehealth companies offer virtual care with licensed medical and/or behavioral health providers. **LiveHealth Online** is Wellpoint's preferred telehealth provider. You can quickly connect with LiveHealth Online through the Sydney mobile app.

See "Doctor and other medical provider services" on page 42 for coverage information.

Walk-in clinics

Walk-in clinics are sites that offer medical care on a walk-in basis, so no appointment is needed. See “Emergency care / urgent care” on pages 45-46 for information about the different types of walk-in clinics.

Wigs

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

	Member costs
Wigs	20% coinsurance

Restrictions:

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

Chapter 5: Covered behavioral health services

Summary of covered behavioral health services

Table 10. Summary of costs for behavioral health services

Important! To be covered, services must be medically necessary. Benefits are limited to the Plan's allowed amounts for the services (page 23).

Service	Member costs with contracted providers	Member costs with non-contracted providers	See page
☎ **Applied Behavior Analysis (ABA)**	$20 copay	Deductible and 20% coinsurance	73
☎ **Inpatient care**			76
▪ Facility charges	$275 quarterly copay and deductible	Deductible and 20% coinsurance	
▪ Professional services	No member costs	Deductible and 20% coinsurance	
Medication-assisted treatment (MAT)	No member costs	No member costs	78
Mobile Crisis Intervention (MCI)	No member costs	No member costs	75
☎ **Outpatient services**	$20 copay	Deductible and 20% coinsurance	78
Substance use disorder assessment / referral	No member costs	No member costs	81
Therapy (outpatient)	$20 copay	Deductible and 20% coinsurance	81
Virtual care (telehealth)	$20 copay *You don't owe a copay for your first three visits.*	Deductible and 20% coinsurance	81

About behavioral health services

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

As a Total Choice member, you can get services from any appropriately-licensed behavioral health provider. However, **contracted providers** – those who have a contract with Carelon Behavioral Health to provide services to Wellpoint members – have agreed to accept Wellpoint's payment as payment in full. This means they won't balance bill Wellpoint members. In addition, you won't owe any coinsurance when you use contracted providers.

Important! When you choose to use a non-contracted provider, you can be balance billed for charges over the allowed amount (that is, above the amount the Plan paid), whether you get the services in Massachusetts or out of state. See pages 23-24 for information about balance billing protection.

Your behavioral health benefits cover services to treat mental health and substance use disorders. These benefits include coverage for:

- ❑ Applied Behavior Analysis (ABA)
- ❑ Autism spectrum disorder
- ❑ Emergency care
- ❑ Inpatient care
- ❑ Medication-assisted treatment (MAT)
- ❑ Outpatient services
- ❑ Substance use disorder assessments / referrals
- ❑ Therapy
- ❑ Virtual care (telehealth)

Applied Behavior Analysis (ABA)

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

	With contracted providers	With non-contracted providers
☎ **Applied Behavior Analysis (ABA)**	$20 copay	Deductible and 20% coinsurance

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

✕ Restrictions:

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

☎ Applied Behavior Analysis (ABA) may need preapproval – Your provider should contact Wellpoint if you will be having ABA services. See the list of behavioral health preapproval requirements on pages 27-28.

Autism spectrum disorders

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

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

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

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

Community Behavioral Health Center — Mobile Crisis Intervention

Important! Always seek emergency care if you (or someone covered under your Plan) present a significant risk to yourself or others. In a life-threatening emergency, go to the closest emergency room (see pages 45-46 for benefits information). If you call Wellpoint seeking non-life threatening emergency care, Wellpoint will connect you with appropriate services within six hours.

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

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

If you or a family member are experiencing a mental health or substance use disorder crisis and feel like you need help within one hour, you can call 877-382-1609. Listen to the message and enter your ZIP code. Your call will be automatically transferred 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 going to a hospital emergency department.

You can go to a CBHC, or help can come to you. This is called **Mobile Crisis Intervention (MCI)**. MCI is for adults and for youth. MCI provides crisis assessment, intervention, and stabilization services. Instead of going to the emergency room, you can get these services in your home or at other locations in the community.

MCI services are available to people of all ages.

Visit www.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.

	With contracted providers	With non-contracted providers
Mobile Crisis Intervention (MCI)	No member costs	No member costs

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

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

Behavioral Health Help Line

The Massachusetts Behavioral Health Help Line (BHHL) is here to connect you directly to clinical help, when and where you need it. Even if you're not sure what kind of help or treatment you may need, we can help guide you.

- ❑ It's free, confidential, and no health insurance is required.
- ❑ Real-time interpretation is available in 200+ languages.
- ❑ If you have hearing problems, you can contact MassRelay at 711 or use the video relay or caption provider of choice. Your messages will be relayed to a BHHL staff member, and their responses will be typed back to you.

The BHHL connects individuals and families to the full range of treatment services for mental health and substance use offered in Massachusetts, including outpatient, urgent, and immediate crisis care. Call for real-time support, initial clinical assessment, and connection to the right evaluation and treatment.

The BHHL is available 24 hours a day, 365 days a year. Call or text 833-773-2445 or chat online at masshelpline.com.

☎ **Notify Wellpoint if you're admitted to the hospital from the emergency room** – Your provider should notify Wellpoint within 24 hours of your admission.

Inpatient behavioral health care (hospital admissions)

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

☎ Inpatient services	With contracted providers	With non-contracted providers
Facility charges	$275 quarterly copay and deductible	Deductible and 20% coinsurance
Professional services	No member costs	Deductible and 20% coinsurance

Table 11 lists the services and programs covered under this benefit.

Table 11. Behavioral health inpatient services

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

✕ Restrictions:

- There's no coverage for non-acute residential treatment. Examples of such treatment include:
  - Clinically-managed, low-intensity residential services
  - Clinically-managed, population-specific, high-intensity residential services
  - Recovery residences
  - Sober homes

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

☎ **Behavioral health inpatient services may need preapproval** – Your provider should notify Wellpoint when you get behavioral health inpatient services. See the list of behavioral health preapproval requirements on pages 27-28.

Medication-assisted treatment (MAT)

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

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

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

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

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

Outpatient services

The Plan covers medically necessary services to treat mental health and substance use disorder conditions that don't require an inpatient hospital admission or overnight stay. **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.

	With contracted providers	With non-contracted providers
☎ **Outpatient services**	$20 copay	Deductible and 20% coinsurance

Table 12 lists the outpatient services covered under this benefit.

Table 12. Behavioral health outpatient services

Outpatient service	Description
Acupuncture withdrawal management (detox)	The use of acupuncture to ease the symptoms of drug or alcohol withdrawal
Community Behavioral Health Center (CBHC) core services	Outpatient programs offering 24/7 crisis intervention, outpatient mental health and substance use disorder treatment, care coordination, and community-based support services. Integrated care for individuals of all ages.
Community support programs (CSP)	Programs to help members access and use behavioral health services
Day treatment	Behavioral health programs offering structured, goal-oriented treatment that focuses on improving one's ability to function in the community
Dialectical behavioral therapy (DBT)	A combination of therapies designed to help change unhealthy behaviors and treat people suffering from behavioral health disorders
Electroconvulsive therapy (ECT)	Psychiatric treatment in which seizures are electrically induced in patients to provide relief from mental disorders
Family stabilization teams (FST)	Programs offering intensive services in the home to help children, adolescents and their families deal with complex life stressors
Family support and training	Peer support to help caregivers navigate the system and access services on behalf of a child with serious emotional disturbance
In-home behavioral services	Specialized behavior management therapy and monitoring provided in the home setting for youth members
Intensive care coordination	Coordination of services for members when multiple services and systems are involved
Intensive outpatient programs (IOP) ▪ For mental health ▪ For substance use disorder [ASAM level 2.1]	Programs that offer thorough, regularly-scheduled treatment in a structured environment. These programs offer at least three hours of therapy a day, up to seven days a week
Medication management	The long-term prescribing of medication as an alternative to the opioid on which a member was dependent. This treatment is usually dispensed through **opiate treatment programs (OTP)** that are licensed to distribute and administer these medications. Medication management also includes **ambulatory withdrawal management**, more commonly known as **outpatient detox**. Ambulatory withdrawal management is a drug or alcohol withdrawal process in which a member has daily visits with a provider throughout withdrawal.
Mobile Crisis Intervention (MCI)	Emergency service program providing a short-term, mobile, on-site, face-to-face therapeutic response to youth experiencing a behavioral health crisis

Outpatient service	Description
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 (PHP) ▪ For mental health ▪ For substance use disorder [ASAM level 2.5]	Non-residential, structured outpatient psychiatric and substance use programs that are more intensive than one would get in a doctor's office, but that are an alternative to inpatient care. These programs offer at least five hours of therapy a day, up to seven days a week.
Psychiatric visiting nurse (VNA) services	Short-term treatment delivered in the home or living environment to treat behavioral health disorders with medication
Psychological testing	Standardized assessment tools to diagnose and assess overall psychological functioning
Structured outpatient addictions programs (SOAP)	Non-residential, structured substance use disorder programs that are more intensive than one would get in a doctor's office, but that are an alternative to inpatient care. These programs offer at least three hours of therapy a day, up to seven days a week.
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)	A non-invasive method of brain stimulation used to treat major depression

✕ Restrictions:

- There's no coverage for treatment performed in a non-conventional setting. Examples of non-conventional settings include:
  - Spas or resorts
  - Therapeutic or residential schools
  - Educational, vocational, or recreational locations
  - Day care or preschools
  - Outward Bound
  - Wilderness, camp or ranch programs
- If you have more than one outpatient service from the same provider on the same day, you only owe one copay.

☎ Behavioral health outpatient services may need preapproval – Your provider should contact Wellpoint if you will be having outpatient services for a behavioral health condition. See the list of behavioral health preapproval requirements on pages 27-28.

Substance use disorder assessment / referral

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

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

Therapy (outpatient)

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

	With contracted providers	With non-contracted providers
Therapy	$20 copay	Deductible and 20% coinsurance

Restrictions:

- If you have more than one type of therapy on the same day and from the same provider, you only owe one copay.
- Family and individual therapy must be conducted in a provider's office, a facility or, if appropriate, at a member's home.
- Group therapy sessions must be 50 minutes or less.

Virtual care (telehealth)

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

	With contracted providers	With non-contracted providers
Virtual care (telehealth)	$20 copay *You don't owe a copay for the first three visits.*	Deductible and 20% coinsurance

Chapter 6: Covered preventive services

The Plan covers preventive or routine office visits, physical exams, and other related preventive services listed in Table 13. Covered preventive services include those services recommended by the U.S. Preventive Services Task Force (USPSTF) as part of the Patient Protection and Affordable Care Act (PPACA), 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. The table also shows gender, age, and frequency recommendations.

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

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

Table 13. Preventive care schedule

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

	Recommendations			
Preventive service	**Males**	**Females**	**Age**	**How often?**
Colorectal cancer screening – Includes colonoscopies, fecal occult blood testing, and other related services and tests Colonoscopies for members under 45 are covered under limited circumstances (see page 88) ☎ Virtual colonoscopies need preapproval	■	■	45 and older	▪ Every 5 years (60 months) ▪ Every 12 months for fecal occult blood test
Depression screening – Includes screening for perinatal depression (during and after pregnancy)	■	■		
Developmental and behavioral screening	■	■		Part of the preventive exam for children
Diabetes screenings: ▪ Type 2 diabetes ▪ Gestational diabetes in pregnant women	■	■		Part of the preventive exam
Domestic violence screening		■		For women of childbearing age; part of the preventive exam
Drug use screening	■	■		Part of the preventive exam
Falls prevention – Vitamin D counseling and/or physical therapy	■	■	65 and over	For at-risk community-dwelling adults; counseling is part of the preventive exam
Fluoride supplements – Starting at the age of primary tooth eruption	■	■	Up to age 5	
Folic acid supplements – To help prevent birth defects		■		Subject to your prescription drug benefit
Gonorrhea preventive medication	■	■	At birth	For newborns
Gonorrhea screening		■		Every 12 months
Gynecological exams		■		Every 12 months
Hearing screening	■	■	At birth	For newborns
Height, weight and body mass index (BMI) measurements	■	■		Part of the preventive exam
Hepatitis B screening and/or titers	■	■		
Hepatitis C screening	■	■		
HIV Pre-Exposure Prophylaxis (PrEP) – Includes medications, testing, monitoring, and adherence counseling	■	■		Medications subject to your prescription drug benefit
HIV screening – For the virus that causes AIDS	■	■		

	Recommendations			
Preventive service	**Males**	**Females**	**Age**	**How often?**
HPV (human papillomavirus) testing – For cervical cancer		■	30 and older	Every 5 years for women with normal cytology results
Hypothyroidism screening	■	■	At birth	For newborns
Immunizations	■	■		
Iron supplements for anemia	■	■	6 to 12 months	For at-risk babies
Lab tests – Other covered screening lab tests: ▪ Hemoglobin ▪ Urinalysis ▪ Chemistry profile, including: ▫ Complete blood count (CBC) ▫ Glucose ▫ Blood urea nitrogen (BUN) ▫ Creatinine transferase alanine amino (SGPT) ▫ Transferase asparate amino (SGOT) ▫ Thyroid stimulating hormone (TSH)	■	■		Part of the preventive exam
Lead exposure screening	■	■		For children
Lung cancer scan – CT lung scan for adults who have smoked	■	■	50-80 years	Every 12 months
Mammograms – Screening for breast cancer		■	35 and older	▪ Once between the ages of 35 and 40 ▪ Yearly after age 40
Nutritional counseling	■	■		For children at high risk of obesity
Obesity screening and counseling	■	■		Part of the preventive exam
Oral health assessment	■	■		Part of the preventive exam for children
Pap smears – Screening for cervical cancer		■		Every 12 months
Phenylketonuria (PKU) screening	■	■	At birth	For newborns
Preeclampsia screening and prevention		■		During pregnancy; part of the preventive exam

	Recommendations			
Preventive service	**Males**	**Females**	**Age**	**How often?**
Preventive exams (children)	■	■	Up to age 19	▪ Four exams while the newborn is in the hospital ▪ Five exams until 6 months of age; then ▪ Every two months until 18 months of age; then ▪ Every three months from 18 months of age until 3 years of age; then ▪ Every 12 months from 3 years of age until 19 years of age
Preventive exams (adults)	■	■	19 and older	Every 12 months
Prostate cancer screening – Digital rectal exam and PSA test	■		50 and older	▪ Digital exam – Part of the preventive exam ▪ PSA test – Every 12 months
Rh incompatibility screening		■		For pregnant women
Sexually transmitted infections (STI) counseling	■	■		Part of the preventive exam
Sickle cell disease screening	■	■	At birth	For newborns
Skin cancer behavioral counseling	■	■		Part of the preventive exam
Syphilis screening	■	■		
Tobacco use counseling and interventions	■	■		▪ Counseling – Part of the preventive exam ▪ Drugs and deterrents – Subject to your prescription drug benefit
Tuberculosis screening	■	■		
Urinary tract infections (UTI) screening – Asymptomatic bacteriuria		■		During pregnancy
Vision screening	■	■		Part of the preventive exam for children
Vision screening (instrument-based)	■	■	3-5 years	

Part 3:

Using Your Plan

Plan and coverage details

For questions about any of the information in Part 3 of this handbook, please call Wellpoint Member Services at 833-663-4176.

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Wellpoint

Chapter 7: Excluded and limited services

This chapter lists services and supplies that are not covered or have limited or restricted coverage under the 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 the 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	No coverage for the removal of acne cysts, injections to raise acne scars, cosmetic surgery, dermabrasion or similar services. Services to diagnose or treat the underlying condition causing the acne are covered.
Acupuncture	Covered only as a behavioral health service when acupuncture is used as part of alcohol or drug withdrawal management
Allowed amounts	No coverage for charges over the Plan's allowed amounts
Alternative treatments	No coverage for alternative treatments that are used in place of conventional medicine, as defined by the National Center for Complementary and Integrative Health (National Institutes of Health)
Ambulances	▪ All ambulance transportation must be medically necessary and must take you to the nearest appropriate hospital or facility. ▪ There is no coverage for transportation that is primarily for the convenience of the individual, individual's family, or physician. ▪ Transfers to a hospital that you prefer (e.g., to be closer to home) are not covered. ▪ Transportation in chair cars or vans is not covered. ▪ The following restrictions apply to emergency transportation: ▫ Based on the severity of your condition, no other form of transportation can safely transport you to the nearest facility. ▫ Air or water ambulance is covered only when your medical condition is such that your health would be endangered by the time needed for ground transportation. ▫ Emergency inter-facility transportation to the nearest appropriate facility may be necessary when your current facility is unable to treat your condition and the treatment is considered a medical emergency. ▪ Non-emergency ground transportation may be covered if it is medically necessary and your medical condition is such that no other form of transportation is viable. Non-emergency ambulance transportation requires preapproval.

Service	What is not covered or has limited coverage
Anesthesia for behavioral health services	Covered for electroconvulsive therapy (ECT) only
Animals	No coverage for expenses related to service animals, pet therapy, or hippotherapy (therapeutic or rehabilitative horseback riding)
Arch supports (e.g., Dr. Scholl's inserts)	Not covered
Assistant surgeons	▪ An assistant surgeon must be a licensed provider (e.g., physician, physician assistant) acting within the scope of his or her license. ▪ Only one assistant surgeon per procedure is covered. Second and third assistants are not covered. ▪ Interns, residents, and fellows are not covered as assistant surgeons.
Athletic trainers	Not covered
B	
Beds / bedding	No coverage for non-hospital beds, orthopedic mattresses, or weighted blankets
Behavioral health services	▪ Primary care visits associated with a behavioral health diagnosis are covered. Otherwise, there is no coverage for the diagnosis, treatment or management of mental health/substance use disorder conditions by medical (non-behavioral health) providers. ▪ No coverage of services for conditions that are not classified in the most current edition of the *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) ▪ Other non-covered behavioral health services include: ▫ Services not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance use disorder ▫ Services not consistent with prevailing national standards of clinical practice for the treatment of such conditions ▫ Services not consistent with prevailing professional research which would demonstrate that the service or supplies will have a measurable and beneficial health outcome ▫ Services that typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; or that are consistent with appropriate level-of-care clinical criteria, clinical practice guidelines or best practices as modified from time to time.
Biofeedback	Not covered to treat behavioral health conditions
Blood	The Plan does not pay for donated blood
Blood pressure cuffs (sphygmomanometers)	Not covered

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 / vans	No coverage for transportation in chair cars or vans
Chiropractic care	▪ Group chiropractic care is not covered. ▪ Services provided by a chiropractor are considered chiropractic care, not physical therapy.
Chronic conditions	There is no coverage for physical therapy, occupational therapy or speech therapy to treat a chronic condition when that treatment is neither curative nor restorative
Clinical trials for treatments other than cancer	No coverage for any clinical research trial other than a qualified clinical trial for the treatment of cancer (pages 37-38)
Cognitive rehabilitation	Not covered, except as related to COVID-19 **Cognitive rehabilitation** is treatment to restore function or minimize effects of cognitive deficits including, but not limited to, those related to thinking, learning, and memory.
Colonoscopies for people under age 45	Covered as a preventive service only under limited circumstances, based on clinical review of family and personal history
Computer-assisted communications devices	Not covered
Convenience items	No coverage for convenience items used during a hospital stay, such as telephones, television, computers, and beauty or barber services
Cosmetic services	No coverage for cosmetic procedures or services except for: ▪ Treatment for HIV-associated lipodystrophy ▪ The initial surgical procedure to correct appearance that has been damaged by an accidental injury Cosmetic services are not covered even if they are intended to improve a member's emotional outlook or treat a member's mental health condition. **Cosmetic services** are services done mainly to improve appearance. They don't restore bodily function or correct functional impairment.
Coverage under another plan or program	No coverage for services provided under another plan, or services that federal, state, or local law mandates must be provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.
Custodial care	Not covered **Custodial care** is a level of care that is chiefly designed to assist with activities of daily living and that cannot reasonably be expected to greatly restore physical health or bodily function.

Service	What is not covered or has limited coverage
D	
Dialysis	No coverage for dialysis to treat a behavioral health condition
Dental care	The Plan does not provide benefits for dental care. Medical services that include treatment related to dental care are covered in certain situations (page 39).
Dentures, dental prosthetics, and related surgery	Not covered
Driving evaluations	Not covered
Drugs – Non-oncology infused	Dispensed by the prescription drug plan and require prior review (Part 4 of this handbook).
Drugs – Off-label	Not covered unless the off-label use meets the Plan's definition of medical necessity or the drug is specifically designated as covered by the Plan. **Off-label** use is the use of a drug for a purpose other than that approved by the FDA.
Drugs – Over-the-counter	Not generally covered and never covered without a prescription. Some over-the-counter drugs, such as tobacco cessation products, are covered by the prescription drug plan when you have a prescription (Part 4 of this handbook).
Drugs – Specialty	Some specialty drugs are covered by Wellpoint and must be preapproved. Preapproval is described on pages 25-28. Other self- or office-administered specialty drugs are dispensed under the prescription drug plan (Part 4 of this handbook). **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 (redundant) services	No coverage for multiple charges for the same service or procedure, on the same date A service is considered **duplicate (redundant)** when the same service is being provided, at the same time, to treat the condition for which it is ordered.

Service	What is not covered or has limited coverage
Durable medical equipment (DME)	Only medically necessary equipment is covered. Types of equipment that are not covered include: ▪ Equipment intended for athletic or recreational use (e.g., exercise equipment, wheelchairs for sports) ▪ Items intended for environmental control or a home modification (e.g., bathroom items, electronic door openers, air cleaners, dehumidifiers, elevators, ramps, stairway lifts) ▪ Added, non-standard features or accessories (e.g., hand controls for driving, transit systems that secure wheelchairs in moving vehicles, wheelchair customizations) ▪ Items specifically designed to be used outdoors (e.g., special wheelchairs for beach access, equipment for use on rough terrain) ▪ Items that serve as backup by duplicating other equipment (e.g., a manual wheelchair as backup for a powered wheelchair) ▪ Equipment upgrades or replacements for items that function properly or that can be repaired
E	
Ear molds	Not covered except when needed for hearing aids for members age 21 and under
Enteral/oral therapy	Prescription and nonprescription enteral/oral formulas are covered only when ordered by a physician for the medically necessary treatment of malabsorption disorders caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. **Enteral therapy** is prescribed nutrition that is administered through a tube that has been inserted into the stomach or intestines. **Oral therapy** is administered by mouth.
Equipment transportation and set-up	No coverage for costs associated with transporting and setting up equipment, such as portable X-ray equipment.
Exercise / recreational equipment	No coverage for equipment intended for athletic or recreational use (e.g., exercise equipment, wheelchairs for sports).
Experimental or investigational services or supplies	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. The fact that a physician ordered it, or that this treatment is being tried after others have failed, does not make it medically necessary.
Eyeglasses and contact lenses	▪ Only covered within six months after an eye injury or cataract surgery ▪ Coverage applies to the initial lenses only ▪ No coverage for deluxe frames or specialty lenses such as progressive or transitional lenses, tinted lenses, anti-reflective coating or polycarbonate lenses

Service	What is not covered or has limited coverage
F	
Facility fees	Not covered for office visits or behavioral health office services.
Family members	No coverage for services received from someone who is in your immediate family. Your immediate family consists of you, your spouse and your children, as well as the brothers, sisters and parents of both you and your spouse. This includes any services that providers perform on themselves.
Fees for non-medical services	Fees for non-medical services are not covered. Some examples of these types of fees include: ▪ Day care services ▪ Food services (e.g., diet programs) ▪ Lab handling fees ▪ Membership and joining fees (e.g., Weight Watchers), with the exception of the fitness reimbursement ▪ Record processing fees, unless required by law ▪ Shipping costs (e.g., the cost of shipping eggs or sperm between fertility clinics) ▪ Storage fees ▪ Transportation and set-up costs (e.g., portable X-ray equipment)
Fitness reimbursement	▪ Any family member may have the fitness membership, but the reimbursement is paid to the plan enrollee only. ▪ You must participate in physical activity an average of four times or more per month. ▪ Ineligible costs include beach or country club memberships or dues; fees for one-day events; annual or day passes (such as for skiing); spas or spa services; personal or home fitness equipment.
Free or no-cost services	▪ No coverage for any medical service or supply that wouldn't have cost anything if there was no medical insurance ▪ No coverage for services that you have no legal responsibility to pay
G	
Genetic testing for behavioral prescribing	Not covered
Government programs	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	There is no coverage for: ▪ Group chiropractic care ▪ Group occupational therapy ▪ Group physical therapy
H	
Hearing aids	▪ Over-the-counter (OTC) hearing aids are not covered ▪ Hearing aid batteries are not covered
Herbal medicine	Not covered
Home modifications or environmental controls	No coverage for items intended for environmental control or home modification such as bathroom items, electronic door openers, air cleaners, dehumidifiers, elevators, ramps, and stairway lifts
Homemaking services	Not covered
Homeopathic / holistic / naturopathic care	Not covered
Household residents	No coverage for services received from anyone who shares your legal residence
Hypnotherapy	Not covered
I	
Immunization titers	Covered for pregnant women only **Immunization titers** are lab tests performed to determine if a person has had a vaccination.
Incontinence supplies	Not covered
Infertility treatment	▪ Experimental infertility procedures are not covered. ▪ The Plan does not pay people to donate their eggs or sperm. ▪ Reversal of voluntary sterilization is not covered. ▪ Shipping costs, such as the cost of shipping eggs or sperm between clinics, are not covered. ▪ Procurement and processing of sperm, eggs, and/or inseminated eggs are covered only for the treatment of infertility. ▪ Storage fees for storing or banking sperm, eggs, and/or inseminated eggs are limited to a maximum of 12 months in storage. ▪ The Plan does not pay people to be surrogates (gestational carriers) for Wellpoint plan members, and there is no coverage for medical services, including in vitro fertilization, for a surrogate who is not a Wellpoint member.

Service	What is not covered or has limited coverage
Intraocular lenses (IOLs)	Monofocal intraocular lenses (IOLs) are covered when implanted in the eye after the removal of cataracts. Presbyopia-correcting IOLs, which restore vision in a range of distances, are not covered. Multifocal IOLs and accommodating IOLs are presbyopia-correcting IOLs and are also not covered.
L	
Lift / riser chairs	Not covered
Light boxes	Covered only for treatment of skin conditions
Long-term maintenance care and long-term therapy	Not covered
M	
Massage therapy	No coverage for massage therapy or any other services from a massage therapist or neuromuscular therapist
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	There is 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 confined in the same hospital ▪ Covered preventive care provided by a hospital or doctor (Chapter 6) ▪ A service or supply that qualifies as covered hospice care (page 53)
Medical orders	There is no coverage for any service or supply that has not been recommended and approved by a physician. All covered services and supplies need a medical order from a physician.
Military service or wartime injuries	No coverage for services to treat a condition that was the result of war (declared or undeclared), or service in the armed forces of any country if you are legally entitled to other benefits (such as through the Veterans Administration)
Missed appointments	Not covered
N	
Narconon treatment and facilities	Not covered
Newborn admissions	If a newborn is admitted to the hospital independently of the mother, it is considered a separate hospital admission and you will owe a separate inpatient copay.

Service	What is not covered or has limited coverage
Non-conventional behavioral health treatments	No coverage for non-conventional behavioral health treatments. Examples of non-conventional treatments include: ▪ Aversive or counter-conditioning ▪ Brain imaging or mapping to diagnose behavioral health disorders ▪ Hemodialysis ▪ Olfactory/gustatory release ▪ Primal therapy ▪ Prometa (GABASYNC) treatment protocol ▪ Rolfing ▪ Structural Integration
Non-conventional treatment settings	No coverage for treatment performed in a non-conventional setting. Examples of non-conventional settings include: ▪ Spas or resorts ▪ Therapeutic or residential schools ▪ Educational, vocational, or recreational locations ▪ Day care or preschools ▪ Outward Bound ▪ Wilderness, camp or ranch programs
Non-covered services and associated services	Non-covered services include those for which there is no benefit and those that the Plan has determined to be not medically necessary. If a service is not covered by the Plan, any associated services are also not covered. For example, anesthesia and facility fees associated with a non-covered surgery are not covered.
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: ▪ Dietary and food supplements that are administered orally, and related supplies ▪ Nutritional supplements to boost caloric or protein intake, including sport shakes, puddings and electrolyte supplements

Service	What is not covered or has limited coverage
O	
Occupational therapy	No coverage for group occupational therapy
Orthodontic treatment	Not covered
Orthopedic mattresses	Not covered
Orthotics	No coverage for temporary or trial orthotics, video tape gait analysis, diagnostic scanning, or arch supports
Oxygen equipment for travel	No coverage for oxygen equipment required for use on an airplane or other means of travel
P	
Park admissions	No coverage for admissions fees to national parks or preserves
Pastoral counselors	Covered for bereavement counseling, or when required by law
Personal items	No coverage for personal items that could be purchased without a prescription (e.g., air conditioners, arch supports, bed pans, bathroom items, blood pressure cuffs, commodes, computer-assisted communications devices, corrective shoes, heating pads, hot water bottles, incontinence supplies, lift or riser chairs, non-hospital beds, orthopedic mattresses, shower chairs, telephones, televisions, thermal therapy devices, whirlpools)
Physical therapy	▪ No coverage for certain therapy services including, but not limited to: acupuncture, aerobic exercise, craniosacral therapy, diathermy, infrared therapy, kinetic therapy, microwave therapy, paraffin treatment, Rolfing therapy, Shiatsu, sports conditioning, ultraviolet therapy, and weight training. ▪ No coverage for group physical therapy
Private duty nursing	Not covered
Programs with multiple services	No coverage for programs that provide multiple services but that bill at a single, non-itemized rate (for example, a daily fee for a full-day rehab program). Itemized bills are always required.
Providers	▪ No coverage for services from providers who have been sanctioned ▪ No coverage for services from unlicensed providers ▪ No coverage for services outside the scope of a provider's license
R	
Reiki therapy	Not covered **Reiki** is a hands-on energy-based therapy.
Religious facilities	No coverage for services received at non-medical religious facilities

Service	What is not covered or has limited coverage
Residential treatment for behavioral health services	No coverage for non-acute residential treatment. Examples of such treatment include: ▪ Clinically-managed, low-intensity residential services ▪ Clinically-managed, population-specific, high-intensity residential services ▪ Recovery residences ▪ Sober homes
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 (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 are not covered, in accordance with Department of Public Health (DPH) regulations. Massachusetts providers are not permitted to 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 purchased to accommodate 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 / 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 stimulator ▪ Fischer Wallace neurostimulators ▪ Vagus nerve stimulation
Storage for blood / bodily fluids	No coverage for the storage of autologous blood donations or other bodily fluids or specimens, except when done in conjunction with a scheduled covered procedure
Surface electromyography (SEMG)	Not covered

Service	What is not covered or has limited coverage
T	
Therapy (behavioral health)	▪ Group therapy sessions must be 50 minutes or less ▪ Family and individual therapy must be conducted in a provider's office, a facility or, if appropriate, at a member's home
Thermal therapy	No coverage for any type of thermal therapy, including the application or purchasing of hot packs, cold packs or continuous thermal therapy devices
Third parties	No coverage for any medical supply or service (such as a court-ordered test or an insurance physical) that is required by a third party but is not otherwise medically necessary. Other examples of a third party are an employer, an insurance company, a school, a court or a sober living facility.
TMJ (temporomandibular joint) disorder	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.
Tobacco cessation counseling	Counseling is also covered as part of your preventive exam.
Transportation to/from appointments	Transportation to the place where you will be receiving hospice services is covered. Non-emergency ground transportation may be covered if it is medically necessary and your medical condition is such that no other form of transportation is viable. Non-emergency 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 (visual acuity problems). Non-covered services include orthoptics for vision correction, radial keratotomy, and other laser surgeries. Refractive errors include astigmatism, myopia (near-sightedness), hyperopia (far-sightedness), and presbyopia (aging-related blurry vision).
W	
Weight loss	▪ Physician services for weight loss treatment are limited to members whose body mass index (BMI) is 40 or more while under the care of a physician. Any such treatment is subject to periodic review. ▪ No coverage for residential inpatient weight loss programs ▪ No coverage for membership fees and food items used to participate in a commercial weight loss program
Wheelchair transit systems	No coverage for transit systems used to secure wheelchairs in moving vehicles.
Wigs	Not covered for any purpose other than the replacement of hair loss resulting from treatment of any form of cancer or leukemia

Service	What is not covered or has limited coverage
Worker's 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.

Chapter 8: About your plan and coverage

Types of healthcare providers

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

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

Primary care providers (PCPs)

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

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

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

Specialists

Specialists, also called **specialty care providers**, are physicians, nurse practitioners and physician assistants who focus on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. As a Wellpoint member, you don't need a referral to see a specialist.

Behavioral health providers

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

Some behavioral health providers are contracted with Carelon Behavioral Health to provide services to Wellpoint members. You have lower copays when you use these **contracted behavioral health providers**. Contracted providers have gone through a credentialing process and must adhere to the quality standards that Wellpoint requires.

Important! Wellpoint's payments to all behavioral health providers are subject to the allowed amount for the claim. Contracted providers accept allowed amounts as payment in full and will not balance bill you. Non-contracted providers, both in Massachusetts and elsewhere, may balance bill you for charges over the allowed amount (that is, above the amount the Plan paid). See pages 23-24 for information about balance billing protection.

Wellpoint will only pay claims from 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 provider. This is true for both contracted and non-contracted behavioral health providers. In Massachusetts, the Department of Public Health (DPH) issues licenses to Massachusetts facilities that provide healthcare services. To be licensed, facilities must meet specific quality and safety standards.

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

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 what type of inpatient facility you go to and the type of care you get, as described in Table 15. See pages 56-58 for coverage details.

Table 15. Types of inpatient facilities

Facility	What this type of facility provides
Acute care hospitals	Medical centers and community hospitals that provide treatment for severe illness, conditions caused by disease or trauma, and recovery from surgery. These hospitals deliver intensive, 24-hour medical and nursing care.
Rehabilitation (rehab) facilities	Specialized hospitals that provide rehab services to restore basic functioning (such as walking or sitting upright) that was lost due to illness or injury. Patients in these facilities have a good potential for recovery and are able to participate in a rehab program that includes therapy services for three to five hours a day.
Long-term care facilities	Specialized hospitals that treat patients who need further care for complex medical conditions but that no longer require the services of a traditional hospital. These patients' needs are mostly medical and their ability to participate in rehab is limited.

Facility	What this type of facility provides
Skilled nursing facilities	Provide lower intensity rehab and medical services. Patients in these facilities have continuing medical needs that require skilled nursing care, but do not need daily physician care. Some of these patients may or may not require rehab, while others may need long-term custodial care. The Plan does not cover custodial care.

Non-hospital-owned facilities

Non-hospital-owned facilities are independent, stand-alone offices that perform outpatient medical services but that aren't owned and operated by a hospital. Facilities that can be either hospital-owned or non-hospital-owned include:

- ❑ Ambulatory surgery centers
- ❑ Walk-in clinics, such as urgent care centers (see "Walk-in clinics", below)
- ❑ Specialized health facilities, such as imaging centers (see "Specialized health facilities" on page 104)

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 costs you may not expect.

For example, if you have outpatient eye or GI surgery at an independent ambulatory surgery center, you'll owe a $150 copay. But if the facility is owned by and bills as a hospital, you'll owe a $250 copay.

Important! 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. Before you use a facility, you may want to ask how your visit will be billed. How your visit is billed determines how much you owe.

Walk-in clinics

Important! Before you use a walk-in clinic, you may want to find out if your visit will be billed as a hospital service. See "Non-hospital-owned facilities" (above) for why this is important.

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

Table 16. Types of walk-in clinics

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

Virtual care (telehealth) through LiveHealth Online

LiveHealth® Online is a telehealth company that offers virtual care with licensed medical and/or behavioral health providers. Using your smartphone, tablet, or computer, you can consult 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.

Access LiveHealth Online from the Sydney Health app or at livehealthonline.com.

Contracted suppliers

Contracted suppliers have contracted with Wellpoint to accept the Plan's allowed amounts for the services listed below. In this handbook, the **checkmark** ✓ identifies services with a contracted supplier benefit.

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

Services from contracted suppliers are covered at 100% of the allowed amount. **Non-contracted suppliers** are covered at 80%, so you'll owe 20% coinsurance (and your deductible, if it applies). In addition, non-contracted suppliers outside of Massachusetts can balance bill you for charges over the allowed amount. Since the Plan doesn't cover balance bills, payment is your responsibility.

Note that federal law prohibits non-contracted suppliers from sending you surprise balance bills. See pages 23-24 for information about surprise billing protection.

Find contracted suppliers at wellpoint.com/mass.

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

Specialized health facilities

Specialized health facilities are independent, freestanding centers that provide a variety of medical services. There are four kinds of specialized health facilities:

- ❑ Dialysis centers
- ❑ Fertility clinics
- ❑ Imaging centers
- ❑ Sleep study centers

Services at specialized health facilities often cost less than at hospitals, and you may save on your member costs too. Be aware, however, that facilities owned and operated by hospitals are hospital sites, not specialized health facilities. The presence of a hospital name indicates that the site is part of a hospital, not an independent facility. See "Non-hospital-owned facilities" on page 102 for why this may be important.

Contracted providers

Contracted providers are healthcare providers – such as doctors, hospitals, and health facilities – who have agreed to accept the Plan's payment as payment in full. Contracted 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 providers

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

Behavioral health providers

Important! Non-contracted behavioral health providers in Massachusetts and elsewhere may balance bill you. To avoid being balance billed, choose contracted behavioral health providers. We urge members to always verify a provider's status as a contracted provider. Because providers' contract status can change during the plan year, it can be unwise to assume that your provider's status hasn't changed.

Also see pages 23-24 for information about surprise billing protection.

How to find providers

From the wellpoint.com/mass website, you can look for:

- ❑ Doctors and hospitals, both in Massachusetts and elsewhere
- ❑ Behavioral health providers who are contracted with Carelon Behavioral Health
- ❑ Contracted suppliers
- ❑ Other kinds of facilities in Massachusetts, like urgent care centers and ambulatory surgery centers

The Sydney Health app lets you search for medical and behavioral healthcare providers in Massachusetts and elsewhere.

How Wellpoint reimburses providers

The Plan routinely reimburses providers on a fee-for-service basis. As various models of health care reform are put in place, as anticipated by legislation in Massachusetts, the Plan may engage certain providers in shared savings and loss arrangements where providers receive additional payments for meeting quality and cost targets. These arrangements may also include other payments to help improve the quality, cost efficiency, and coordination of care. Explanations of this type of provider payment will be available on the Plan website and on request as they are put in place. In this Plan, providers may discuss the way they are compensated with you.

How to submit a claim

To receive benefits from the Plan, a claim must be filed for each service. Most hospitals, doctors and other healthcare providers will submit claims for you. If your provider files claims on your behalf, the provider will be paid directly. If you submit your own claim, you must provide written proof of the claim with the information listed below. To find the allowed amount for a claim, see page 23.

You must provide this information when you submit a claim:

- Diagnosis
- Date of service
- Amount of charge
- Name, address and type of 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 applicable
- Accident information, if applicable
- Proof of payment

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

Proof of payment is a record that shows a payment has been made by the member for services rendered. This includes a receipt, bank statement, invoice provided by the 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.

Download claim forms and other materials from wellpoint.com/mass.

Claims for prescription drug services – These claims must be submitted directly to the administrator of those services. See Part 4 of this handbook (pages 140-159).

Deadlines for filing claims

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

Recovery of overpaid claims

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

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

Checking your claims for billing accuracy

The Bill Checker program

The goal of the Bill Checker program is to detect overpayments that are the result of billing errors that only you may recognize. 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 will share in any actual savings realized by the Plan.

What you need to do

You must ask the doctor to send you an itemized bill for the services you received. As soon as possible, review this bill for any charges that indicate treatment, services or supplies that you did not receive. Check items such as:

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

If you find an error

If you find an error, contact the doctor or the doctor's billing office and report the exact charges you are questioning. Request an explanation of any discrepancies and ask for a revised itemized bill showing any adjustments.

How to get your share of the savings

To get your share of the savings, you must send copies of both the original and revised bills to the Plan, along with the completed *Bill Checker* form.

Download the *Bill Checker* form at wellpoint.com/mass.

Be sure to include the enrollee's name and ID number on the Bill Checker form. The Plan will review the two bills and, if a billing error is confirmed, you will receive 25% of any savings that the Plan realizes. All reimbursements are subject to applicable state and federal income taxes.

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

To detect fraud, waste, abuse and other inappropriate activity, Wellpoint reviews claims both before and after payment. A claim under this review may be denied if the doctor fails to submit medical records associated with the claim. If a claim is denied as a result of this review, the doctor – whether in Massachusetts or elsewhere – may bill the member.

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

Deadlines on bringing legal action

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

Right of reimbursement (payment from a third party)

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

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

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

For additional information about the right of reimbursement, also called subrogation, see page 175.

About your privacy rights

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

About the review process

Wellpoint reviews certain medical services and inpatient admissions to make sure they are eligible for benefits. See 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 ensure that benefits are paid for services that meet the Plan's definition of medical necessity.

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

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

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

When preapproval is first requested

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

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

If the service is approved

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

If the service is not approved

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

- ❑ **Your doctor can ask Wellpoint to reconsider** – Your doctor can ask to speak with a physician advisor or submit more supporting information to be reviewed by a physician advisor. A request for reconsideration must occur within three business days of receiving notice of an adverse benefit determination.
- ❑ **You can appeal** – You and your doctor have a legal right to appeal an adverse benefit determination. See 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 made by the Plan within 180 days of being notified of the determination. See Appendix C for instructions on how to file an appeal.

> **Appeals for prescription drug services** – These appeals must be filed with the administrator of those services. See Part 4 of this handbook (pages 140-159).

Chapter 9: About enrollment and membership

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

Free or low-cost health coverage for children and families

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

Application for coverage

Eligibility of members and dependents, as well as coverage effective dates, are determined by the GIC. You must apply to the GIC for enrollment in the Plan. Visit https://www.mass.gov/mygiclink-member-benefits-portal for enrollment instructions. Questions? Active state and municipal employees may contact their GIC Coordinator at www.mass.gov/service-details/find-your-gic- benefit-coordinator and retirees can contact the GIC at www.mass.gov/forms/contact-the-gic or by calling 617-727-2310.

You must enroll dependents when they become eligible. Newborns (including grandchildren, if they are eligible dependents of your covered dependents) must be enrolled within 60 days of birth, and adopted children within 60 days of placement in the home. Spouses must be enrolled within 60 days of the marriage.

You must complete an enrollment form to enroll or add dependents. Additional documentation may be required, as follows:

- ❑ **Newborns:** copy of hospital announcement letter or the child's certified birth certificate
- ❑ **Adopted children:** photocopy of proof of placement letter, court decree of adoption or amended birth certificate
- ❑ **Foster children ages 19-26:** photocopy of proof of placement letter or court order
- ❑ **Spouses:** copy of certified marriage certificate

When coverage begins

Coverage under the Plan starts as follows:

For new employees

New employee coverage begins on the first day of the month following 60 calendar days from the first date of employment, or two calendar months, whichever comes first.

For persons applying during an annual enrollment period

Coverage begins each year on July 1.

For spouses and dependents

Coverage begins on the later of:

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

For surviving spouses

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

When coverage ends for enrollees

Your coverage ends on the earliest of:

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

When coverage ends for dependents

A dependent's coverage ends on the earliest of:

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

Duplicate coverage

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

Special enrollment condition

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

Continuing coverage upon termination of employment

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

Continuing health coverage for survivors

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

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

Coverage will end on the earliest of:

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

Option to continue coverage for dependents age 26 and over

A dependent child who reaches age 26 is no longer eligible for coverage under this Plan. Dependents age 26 or over who are full-time students at accredited educational institutions may continue to be covered. However, you must pay 100% of the individual premium. The student must also submit an application to the GIC no later than 30 days after his or her 26th birthday. If this application is submitted late, your dependent may apply during the GIC's spring annual enrollment period. Full-time students age 26 and over are not eligible for continued coverage if there has been a two-year break in their GIC coverage.

Option to continue coverage after a change in marital status

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

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

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

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

Notice of COBRA continuation coverage rights

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

- ❑ Your spouse dies;
- ❑ Your spouse's hours of employment are reduced;
- ❑ Your spouse's employment ends for any reason other than his or her gross misconduct;

- ❑ Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- ❑ You become divorced or legally separated from your spouse.

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

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

When is COBRA continuation coverage available?

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

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

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA continuation coverage?

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

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

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

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

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

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

Conversion to non-group health coverage

Under certain circumstances, a person whose Plan coverage is ending has the option to convert to non-group health coverage arranged for by Wellpoint. Conversion to non-group health coverage may offer less comprehensive benefits and higher member cost-sharing than either COBRA coverage or plans offered under the Health Insurance Marketplaces in many states. Contact Wellpoint for details of converted coverage.

A certificate for non-group health coverage can be obtained if:

1. Employment for coverage purposes ends for any reason other than retirement; or
2. Status changes occur for someone who is not eligible for continued coverage under the Plan (including those members who have exhausted their COBRA benefits).

A certificate of coverage is also available to the following persons whose coverage under the Plan ceases:

1. Your spouse and/or your dependents, if their coverage ceases because of your death
2. Your child, covering only that child, if that child ceases to be covered under the Plan solely because the child no longer qualifies as your dependent
3. Your spouse and/or dependents, if their coverage ceases because of a change in marital status

You cannot obtain a certificate of coverage if you are otherwise eligible under the Plan, or if your coverage terminated for failure to make a required payment. No certificate of coverage will be issued in a state or country where Wellpoint is not licensed to issue it.

The certificate of coverage will cover you and your dependents who cease to be covered under the Plan because your health coverage ends. It will also cover any of your dependent children born within 31 days after such coverage ends.

The following rules apply to the issuance of the certificate of coverage:

1. Written application and payment for your first premium must be submitted within 31 days after your coverage under the Plan ends.
2. The certificate of coverage is governed by the rules for converted coverage Wellpoint is using at the time your written application is received. Such rules include: the form of the certificate; its benefits; the individuals covered; the premium payable, and all other terms and conditions of such certificate.
3. If the certificate will be delivered to a state outside of Massachusetts, it may be issued on the form offered by that state.
4. The certificate of coverage will become effective the day after your coverage under the Plan ends.
5. No evidence of insurability will be required.

Coordinating benefits with other health plans (COB)

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

Definition of plan

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

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

Determining the order of coverage

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

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

a) The Plan determines its **covered expenses** – that is, what the Plan would pay in the absence of other insurance; then

b) The Plan subtracts the **primary plan's benefits** – benefits paid by the other plan, or the reasonable cash value of any benefits in the form of services – from the covered expenses in (a) above; and then

c) The Plan pays the difference, if any, between (a) and (b).

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

1. The plan without a COB provision is primary.
2. The plan that covers the person as an employee, member, or retiree (that is, other than as a dependent) is primary, and the plan that covers the person as a dependent is secondary.

3. The order of coverage for a dependent child who is covered under both parents' plans is determined by the **birthday rule**, as follows:
   a) The primary plan is the plan of the parent whose birthday falls first in the calendar year, or
   b) If both parents have the same birthday (month and day only), the primary plan is the plan that has covered a parent for the longest period of time

   However, if the other plan has a rule based on the gender of the parent, and if the plans do not agree on the order of coverage, the rules of the other plan will determine the order.
4. The order of coverage for dependent children who are covered under more than one plan, and whose parents are divorced or separated, follows any applicable court decree.

   If there is no such decree determining which parent is financially responsible for the child's healthcare expenses, coverage is determined as follows:
   a) First, the plan covering the parent with custody of the child (the custodial parent)
   b) Second, the plan covering the custodial parent's spouse, if applicable
   c) Third, the plan covering the non-custodial parent
   d) Fourth, the plan covering the non-custodial parent's spouse, if applicable
5. According to the **active before retiree rule**, the plan that covers a person as an active employee is primary, and the plan that covers that same person as a retiree is secondary. This applies both to that person and his or her dependents.

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

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

Right to receive and release information

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

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

Facility of payment

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

Right of recovery

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

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

COB for persons enrolled in Medicare

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

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

Special provisions applicable to employees and dependents who are 65 or older and eligible for Medicare

Active employees and their dependents age 65 or over who are eligible for medical coverage under the Plan may continue that coverage, regardless of their eligibility for or participation in Medicare.

Medical coverage primary to Medicare coverage for the disabled

Employees or dependents under age 65 who are covered under the Plan and are entitled to Medicare disability for reasons other than end-stage renal disease (ESRD) may continue their coverage under Wellpoint Total Choice, regardless of their eligibility for or participation in Medicare.

Health coverage primary to Medicare coverage for covered persons who have end-stage renal disease

For all covered persons with end-stage renal disease (ESRD), coverage under Wellpoint Total Choice will be primary to Medicare during the Medicare ESRD waiting period and the Medicare ESRD coordination period.

End-stage renal disease (ESRD) means that stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life.

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

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

During that 30-month period, Wellpoint is the primary payer and Medicare is the secondary payer for the purpose of the coordination of benefits (COB). After the 30 months, Medicare becomes the primary payer and the Plan becomes the secondary payer. At this point, you must change health plans. Contact the GIC at:

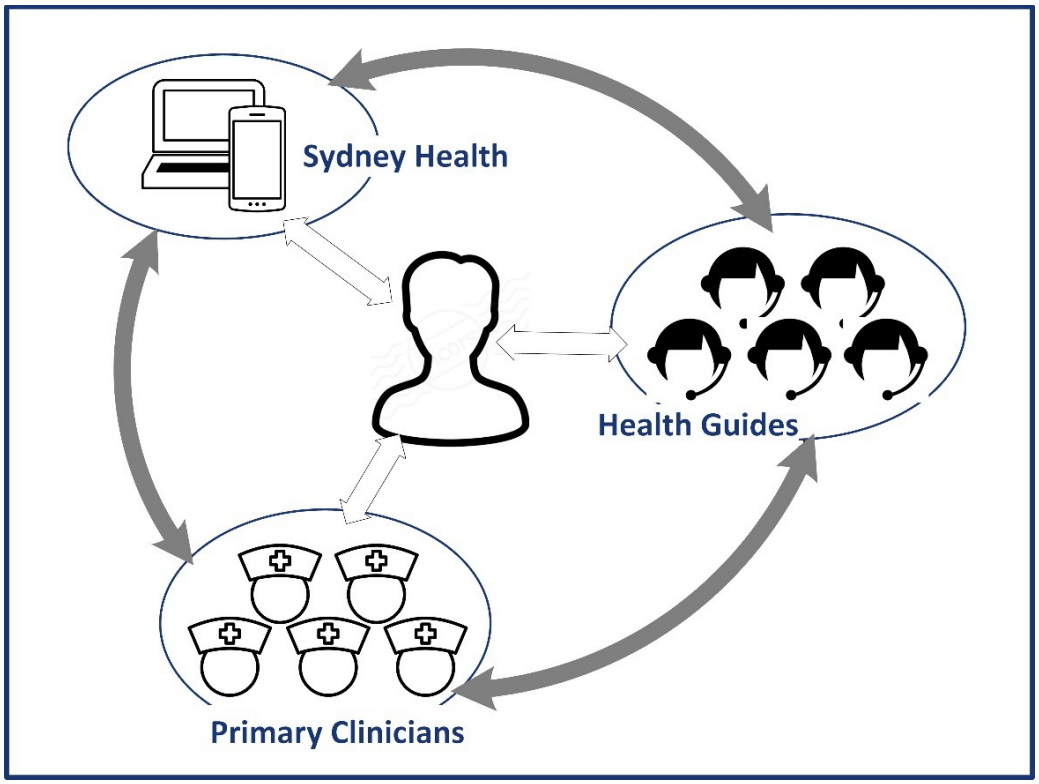
Group Insurance Commission
P.O. Box 556
Randolph, MA 02368

Chapter 10: Other plan resources

The Whole Health, Whole You program

Wellpoint's **Whole Health, Whole You** program combines healthcare professionals and supporting technology that work together to offer you more personal service and an improved member experience. *Whole Health, Whole You* integrates these three components:

- **Health guides** (page 124) are specially trained representatives who take members' calls and answer questions.
- **Primary clinicians** (pages 124-125) work one-on-one with members and their families to address personal healthcare goals and issues, like chronic health conditions and healthy living goals.
- **Sydney Health** (page 125) gives you electronic access to plan information and Wellpoint Member Services from your mobile device.



Because the different components of *Whole Health, Whole You* can quickly and easily share information with you and with each other, they can provide more personal and thorough responses to your questions and concerns.

Wellpoint Health Guides: When you call

Wellpoint health guides answer calls from members. These specially trained service representatives can answer questions and help in a number of other ways.

Health guides can help you...

- Get answers to questions about your plan benefits or claims
- Find out if a service is covered
- Learn more about how your Wellpoint coverage works
- Find out if you're due for services, like a follow-up appointment or preventive test
- Find providers
- Schedule appointments
- Learn how to compare costs so you can find a cost-effective provider
- Connect with benefits and programs that fit your health needs, like cancer and behavioral health support

How to reach a health guide

	Contact	Hours (Eastern time)
By phone	833-663-4176 / TTY: 711 (toll free)	7:30 a.m. to 6:00 p.m. (M-Th) 7:30 a.m. to 5:00 p.m. (F)
Through the member portal	Use Live Chat or send a message from your Wellpoint account	Anytime

Wellpoint Clinical Team: When you need support

Wellpoint's clinical team consists of healthcare professionals working together to support the health of Wellpoint members. A primary clinician is your point of contact who works with you directly and, when appropriate, connects you with other specialized professionals on the team.

Primary clinicians work one-on-one with members and their families to address healthcare related issues. Once you connect with your primary clinician, he or she will continue to be the personal health consultant for you and your family – someone you can contact directly. Your primary clinician may also reach out to bring health issues to your attention, or to offer assistance should a health concern arise.

Your primary clinician can help you...

- Get answers to questions about you and your family's healthcare needs
- Determine how to best use your benefits
- Get advice from other professionals on the clinical team, such as health coaches, dieticians, and pharmacists
- Find out how to access other medical and wellness services
- Set and reach your own health goals – like losing weight or quitting smoking
- Arrange care if you need surgery or a medical procedure

Complex health issues almost always require many different types of expertise. This is true whether you are dealing with an ongoing condition like diabetes, or an urgent situation that arises unexpectedly, like a stroke or cancer diagnosis.

For this reason, Wellpoint's clinical team includes healthcare professionals with expertise in a variety of areas. Working as a team, they can support you and your family, and assist you in effectively managing your healthcare needs.

When you face a complex health issue, the clinical team can help you...

- Understand your diagnosis and treatment options
- Coordinate services where many providers are involved
- Coordinate services before, during, and after a hospital stay
- Facilitate 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

Sydney Health: Access from your smartphone

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

Use the Sydney Health app to...

- Get information about your plan benefits
- Check on the status of your claims
- Look for doctors, hospitals and other health providers
- Keep track of your member costs
- See a doctor face-to-face online with LiveHealth Online
- Get suggestions and tips for managing health conditions like diabetes or asthma
- Sync with a Fitbit or other fitness tracker
- Get your electronic member ID card
- Get digital reminders about scheduling checkups and important tests

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

You can also access Sydney Health online by logging in at wellpoint.com/mass. See page 126 for instructions on how to register for your Wellpoint account, if you haven't already done so.

Behavioral health support services

Behavioral health case management

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

What case managers do...

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

Case management can help if you...

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

Behavioral health case managers are experienced and licensed nurses, social workers, and mental health experts. To find out more about behavioral health care management, call Wellpoint Member Services and ask to speak with a primary clinician.

Behavioral health quality programs

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

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

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

About wellpoint.com/mass

You can find additional information and resources at the wellpoint.com/mass website. At the website, you can:

- ❑ **Check on your claims and other account information** – You'll need to register as a Wellpoint member (if you haven't already registered through the Sydney Health app). Once you're registered, you can check your account anytime.

  Register by creating a user ID and password to protect the privacy of your information. Dependents age 18 or older can access their individual claims information by establishing their own user IDs and passwords.

- ❑ **Download forms, fliers, and other materials, including this handbook** – We recommend using your handbook as a PDF because it is almost always easier and faster to find information by searching in a PDF.
- ❑ **Look for healthcare providers such as:**
  - Doctors and hospitals, both in Massachusetts and elsewhere
  - Behavioral health providers who are contracted with Carelon Behavioral Health
  - Contracted suppliers
  - Other kinds of facilities in Massachusetts, like urgent care centers and ambulatory surgery centers

In this handbook, the **computer** 💻 symbol lets you know about information you can find, tasks you can perform, and resources that are available through wellpoint.com/mass.

Comparing costs at 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 wellpoint.com/mass. If you haven't already registered for your Wellpoint account, see the section above for instructions on how to do so.

Calling the 24-Hour Nurse Line

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

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

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

How to ask for a claim review

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

- ❑ **Call** Wellpoint Member Services at 833-663-4176
- ❑ **Log into your Wellpoint account** to send a message or use Live Chat
- ❑ **Mail** your written request to:

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

How to ask to have medical information released

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

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

 Download the *Member Authorization Form* from wellpoint.com/mass.

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

Chapter 11: Plan definitions

Term	What it means...
A	
Acupuncture withdrawal management (detox)	The use of acupuncture to ease the symptoms of drug or alcohol withdrawal.
Acute residential treatment	Short-term, 24-hour programs that provide behavioral health treatment within a protected and structured environment.
Acute residential withdrawal management	Drug or alcohol withdrawal (detox) that is medically monitored, for members at risk of severe withdrawal.
Adverse benefit determination *(Appendix C)*	A determination to deny, reduce or terminate, or fail to provide or make a payment (in whole or in part) for a benefit based on any of the following: ▪ The case does not meet the Plan's requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness ▪ The services were determined to be experimental or investigational ▪ The services were not covered based on any plan exclusion or limitation ▪ The person was not eligible to participate in the Plan ▪ The imposition of source of injury exclusion, network exclusion, or other limitation of an otherwise covered benefit ▪ Any instance where the Plan pays less than the total amount of expenses submitted with regard to a claim, including deductible, coinsurance and copays ▪ A rescission of coverage (a retroactive cancellation), except if it results from failure to pay premiums
Allowed amount *(page 23)*	The maximum amount the Plan pays for a covered healthcare service. The allowed amount is the amount Wellpoint determines to be within the range of payments most often made to similar providers for the same service. The Plan has established allowed amounts for most services from providers. If a non-Massachusetts provider charges more than the allowed amount, you may have to pay the difference. (Also see **Balance billing**.)
Ambulatory surgery center	An independent, freestanding facility licensed to provide same-day medical services that require dedicated operating rooms and post-operative recovery rooms. These facilities are independent centers, not hospital-run facilities located in a hospital or elsewhere. The presence of a hospital name indicates that the site is a hospital facility, not an ambulatory surgery center.
Ambulatory withdrawal management	Drug or alcohol withdrawal process in which a member has daily visits with a provider throughout withdrawal. More commonly called **outpatient detox**.

Term	What it means...
Appeal *(Appendix C)*	A request that Wellpoint review an adverse benefit determination or a grievance.
Applied Behavior Analysis (ABA)	Specialized therapy used to treat autism spectrum disorders that focuses on improving appropriate behaviors and minimizing negative behaviors.
B	
Balance billing *(pages 23-24)*	When a provider bills you for the difference between what the provider billed and the amount paid by the Plan (the allowed amount). For example, if the provider's charge is $100 and the allowed amount is $70, the provider may balance bill you for the remaining $30.
Behavioral health services *(Chapter 5)*	Services to treat mental health and substance use disorder conditions.
C	
Calendar quarter	The four calendar quarters of the year are: ▪ July/August/September ▪ October/November/December ▪ January/February/March ▪ April/May/June
Clinical stabilization services (CSS)	Clinically managed detox and recovery services provided in a non-medical setting.
Coinsurance *(page 22)*	Your share of the costs of a covered healthcare service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance *plus* any copays and deductible that may apply.
Community-based acute treatment (CBAT)	Treatment for children and adolescents with serious behavioral health disorders who need a protected and structured environment.
Community support programs (CSP)	Programs to help members access and use behavioral health services.
Contracted provider	Any healthcare provider – such as a doctor, hospital or facility – that has agreed to accept the Plan's payment as payment in full. Contracted providers have gone through a credentialing process and must adhere to the quality standards that Wellpoint requires.
Contracted suppliers *(page 103)*	Suppliers that the Plan contracts with to provide certain services or equipment including, but not limited to, durable medical equipment (DME), medical supplies, and home health care. You get these services at a higher benefit level when you use contracted suppliers.
Copay (copayment) *(pages 20-22)*	A fixed amount you pay for a covered healthcare service, usually when you get the service. The dollar amount of the copay depends on the service it applies to. Not all services have copays.
Cosmetic services *(page 89)*	Services performed mainly to improve appearance. These services do not restore bodily function or correct functional impairment. Cosmetic services are not covered.

Term	What it means...
Cost sharing *(Chapter 2)*	Your share of the cost for a covered service that you must pay out of your own pocket. Your share can include a copay, coinsurance, and/or deductible.
Crisis stabilization unit (CSU)	24-hour observation and supervision for behavioral health conditions when inpatient care isn't needed.
Custodial care *(page 89)*	A level of care that is chiefly designed to assist with activities of daily living and cannot reasonably be expected to greatly restore health or bodily function.
D	
Day treatment	Behavioral health programs offering structured, goal-oriented treatment that focuses on improving one's ability to function in the community.
Deductible *(page 19)*	A set dollar amount you pay toward covered services before the Plan 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 are subject to the deductible. The deductible doesn't apply to all services.
Dependent *(Chapter 9)*	1. The employee's or retiree's spouse or a divorced spouse who is eligible for dependent coverage pursuant to Massachusetts General Laws Chapter 32A as amended 2. A GIC-eligible child, stepchild, adoptive child or eligible foster child of the member, or of the member's spouse, until the end of the month following the dependent's 26th birthday 3. A GIC-eligible unmarried child who upon becoming 19 years of age is mentally or physically incapable of earning his or her own living, proof of which must be on file with the GIC 4. A dependent of a dependent, if the primary dependent is either a full-time student or an IRS dependent, or has been an IRS dependent within the past two years If you have questions about coverage for someone whose relationship to you is not listed above, contact the GIC.
Dialectical behavioral therapy (DBT)	A combination of behavioral, cognitive and supportive therapies designed to help change unhealthy behaviors and treat people suffering from behavioral health disorders.
DME (durable medical equipment)	Equipment and supplies ordered by a healthcare provider for everyday or extended use. Oxygen equipment, wheelchairs, and crutches are all examples of DME.
DPH-licensed providers	The Massachusetts Department of Public Health (DPH) issues licenses to Massachusetts facilities that provide healthcare services. To be licensed, facilities must meet specific quality and safety standards.
Dual diagnosis acute treatment (DDAT)	Clinically-managed detox and recovery services for those with both a substance use and mental health condition who require a protected and structured environment.
E	
Elective	A medical service or procedure is elective if you can schedule it in advance, choose where to have it done, or both.

Term	What it means...
Electroconvulsive therapy (ECT)	Psychiatric treatment in which seizures are electrically induced to provide relief from mental disorders.
Emergency *(pages 45-46)*	An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: ▪ Your health would be put in serious danger, or ▪ You would have serious problems with your bodily functions, or ▪ You would have serious damage to any part or organ of your body.
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 *(Chapter 7)*	Healthcare services that the Plan doesn't pay for or cover.
Experimental or investigational procedure	A service that is determined by the Plan to be experimental or investigational; that is, inadequate or lacking in evidence as to its effectiveness, through the use of objective methods and study over a long enough period of time to be able to assess outcomes. The fact that a physician ordered it or that this treatment has been tried after others have failed does not make it medically necessary.
F	
Family stabilization team (FST)	Programs offering intensive services in the home to help children, adolescents and their families deal with complex life stressors.
Family support and training	Peer support to help caregivers navigate the system and access services on behalf of a child with serious emotional disturbance
G	
Grievance	A complaint that you communicate to the Plan.
H	
Healthcare provider	A person, place, or organization that delivers healthcare services or supplies. A provider can be a **person** (like a doctor), a **place** (like a hospital), or an **organization** (like hospice).
Healthcare services	In this handbook, we use "healthcare services" when we're talking about both medical and behavioral health services.
High-tech imaging *(page 51)*	Tests such as MRIs, CT scans, and PET scans that give a more comprehensive view of the human body than plain film X-rays. Many of these tests are also much more expensive than traditional X-rays.
Home state	The state where you live and get your routine health care.

Term	What it means...
Hospital / acute care hospital *(pages 56-58)*	A medical center or community hospital that provides treatment for severe illness, conditions caused by disease or trauma, and recovery from surgery. Acute care hospitals deliver intensive, 24-hour medical and nursing care and meet all of the following conditions: ▪ Operate pursuant to law for the provision of medical care ▪ Provide continuous 24-hour-a-day nursing care ▪ Have facilities for diagnosis and major surgery ▪ Provide acute medical/surgical care or acute rehabilitation care ▪ Are licensed as an acute hospital ▪ Have an average length of stay of less than 25 days
I	
In-home behavioral services	Specialized behavior management therapy and monitoring provided in the home setting for youth members
Injury	Accidental bodily harm caused by something external (outside of your body).
Inpatient behavioral health services *(pages 76-78)*	Treatment for behavioral health conditions that have severe symptoms but that are expected to improve with intensive, short-term treatment.
Inpatient medical care *(pages 56-58)*	Medical care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Inpatient hospital services may also be referred to as **hospitalization**.
Intensive care coordination	Coordination of services for members when multiple services and systems are involved
Intensive outpatient program (IOP)	Programs that offer thorough, regularly-scheduled behavioral health treatment in a structured environment. These programs offer at least three hours of therapy a day, up to seven days a week.
L	
Long-term care facilities *(pages 56-58)*	Specialized hospitals that treat patients who need further care for complex medical conditions but no longer require the services of a traditional hospital.
M	
Maintenance care	A treatment plan or therapy performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the nature of the treatment becomes supportive rather than corrective.

Term	What it means...
Medical necessity	With respect to care under the Plan, medical necessity means that treatment will meet at least the following standards: 1. Is adequate and essential for evaluation or treatment consistent with the symptoms, proper diagnosis and treatment appropriate for your illness, disease or condition as defined by standard diagnostic nomenclatures (DSM-V or its equivalent ICD-10CM) 2. Is reasonably expected to improve or palliate your illness, condition or level of functioning 3. Is safe and effective according to nationally-accepted standard clinical evidence that is generally recognized by medical professionals and peer-reviewed publications 4. Is the most appropriate and cost-effective level of care that can safely be provided for your diagnosed condition 5. Is based on scientific evidence for services and interventions that are not in widespread use **Important!** The fact that a doctor may prescribe, order, recommend or approve a procedure, treatment, facility, supply, device or drug does not, in and of itself, make it medically necessary or make the charge a covered expense under the Plan, even if it has not been listed as an exclusion.
Medical services	In this handbook, medical services are services to treat medical (physical) conditions – in contrast to **Behavioral health services**.
Medical supplies or equipment	Disposable items that physicians prescribe as medically necessary to treat a disease or injury. Such items include surgical dressings, splints and braces.
Medication-assisted treatment (MAT) *(page 78)*	Long-term prescribing of medication as an alternative to the opioid on which a member was dependent. Typically, a member goes to a clinic daily to get the medication.
Medication management	Visits with a behavioral health provider who can evaluate and prescribe medication, if needed.
Member	An enrollee or his/her dependent who is covered by the Plan.
Member costs *(Chapter 2)*	Costs that you pay yourself toward your medical bills: deductible, copays, and coinsurance. Member costs are also known as **out-of-pocket costs**.
Mobile crisis intervention	Emergency service program providing a short-term, mobile, on-site, face-to-face therapeutic response to youth experiencing a behavioral health crisis
N	
Neuropsychological (neuropsych) testing	Testing to find out if a problem with the brain is affecting one's ability to reason, concentrate, solve problems, or remember.
Non-contracted supplier *(page 103)*	A supplier who does not have a contract with the Plan to provide certain services or equipment including, but not limited to, durable medical equipment and medical supplies. You pay more member costs when you use non-contracted suppliers.

Term	What it means...
Non-hospital-owned facility *(page 102)*	Facilities that perform outpatient medical services but that are not owned by or operated by a hospital. Non-hospital-owned locations include many ambulatory surgery centers and urgent care centers.
O	
Observation care	A well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made about whether a patient will need inpatient hospital treatment or if he or she can be discharged from the hospital. Observation care is considered outpatient and is usually provided in medical centers and community hospitals.
Opiate treatment programs (OTP)	Programs licensed to distribute and administer medications as an alternative to an opioid on which a member was dependent.
Out-of-pocket costs	See **Member costs**
Out-of-pocket (OOP) maximum *(page 22)*	A limit on the member costs (deductible, copays, coinsurance) you have to pay for covered services. Once you reach this limit, the Plan then pays 100% of the allowed amounts for the rest of the plan year. Your OOP maximum caps the member costs you owe for: ▪ Medical services ▪ Behavioral health services ▪ Prescription drugs Your OOP maximum doesn't include premiums, balance bills, or costs for services that the Plan doesn't cover.
Outpatient behavioral health services *(pages 78-80)*	Services that don't require an inpatient hospital admission or overnight stay. Outpatient services include office services as well as more intensive types of behavioral health treatment.
Outpatient hospital services	Care at a hospital that doesn't require being admitted to the hospital. Outpatient care usually doesn't include an overnight stay. **Outpatient services** sometimes means health care provided at any non-hospital facility, such as a doctor's office or walk-in clinic.
P	
Palliative care	Medical care that focuses on treating symptoms – like severe pain, or difficulty breathing – to make you more comfortable. Palliative care is not intended to cure underlying conditions.
Partial hospitalization programs (PHP)	Non-residential, structured outpatient psychiatric and substance use programs that are more intensive than one would get in a doctor's office, but that are an alternative to inpatient care. These programs offer at least five hours of therapy a day, up to seven days a week.

Term	What it means...
Physician	Includes the following healthcare providers acting within the scope of their licenses or certifications: ▪ Certified nurse midwife ▪ Chiropractor ▪ Dentist ▪ Nurse practitioner ▪ Optometrist ▪ Physician ▪ Physician assistant ▪ Podiatrist See page 99 for a list of types of behavioral health providers.
Plan year	The plan year starts on July 1 each year and ends the following June 30th.
Preapproval *(Chapter 3)*	Review process to confirm that a service you're going to have is eligible for benefits. Preapproval review lets you make sure that services you'll be getting are covered under the Plan.
Preferred vendors	See **Contracted suppliers**
Provider	See **Healthcare provider**
Psychiatric visiting nurse (VNA) services	Short-term treatment delivered in the home or living environment to treat a behavioral health disorder with medication.
Psychological (psych) testing	Standardized assessment tools to diagnose and assess overall psychological functioning.
R	
Rehabilitation (rehab) facilities *(pages 56-58)*	Specialized hospitals that provide rehab services to restore basic functioning (such as walking or sitting upright) that was lost due to illness or injury.
Rehabilitation (rehab) services	Health care services that help a person keep, get back or improve skills and functioning for daily living that were lost or impaired due to illness, injury or disability. These services may include physical therapy, occupational therapy, and speech-language pathology in a variety of inpatient and/or outpatient settings.
Respite care	Services given to an ill patient to relieve the family or primary care person from caregiving functions.
Retail health clinic *(page 102-103)*	Walk-in clinics located in retail stores or pharmacies. They offer basic services like vaccinations and treatment for colds or mild sinus infections.

Term	What it means...
S	
Skilled care	Medical services that can only be provided by a registered or certified professional healthcare provider.
Skilled nursing facility *(pages 56-58)*	An institution that provides lower intensity rehab and medical services. Skilled nursing facilities must meet all of the following conditions: ▪ Operates according to law ▪ Is approved as a skilled nursing facility for payment of Medicare benefits, or is qualified to receive such approval, if requested ▪ Is licensed or accredited as a skilled nursing facility (if applicable) ▪ Primarily engages in providing room and board and skilled care under the supervision of a physician ▪ Provides continuous 24-hour-a-day skilled care by or under the supervision of a registered nurse (RN) ▪ Maintains a daily medical record for each patient 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 *(page 101-103)*	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	The legal spouse of the covered employee or retiree.
Structured outpatient addictions programs (SOAP)	Non-residential, structured substance use disorder programs that are more intensive than one would get in a doctor's office, but that are an alternative to inpatient care. These programs offer at least three hours of therapy a day, up to seven days a week.
Substance use disorder assessment / referral *(page 81)*	A comprehensive assessment of substance use to allow a provider to refer a member to appropriate care.
T	
Telehealth companies	Companies that offers virtual care with licensed medical and/or behavioral health providers. **LiveHealth Online** is Wellpoint's preferred telehealth provider and can be accessed through the Sydney Health app.
Therapeutic mentoring services	One-on-one support, coaching, and skill building for youth to address daily living, social, and communication needs.

Term	What it means...
Transcranial magnetic stimulation (TMS)	A non-invasive method of brain stimulation used to treat major depression.
Transitional care unit (TCU)	Facilities that help children and adolescents transition from an acute care facility to home, a residential program, or foster care.
U	
Urgent care *(pages 45-46)*	Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.
Urgent care center *(page 103)*	An independent, freestanding facility that treats conditions that should be handled quickly but that aren't life-threatening. Urgent care centers often do X-rays, lab tests and stitches.
V	
Virtual care (telehealth)	Provider visits that are conducted using electronic communication methods instead of in a face-to-face meeting. Both telephone calls and video communications with providers are considered virtual care.
Visiting nurse association	An agency certified by Medicare that provides part-time, intermittent skilled care and other home care services in a person's place of residence and is licensed in any jurisdiction requiring such licensing.
W	
Walk-in clinics *(page 102-103)*	Sites that offer medical care on a walk-in basis, so no appointment is needed. Urgent care centers and retail health clinics are two examples of walk-in clinics.

Part 4:

Your Prescription Drug Benefits

Description of coverage for prescription drugs

For questions about any of the information in Part 4 of this handbook, please call CVS Caremark at 877-876-7214.

Administered by

CVS caremark®

Chapter 12: Your prescription drug plan

GIC's Pharmacy Benefit

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

For questions about any of the information in this section, please contact CVS Caremark at 1-877-876-7214 (option 2).

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 1-877-876-7214 (option 2).

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 copayments pharmacy benefit: Tier 1 (mostly generic drugs), Tier 2 (preferred drugs), Tier 3 (non-preferred drugs), or drugs which 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 17. Deductible for prescription drugs

Deductible (fiscal year July 1 through June 30)	
For individual coverage	**$100 for one person**
For family coverage	**$200 for the entire family** *No more than $100 per person will be applied to the family deductible* *Multiple family members can satisfy the family deductible.*

Table 18. Copayments for prescription drugs

Copayments for	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 – Non-Preferred Drugs	$65	$165

Copayments for	Participating retail pharmacy up to a 30-day supply	Mail order or CVS Pharmacy up to a 90-day supply
Other ▪ Orally administered anti-cancer drugs ▪ ACA preventive drugs: Refer to the "Preventive Drugs" section below for detailed information. Or visit https://info.caremark.com/oe/gic for more information.	$0 member cost (deductible does not apply)	$0 member cost (deductible does not apply)

Copayments for specialty drugs	Specialty drugs must be filled only through CVS Specialty, a specialty pharmacy. Please call CVS Specialty toll free at 800-237-2767.
Specialty Drugs: Tier 1	$10 per 30-day supply
Specialty Drugs: Tier 2	$30 per 30-day supply
Specialty Drugs: Tier 3	$65 per 30-day supply
Orally administered anti-cancer specialty drugs	$0 per 30-day supply

Specialty medications may be dispensed up to a 30-day supply.
Some exceptions may apply.

Copayments for ADHD medications	May be filled through mail order or any network pharmacy. Quantities are limited up to a 90-day supply per state statute.
Tier 1	$10 per 30-day supply $20 per 60-day supply $30 per 90-day supply
Tier 2	$30 per 30-day supply $60 per 60-day supply $90 per 90-day supply
Tier 3	$65 per 30-day supply $130 per 60-day supply $195 per 90-day supply

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 19. Out-of-pocket limit

Individual	$5,000
Family	$10,000

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.

Register at caremark.com 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, 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 1-877-876-7214 (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

PLEASE NOTE: CVS Caremark will allow two 30-day fills for long-term medications at your regular pharmacy before being asked to switch to 90-day supplies. If you want to keep filling your long-term medication prescriptions at your current pharmacy in 30-day supplies without paying the full cost, **you must opt-out once your new plan starts by calling CVS Caremark at 1-877-876-7214 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.

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.

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.

Convenient for You

You get up to a 90-day supply of your maintenance medications – which means fewer refills and fewer visits to your pharmacy, as well as lower copayments. Once you begin using mail order, you can order refills online or by phone, or you can use your local CVS Pharmacy.

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 https://www.caremark.com/manage-prescriptions/get-prescriptions 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 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 will have to fill your specialty medications with CVS Specialty. This means that your prescriptions can be sent to your home, doctor's office, or at 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: 7:30 a.m. to 9 p.m. ET M-F; 9 a.m. to 4 p.m. ET 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

Claim Forms*

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 20. Claims reimbursement

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

* Claim forms are available to registered users on caremark.com or by calling 1-877-876-7214 (option 2).

Other Plan Provisions

ACA Preventive Drugs

Coverage will be provided for the following drugs:

Preventive Drugs	
Aspirin	Generic OTC aspirin, 81mg to help prevent illness and death from preeclampsia in females who are between 12 and 59 years old
Bowel preparation medications	Generic and brand products until generics become available (Rx only) for adults ages 45 to 75 years old
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.
Diabetes prevention	Generic (Rx only) metformin 850mg for preventing or delaying diabetes in adults aged 35 to 70
Folic acid supplements	Generic OTC products (0.4mg – 0.8mg strengths only) when prescribed for women 55 years of age or younger
HIV Pre-Exposure Prophylaxis (PrEP)	Generic (Rx only)
Immunization vaccines	Generic or brand versions prescribed for children or adults
Oral fluoride supplements	Generic and brand prescription versions, children 5 years of age or younger for the prevention of dental caries
Breast cancer	Generic prescriptions (anastrozole, exemestane, raloxifene, tamoxifen) for the primary prevention of breast cancer for females who are at increased risk, age 35 years and older
Tobacco cessation	Generic (Rx and OTC) tobacco cessation products and brand-name Rx 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 40 to 75 years old

Call CVS Caremark at 1-877-876-7214 (option 2) for additional coverage information on specific preventative drugs.

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 per 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 per 30-day supply.
Coronary Artery Disease	Generic amlodipine besylate and metoprolol succinate are $0 cost, preferred brands capped at $25 per 30-day supply.

Please visit https://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 towards 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 21. Current examples of drugs requiring prior authorization for specific conditions[1]

Drug Class	Products Requiring Prior Authorization (PA)
Topical Acne Products	Aklief®, Arazlo®, Tazorac® 0.05% and 0.1% cream, gel; Fabior 0.1% foam; (Retin-A®, Retin-A Micro®; Avita®; Atralin™ gel; other generic topical tretinoin products) and Clindamycin Phosphate 1.2% and Tretinoin 0.025% gel (Ziana®; Veltin™), Winlevi®
Testosterone – Topical	Androderm, AndroGel, Axiron, Fortesta, Natesto, Testim, Vogelxo
Testosterone – Injectable	Aveed®, Depo-Testosterone® [testosterone cypionate injection, generics], Delatestryl®, 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)
Nutritional Supplements	Non-prescription 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, Contrave (bupropion; naltrexone), Diethylpropion Phendimetrazine, Lomaira (phentermine), generic phentermine, Xenical (orlistat), Qsymia, Saxenda, Wegovy
Dry Eyes	Cequa®, Restasis®, Vevye®, Xildra®

1 This list is not all inclusive and is subject to change during the year. Call CVS Caremark toll free at 1-877-876-7214 (option 2) to check if your drugs are included in the program.

Table 22. Current examples of top drug classes that may require prior authorization for medical necessity

▪ Asthma/COPD Agents	▪ Growth Hormones
▪ Autoimmune Agents	▪ Hepatitis C Agents
▪ Dermatological Agents	▪ Insulins
▪ Diabetic Supplies	▪ Nasal Steroids
▪ Erectile Dysfunction Oral Agents	▪ Ophthalmic Agents
▪ Erythropoiesis-Stimulating Agents	▪ Opioid Analgesics
▪ Glaucoma	▪ Osteoarthritis – Hyaluronic Acid Derivatives
	▪ Proton Pump Inhibitors

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 National Preferred Formulary or call CVS Caremark toll free at 1-877-876-7214 (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 Cialis®, Imitrex®, and lidocaine ointment.

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 which 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 CVS Caremark
- Select medical devices 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)

Definitions

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.

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 https://www.cvsspecialty.com/resource-center/biosimilars.html 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.

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.

Copayment – 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.

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.

FDA – The U.S. Food and Drug Administration.

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 National Preferred 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.

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.

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.

Non-Preferred Drug – A non-preferred drug is a medication that usually has an alternative, therapeutically equivalent drug available on the formulary.

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).

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 which, 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 which 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.

Special Medical Formulas or Food Products – Special medical formulas or food products means non-prescription 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. These products require prior authorization to determine medical necessity.

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

Specialty Drugs – Specialty drugs are usually injectable and 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 timeframes and processes contained in this document refer to CVS Caremark® standard protocols based on federal laws and regulations. Timeframes 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 timeframe.

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 timeframes:

- **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 1-877-876-7214 (option 2) and can be transferred to the appeals team to work an urgent appeal over the phone. Preferred method for receiving an appeal is via fax.

- ❑ **Non-specialty PA:**
  PA fax: 888-836-0730
  PA phone number: 800-294-5979
- ❑ **Specialty PA:**
  PA fax: 866-249-6155
  PA 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
- ❑ Include any office chart, labs, or other clinical notes

The doctor can call to request an urgent appeal and would be transferred to the appeal department.

If you have questions or need help submitting an appeal, please call Customer Care for assistance at 1-877-876-7214 (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 preservice appeal: 72 hours
- ❑ Non-urgent preservice appeal:
  - For plans with one level of appeal: 30 days
  - For plans with two levels of appeal: 15 days
- ❑ Post-service appeal: 30 days

Review of Adverse Benefit Determinations

First-Level Clinical Appeal

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 timeframe.

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 timeframes 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 the 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 1-877-876-7214 (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.

Part 5:

Appendices

Notices and reference information

Appendix A: GIC notices

Notice of Group Insurance Commission Privacy Practices

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

Effective July 1, 2022

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

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

Required and permitted uses and disclosures

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

Run our organization

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

Pay for your health services

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

Provide you with information on health-related programs or products

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

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

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

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

Do research

We can use or share your information for health research.

Comply with the law

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

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

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

Organizations that assist us

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

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

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

- ❑ **Get a copy of your health and claims records** – You can ask to see or get a copy of your health and claims records and other health information we have about you. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). We will provide a copy or a summary of your health and claims records. We may charge a reasonable, cost-based fee.
- ❑ **Ask us to correct our records** – You can ask us to correct your health and claims records if you think they are incorrect or incomplete. You must ask for this in writing along with a reason for your request. We may say "no" to your request, but we'll tell you why in writing within 60 days. If we deny your request, you may file a written statement of disagreement to be included with your information for future disclosures.
- ❑ **Request confidential communications** – You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- ❑ **Ask us to limit what we use or share** – You can ask us not to use or share certain health information for payment or our operations, and disclosures to family members or friends. You must ask for this in writing. We are not required to agree to your request, and in some cases federal law does not permit a restriction.
- ❑ **Get a list of those with whom we've shared information** – You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make or was part of a limited data set for research).
- ❑ **Get a copy of this privacy notice** – You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. (An electronic version of this notice is on our website at www.mass.gov/gic)
- ❑ **Choose someone to act for you** – If you have given someone power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- ❑ **Receive notification of any breach or your unsecured PHI**
- ❑ **File a complaint if you feel your rights are violated** – You can complain if you feel we have violated your rights by writing to us at: GIC Privacy Officer, P.O. Box 566, Randolph, MA 02368. Filing a complaint or exercising your rights will not affect your GIC benefits. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call 617-727-2310 or TTY for the deaf and hard of hearing at 617-227-8583.

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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Wellpoint 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 www.socialsecurity.gov or by phone at 800-772-1213 (TTY: 800-325-0778).

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

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

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

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

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its website at **https://www.dol.gov/vets.** An interactive online USERRA Advisor can be viewed at **https://webapps.dol.gov/elaws/vets/userra/**. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

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

Appendix B: Mandates and required member notices

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office, or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-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 July 31, 2024. Contact your state for more information on eligibility.

Premium assistance under Medicaid and CHIP

ALABAMA – Medicaid

Website: http://myalhipp.com/
Phone: 855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program

Website: http://myakhipp.com/
Phone: 866-251-4861
Email: CustomerService@MyAKHIPP.com

Medicaid eligibility:
https://health.alaska.gov/en/division-of-public-assistance/

ARKANSAS – Medicaid

Website: http://myarhipp.com/
Phone: 855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program

Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676

Email: hipp@dhcs.ca.gov

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

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

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

CHP+: https://hcpf.colorado.gov/chp

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

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

HIBI Customer Service: 855-692-6442

FLORIDA – Medicaid

Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 877-357-3268

GEORGIA – Medicaid

GA HIPP website:
https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp

Phone: 678-564-1162, press 1

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

Phone: 678-564-1162, press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program

All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 800-403-0864
Member Services phone: 800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid website:
https://hhs.iowa.gov/programs/welcome-iowa-medicaid

Medicaid phone: 800-338-8366

Hawki website:
https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki

Hawki phone: 800-257-8563
HIPP website:
https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP phone: 888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 800-792-4884
HIPP phone: 800-967-4660

KENTUCKY – Medicaid

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

Phone: 855-459-6328
Email: KIHIPP.PROGRAM@ky.gov KCHIP website: https://kynect.ky.gov
Phone: 877-524-4718
Kentucky Medicaid Website:
https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

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

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

MAINE – Medicaid

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

Phone: 800-442-6003 TTY: Maine relay 711

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

Phone: 800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

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

Phone: 800-862-4840

TTY: 711

Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/health-care-coverage/

Phone: 800-657-3672

MISSOURI – Medicaid

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

Phone: 573-751-2005

MONTANA – Medicaid

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

Phone: 800-694-3084

Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

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

Phone: 855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA – Medicaid

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

Medicaid phone: 800-992-0900

NEW HAMPSHIRE – Medicaid

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

Phone: 603-271-5218

Toll-free number for the HIPP program: 800-852-3345, ext. 15218

Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

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

Phone: 800-356-1561

CHIP Premium Assistance phone: 609-631-2392

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

CHIP phone: 800-701-0710 (TTY: 711)

NEW YORK – Medicaid

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

Phone: 800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/

Phone: 919-855-4100

Website: https://www.hhs.nd.gov/healthcare

Phone: 844-854-4825

NORTH DAKOTA – Medicaid

Website: https://www.hhs.nd.gov/healthcare

Phone: 844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org

Phone: 888-365-3742

OREGON – Medicaid and CHIP

Website: http://healthcare.oregon.gov/Pages/index.aspx

Phone: 800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website:
https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 800-692-7462
CHIP website:
https://www.pa.gov/agencies/dhs/resources/chip.html
CHIP phone: 800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

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

SOUTH CAROLINA – Medicaid

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

SOUTH DAKOTA – Medicaid

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

TEXAS – Medicaid

Website:
https://www.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: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 888-222-2542
Adult Expansion website:
https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program website:
https://medicaid.utah.gov/buyout-program/
CHIP website: https://chip.utah.gov/

VERMONT – Medicaid

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

VIRGINIA – Medicaid and CHIP

Websites:
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select

https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurancepremium- payment-hipp-programs

Medicaid/CHIP phone: 800-432-5924

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov/
Phone: 800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Websites: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid phone: 304-558-1700
CHIP toll-free phone:
855-MyWVHIPP (855-699-8447)

WISCONSIN – Medicaid and CHIP

Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 800-362-3002

WYOMING – Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

- ❑ U.S. Department of Labor
  Employee Benefits Security Administration
  www.dol.gov/agencies/ebsa
  866-444-EBSA (3272)
- ❑ U.S. Department of Health and Human Services and Centers for Medicare & Medicaid Services **www.cms.hhs.gov**
  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.

OMB Control Number 1210-0137 (expires 1/31/2026)

Coverage for reconstructive breast surgery

Coverage is provided for reconstructive breast surgery as follows:

1. All stages of breast reconstruction following a mastectomy
2. Reconstruction of the other breast to produce a symmetrical appearance after mastectomy
3. Prosthetics and treatment of physical complications of all stages of mastectomy, including lymphedemas

Benefits for reconstructive breast surgery will be payable on the same basis as any other illness or injury under the Plan, including the application of appropriate 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 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 Behavioral Health)

Your behavioral health benefits are administered by Wellpoint in partnership with Carelon Behavioral Health. Carelon maintains contracts with behavioral health providers as well as providing some other administrative services like case management. This section outlines your member rights and responsibilities for services provided by Carelon.

Member rights

Company and provider information

- ❑ You have the right to receive information about Carelon's services, benefits, practitioners, providers, member rights and responsibilities and clinical guidelines.

Respect

- ❑ You have the right to be treated with respect, dignity and privacy regardless of race, gender, veteran status, religion, marital status, national origin, physical disabilities, mental disabilities, age, sexual orientation, or ancestry.
- ❑ You have a right to receive information in a manner and format that is understandable and appropriate. You have the right to oral interpretation services free of charge for any Carelon materials in any language.
- ❑ You have the right to be free from restraint and seclusion as a means of coercion, discipline, convenience, or retaliation.

Member input

- ❑ You have the right to have anyone you choose speak for you in your contacts with Carelon. You have the right to decide who will make medical decisions for you if you cannot make them. You have the right to refuse treatment, to the extent allowed by the law.
- ❑ You have the right to be a part of decisions that are made about plans for your care. You have the right to talk with your provider about the best treatment options for your condition, regardless of the cost of such care, or benefit coverage.
- ❑ You have the right to obtain information regarding your own treatment record with signed consent in a timely manner and have the right to request an amendment or correction be made to your medical records.
- ❑ You have the right to a copy of your rights and responsibilities. You have a right to tell Carelon what you think your rights and responsibilities as a member should be.
- ❑ You have the right to exercise these rights without having your treatment adversely affected in any way.

Complaints

- ❑ You have the right to make complaints (verbally or in writing) about Carelon staff, services or the care given by providers.
- ❑ You have a right to appeal if you disagree with a decision made by Carelon about your care. Carelon administers your appeal rights as stipulated under your benefit plan.

Confidentiality

- ❑ You have the right to have all communication regarding your health information kept confidential by Carelon and Wellpoint staff and by contracted providers and practitioners, to the extent required by law.

Access to care, services and benefits

- ❑ You have the right to know about covered services, benefits, and decisions about healthcare payment with your plan, and how to seek these services. You have the right to receive timely care consistent with your need for care.

Claims and billing

- ❑ You have the right to know the facts about any charge or bill you receive.

Member responsibilities

- ❑ You have the responsibility to provide information, to the best of your ability, that Carelon or your provider may need to plan your treatment.
- ❑ You have the responsibility to learn about your condition and work with your provider to develop a plan for your care. You have the responsibility to follow the plans and instructions for care you have agreed to with your provider.
- ❑ You are responsible for understanding your benefits, what's covered and what's not covered. You are responsible for understanding that you may be responsible for payment of services you receive that are not included in the covered services list for your coverage type.

- ❑ You have the responsibility to notify the GIC and your provider of changes such as address changes, phone number change, or change in insurance.
- ❑ If required by your benefit, you are responsible for choosing a primary care provider and site for the coordination of all your medical care.
- ❑ You are responsible for contacting your behavioral health provider, if you have one, if you are experiencing a mental health or substance use emergency.

Carelon Behavioral Health's *Member Rights and Responsibilities* is available in both English and Spanish from Carelon's website (www.carelonbehavioralhealth.com). You can also request a copy by calling Carelon at 888-204-5581 (TTY: 711).

Right of reimbursement (subrogation)

These provisions apply when Wellpoint pays benefits as a result of injuries or illnesses you or your dependent (hereafter "you") sustained and you have a right to a recovery or have received a recovery from any source. A "recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements or court orders characterize, allocate, or designate the money you receive as a recovery, it shall be subject to these provisions. Wellpoint's rights of subrogation and reimbursement are not subject to application of the made whole or common fund doctrines and Wellpoint's rights will not be reduced due to your negligence.

Subrogation

Wellpoint is subrogated to your rights of recovery and has the right to recover payments it makes from any party responsible for compensating you for your illnesses or injuries. Wellpoint has the right to take whatever legal action it sees fit against such party to recover the benefits it has paid. Wellpoint's subrogation claim shall be first satisfied before any part of a recovery is applied to your claim, attorney fees, other expenses/costs.

Reimbursement

Wellpoint has the right to be reimbursed from any recovery you receive in the amount of benefits paid on your behalf. This right of reimbursement will be considered a priority lien by agreement against any recovery. You will not have to reimburse Wellpoint for any more than the amount Wellpoint paid in benefits.

Your Duties

You and your legal representative must do whatever is necessary to enable Wellpoint, or its designee, to exercise its rights and will do nothing to prejudice those rights. You must cooperate with Wellpoint in the investigation, settlement and protection of its rights.

You agree to promptly notify Wellpoint of any pursuit of a recovery (filing a lawsuit or otherwise), your retention of a legal representative (if applicable), and the occurrence of a settlement or verdict. You and your legal representative acknowledge that Wellpoint's lien is automatically created by the terms of this handbook, any recovery will be held in trust, and Wellpoint shall be immediately repaid from the recovery in the amount of the benefits paid on your behalf.

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” on page 174.

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.

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.

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
لك الحق في الحصول على مساعدة بلغتك مجانًا. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

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 ਿਅਧਕਾਰ ਹੈ। ਬਸ ਆਪਣy ਆਈਡੀ ਕਾਰਡ ਤੇ ਿਦੱਤੇ 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

Notes

Notes

To find out about ...

Wellpoint | Commonwealth of Massachusetts Group Insurance Commission

P.O. Box 4095, Woburn, MA 01888 | 833-663-4176 | wellpoint.com/mass

Claims are administered by Wellpoint Life and Health Insurance Company.