Evidence of Coverage
Qualified Health Plans

ConnectorCare, Platinum, Gold, Silver, Bronze

This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance. Please see page 3 for additional information.
TRANSLATION SERVICES

If you, or someone you are helping, have questions about BMC HealthNet Plan, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-855-833-8120.

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de BMC HealthNet Plan, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-855-833-8120.

Se tu o qualcuno che stai aiutando avete domande su BMC HealthNet Plan, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-855-833-8120.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу BMC HealthNet Plan, вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-855-833-8120.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về BMC HealthNet Plan, quý vị sẽ có quyền được giúp và có thể thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-855-833-8120.
INTRODUCTION

Welcome to Boston Medical Center Health Plan. Boston Medical Center Health Plan, Inc., also known as BMC HealthNet Plan (“BMCHP”) is a not-for-profit Massachusetts licensed health maintenance organization. We arrange for the provision of health care services to members through contracts with network providers. Network providers include doctors, other health care professionals, and hospitals. All network providers are located in our service area. As a member, you agree to receive all your health care (with some exceptions – such as emergencies) from network providers who are in the provider network shown on your Schedule of Benefits. When you become a member, you will need to choose a Primary Care Provider (PCP) to manage your care. Your PCP is a network doctor, physician assistant or nurse practitioner. Your PCP will provide you with primary care services. If the need arises, your PCP can arrange for you to receive care from other network providers.

The Qualified Health Plan Program (“Qualified Health Plan Program”) is a health insurance program overseen by the Commonwealth Health Insurance Connector Authority (the “Health Connector”).

BMC HealthNet Plan Qualified Health Plan. Through an arrangement with the Health Connector, BMCHP offers BMC HealthNet Plan Qualified Health Plan, referred to in this EOC as the “plan.” Individuals and group members meeting the Health Connector’s and plan’s eligibility requirements for the Qualified Health Plan Program can enroll in our plan. In exchange for a premium that the individual or group pays, BMCHP agrees to provide the coverage described in this EOC to enrolled members for the time period covered by the premium. By submitting a signed membership application, and by paying applicable premiums, subscribers agree (on behalf of themselves and, if applicable, their enrolled dependents) to all the terms of this EOC.

This Evidence of Coverage (EOC), which includes your Schedule of Benefits, is an important legal document. It describes the relationship between you and BMCHP. It also describes your rights and obligations as a member. It tells you how the plan works; describes covered services, non-covered services, and certain benefit limits and conditions; and tells you what cost-sharing you must pay for covered services. It also describes other important information. We hope you will read this EOC and save it for future use. The Table of Contents will help you find what you need to know.

Definitions: Italicized words in this EOC have meanings that are explained in the Definitions section (Appendix A) located toward the end of the EOC. If you need any help understanding this EOC, please contact us. We’re here to help!

MINIMUM CREDITABLE COVERAGE AND MANDATORY HEALTH INSURANCE REQUIREMENTS

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) 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 Health Connector at 1-877-MA-ENROLL or visit the Health Connector website (www.mahealthconnector.org).

Minimum Creditable Coverage Standards. This health plan meets applicable Minimum Creditable Coverage standards that are effective as of January 1, 2017 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2017. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR 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 visit its website at www.mass.gov/doi.
Member Services Department: 1-855-833-8120 (toll-free) Monday – Friday 8 a.m. – 6 p.m.

We’re Here to Help: The Member Services Department is available to help answer your questions. We strive to provide excellent service. Calls to Member Services may be monitored to ensure quality service. We can help with:

- How the plan works.
- Selecting a Primary Care Provider (PCP).
- Benefits.
- Enrollment, eligibility and claims.
- Network provider information.
- ID cards, registering a concern, billing and change of address notification.
- Member Satisfaction Process (grievances or appeals).
- Utilization Review Information: Call Member Services if you want to find out the status of a utilization review (medical necessity review) decision.
- **Members with total or partial hearing loss:** You may communicate with Member Services by calling our TTY machine at 711.
- **Non-English Speaking Members:** A free language translation service is available to members upon request. This service helps with questions about plan administrative procedures. This service provides you with access to interpreters who can translate over 140 languages. Call Member Services.

Nurse Advice Line: 1-866-763-4695 (24 hours and toll free). All Calls are Confidential. Members can call and speak to a nurse over the phone to get answers to health related questions. Call any day at any time. A registered nurse will help you. After you explain your symptoms, the nurse may: give you advice about caring for yourself at home; suggest you go to an emergency room; or call your doctor.

To Obtain Emergency Medical Care: In an emergency, seek care at the nearest emergency facility. If needed, call 911 for emergency medical assistance. (If 911 services are not available in your area, call the local number for emergency medical services.)

To Obtain Routine or Urgent Medical Care: For routine and urgent care inside the service area, always call your PCP.

To Obtain Mental Health and Substance Use Disorder Services: The plan contracts with Beacon Health Strategies, LLC, to manage all mental health and substance use disorder services. If you need these services, you may do any of the following:

- Call the toll-free 24-hour mental health/substance use disorder telephone line – staffed by Beacon-at 1-877-957-5600 for help finding a network provider.
- Go directly to a network provider who provides mental health or substance use disorder services.
- Call your PCP.
- Visit Beacon’s website (www.beaconhealthstrategies.com); or follow the link on the plan’s website (www.bmchp.org) to look up network providers.

To Obtain Durable Medical Equipment, Prosthetics, Orthotics or Medical Supplies (Including Medical Formulas and Low Protein Food): The plan contracts with Northwood, Inc. to manage most of these services. Some equipment and supplies are still managed by the plan. If you need these services, you may do any of the following:

- Contact our Member Services Department at 1-855-833-8120.
- Call your PCP for help finding a network provider.
- Visit our website (www.bmchp.org) to look up network providers.

To Obtain Pharmacy Services: The plan contracts with EnvisionRx Options. This is the plan’s pharmacy benefits manager. EnvisionRx Options manages your prescription drug benefit. If you need help with this benefit, such as information about covered drugs or network pharmacies, you may do any of the following:

- Contact Member Services at 1-855-833-8120 or visit our website (www.bmchp.org)
- Contact EnvisionRx Options:
To Obtain Mail Order Drugs: The plan contracts with EnvisionPharmacies for mail order drug services. Before you can use the mail order drug program, you must have filled a 30-day supply of each medication, two times at a retail pharmacy within the previous 3 months. Only certain maintenance drugs are available through mail order. To use the mail order service you must first enroll with EnvisionPharmacies. To enroll in this service and begin getting medications in the mail you must either contact EnvisionPharmacies by phone at 866-909-5170 or complete the mail order enrollment form that was included in your member welcome packet and is also available on the EnvisionPharmacies website. Your prescribing provider may also call EnvisionPharmacies at 1-866-909-5170 or fax your prescription to them at 1-866-909-5171. Once you have enrolled, you can refill prescriptions by mail, phone, or online at www.envisionpharmacies.com.

BMCHP WEBSITE: www.bmchp.org
BMCHP ADDRESSES: BMCHP Corporate Headquarters:

    Boston Medical Center Health Plan, Inc.
    529 Main Street Suite 500
    Charlestown, MA 02129
    1-855-833-8120

TO CONTACT THE HEALTH CONNECTOR: For information about Qualified Health Care Program eligibility and enrollment options, benefits, and premiums, contact the Health Connector:

    Commonwealth Health Insurance Connector Authority
    Qualified Health Care Program
    PO Box 120089
    Boston, MA 02112-9914
    For persons with total or partial hearing loss, please call TTY: 877-623-7773.
    Hours of Operation: 8 a.m. – 6 p.m. Monday through Friday.
    Website: www.mahealthconnector.org
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CHAPTER 1. SCHEDULE OF BENEFITS AND COST-SHARING INFORMATION

Schedules of Benefits: When you enroll in the plan you receive a Schedule of Benefits and this EOC document. The Schedule of Benefits for your selected benefit package is an important document.

- It contains a summary of covered services and any related benefit limits.
- It tells you the amount of your cost-sharing (deductibles, copayments and coinsurance) and out-of-pocket maximums.
- It tells you the provider network you must use to obtain your covered services.
- Make sure to keep your Schedule of Benefits with this EOC.

And please be sure to read about all your benefits in detail in Chapter 3 of this EOC, including non-covered services (exclusions).

Cost-Sharing Information: You may be required to share the costs of covered services. See your Schedule of Benefits for the cost-sharing that applies to the benefit package in which you are enrolled. Cost-sharing may include one or more of the following:

**Deductible:** Your benefit package may have an annual deductible. The deductible is the amount you pay for certain covered services in a benefit year before the plan is obligated to pay for those covered services. Once you meet your deductible, you pay either: nothing, or the applicable copayment or coinsurance for those covered services for the remainder of the benefit year. See your Schedule of Benefits.

- Individual Deductible: The amount an individual member pays for certain covered services before any payments are made by the plan for those services.
- Family Deductible:
  - The family deductible applies to all members of a family.
  - All amounts any member in a family pays toward his/her individual deductibles are applied toward the family deductible. However, the most an individual can contribute toward the family deductible per benefit year is equal to the individual deductible amount.*
  - Once the family deductible has been met during a benefit year, all members in a family will thereafter have satisfied their individual deductibles for the remainder of that benefit year.

*If your benefit package is a Health Savings Account (HSA)-compatible plan, and you select family coverage, there is no individual deductible. In such case, no benefits are payable for any enrolled individual family member until the family deductible has been satisfied. See your Schedule of Benefits for more information.

Notes:

- The following are not included in the deductible: copayments; coinsurance; prescription drug (Rx) deductibles (if applicable); premiums; member costs that are more than the plan’s allowed amount paid to non-network providers; and any payments you make for non-covered services.
- Payments you made for covered services received prior to the start of a benefit year are not counted toward your deductible in the current benefit year. At the start of each new benefit year, your deductible accumulation will begin at zero and you will start building again toward your deductible for the new benefit year.
- The amount credited toward a member’s deductible is based on the plan’s allowed amount on the date of service. See Appendix A: Definitions for further information on allowed amounts.
- Some benefit packages may have a separate prescription drug (Rx) deductible. See next paragraph.

**Prescription Drug (Rx) Deductible:** Your benefit package may have a separate deductible for certain prescription drugs. This is called an Rx deductible. This is the amount you pay for certain covered prescription drugs in a benefit year before the plan is obligated to pay for those covered drugs. Once you meet your Rx deductible, you pay only the applicable copayment or coinsurance for those drugs for the remainder of the benefit year. See your Schedule of Benefits.

- Individual Rx Deductible: The amount an individual member pays for certain covered prescription drugs before any payments are made by the plan for those drugs.
Family Rx Deductible:
- The family Rx deductible applies to all members of a family.
- All amounts any member in a family pays toward his/her individual Rx deductible are applied toward the family Rx deductible. However, the most an individual can contribute toward the Rx deductible per benefit year is equal to the individual Rx deductible amount.
- Once the family Rx deductible has been met during a benefit year, all members in a family will thereafter have satisfied their individual Rx deductibles for the remainder of that benefit year.

Notes:
- Payments you made for covered prescription drugs received prior to the start of a benefit year are not counted toward your Rx deductible in the current benefit year. At the start of each new benefit year, your Rx deductible accumulation will begin at zero and you will start building again toward your Rx deductible for the new benefit year.
- The amount credited toward a member’s Rx deductible is based on the plan’s allowed amount on the date of service. See Appendix A: Definitions for further information on allowed amounts.

Copayment: A fixed amount you must pay for certain covered services. Copayments are paid directly to the provider at the time you receive care (unless the provider arranges otherwise).

Note: Copayments you paid for covered services received prior to the start of a benefit year are not counted toward your out-of-pocket maximum for your current benefit year. At the start of each new benefit year, your accumulation will begin at zero and you will start building again toward your annual out-of-pocket maximum for the new benefit year.

Coinsurance: An amount you must pay for certain covered services – stated as a percentage. You pay the applicable percentage of the plan’s allowed amount on the date of service. See Appendix A: Definitions for further information on allowed amounts.

Note: Coinsurance you paid for covered services received prior to the start of a benefit year is not counted toward your out-of-pocket maximum for your current benefit year. At the start of each new benefit year, your accumulation will begin at zero and you will start building again toward your annual out-of-pocket maximum for the new benefit year.

Out-of-Pocket Maximum: Your benefit package may have an out-of-pocket maximum. This is the maximum amount of cost-sharing you are required to pay in a benefit year for most covered services.

The out-of-pocket maximum consists of all1: deductibles, copayments and coinsurance. However, it does not include2:
- premiums;
- member costs that are more than the allowed amount for covered services paid by the plan to non-network providers; and
- costs for non-covered services.

Once you meet your out-of-pocket maximum, you no longer pay deductibles, copayments or coinsurance for the rest of that benefit year.3

- Individual Out-of-Pocket Maximum: The maximum amount of cost-sharing an individual is required to pay in a benefit year for most covered services.
- Family Out-of-Pocket Maximum:
  - All amounts any members in a family pay toward their individual (or self-only) out-of-pocket maximum are applied toward the family out-of-pocket maximum. However, the most an individual can contribute toward the family out-of-pocket maximum per benefit year is equal to the individual (or self-only) out-of-pocket maximum amount.

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1 Unless your Schedule of Benefits states otherwise.
2 Unless your Schedule of Benefits states otherwise.
3 Unless your Schedule of Benefits states otherwise.
Once the family out-of-pocket maximum has been met during the benefit year, all family members will thereafter have satisfied their individual out-of-pocket maximum for the remainder of that benefit year.

Please note:

- Deductibles, copayments and coinsurance you paid prior to the start of a benefit year are not counted toward your out-of-pocket maximum for your current benefit year. At the start of each new benefit year, your accumulation will begin at zero and you will start building again toward your annual out-of-pocket maximum for the new benefit year.

Prescription Drug Out-of-Pocket Maximum ("Rx Out-of-Pocket Maximum"): Your benefit package may have an Rx out-of-pocket maximum. If so, this is the maximum amount of cost-sharing you are required to pay in a benefit year for covered prescription drugs.

The Rx out-of-pocket maximum consists of: Rx deductibles, Rx copayments and Rx coinsurance. However, it does not include:

- member costs that are more than the allowed amount for covered prescription drugs paid by the plan to non-network pharmacy providers; and
- costs for non-covered prescription drugs.

Once you meet your Rx out-of-pocket maximum, you no longer pay any Rx deductible, Rx copayments or Rx coinsurance for the rest of that benefit year.

Your benefit package may contain just an individual Rx out-of-pocket maximum, or both an individual and family Rx out-of-pocket maximum:

- Individual Rx Out-of-Pocket Maximum: The maximum amount of cost-sharing an individual is required to pay in a benefit year for covered prescription drugs.
- Family Rx Out-of-Pocket Maximum:
  - All amounts any members in a family pay toward their individual Rx out-of-pocket maximum are applied toward the family Rx out-of-pocket maximum. However, the most an individual can contribute toward the family Rx out-of-pocket maximum per benefit year is equal to the individual Rx out-of-pocket maximum amount.
  - Once the family Rx out-of-pocket maximum has been met during the benefit year, all family members will thereafter have satisfied their individual Rx out-of-pocket maximum for the remainder of that benefit year.

Benefit Year: The benefit year is the consecutive 12 month period during which: benefits are purchased and administered; deductibles, coinsurance and the out-of-pocket maximums are calculated; and most benefit limits apply.

For individual subscribers: The benefit year is a calendar year. However, in some cases, depending on your coverage effective date, your first benefit year will not be a full 12 months. You will be notified if this is the case. The notice will tell you whether your deductibles and out-of-pocket maximums, if any, will be prorated for that short benefit year.

For subscribers enrolled through a group contract: Your benefit year begins on the group effective date (always the first of a calendar month) and continues for 12 months from that date. (For example, if the group effective date is April 1, your benefit year runs from April 1 to March 31.) The benefit year then renews thereafter for 12 month periods. (If you were a new employee who became a subscriber after the group effective date, your benefit year is the same as the benefit year for all subscribers in your group. That means that your first benefit year will not be a full 12 months.)

For new dependents that are added during a benefit year (for example, a new baby or new spouse): the new dependent’s benefit year begins on his or her coverage effective date and runs for the same time

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4 Unless your Schedule of Benefits states otherwise.
5 Unless your Schedule of Benefits states otherwise.
period as the subscriber’s benefit year.

**Benefit Limits:** For certain covered services, day, visit or dollar benefit maximums may apply. Your Schedule of Benefits describes benefit limits. Once the amount of the benefits you have received reaches the benefit limit for the specific covered service, no more benefits will be provided for that service for the remainder of the benefit year (or other designated time period). If you receive more services beyond the benefit limit, you must pay the full amount for those services.

**For More Information:** To obtain information about the estimated or maximum allowed amount for a proposed (medically necessary) covered service (such as a proposed hospital admission) and the estimated amount of your cost-sharing for that proposed covered service, you can call Member Services toll-free at 1-855-833-8120. You can also make a request for this information on our website: [www.bmchp.org](http://www.bmchp.org).

Based on the information available to us at the time of your request, we will tell you the estimated allowed amounts and your estimated cost-sharing. Any estimates we give you do not guarantee coverage. Coverage is based on meeting all the applicable rules in this EOC. (For example, you must be a member of the plan on the date the service is given to you.) There is no coverage for non-covered services.

**Note:** additional cost-sharing, as set forth in your Schedule of Benefits, may apply for unforeseen covered services given to you during the provision of the proposed covered service.
CHAPTER 2. HOW THE PLAN WORKS

Benefit Packages: BMC HealthNet Plan Qualified Health Plan (the “plan”) has different benefit packages. Benefit packages differ in premium and in cost-sharing. They may also differ in the provider network available to you. The specific covered services, provider network, deductibles, copayments, coinsurance and out-of-pocket maximums for each benefit package are listed in your Schedule of Benefits.

Choose a Primary Care Provider (PCP): When you enroll in the plan, you must choose a primary care provider, known as a PCP. You may choose any PCP who is in your provider network and who is available to accept you.

- A PCP may be a doctor of internal medicine, family practice, general practice or pediatric medicine; or may be a physician assistant or nurse practitioner.
- Each member of a family may choose a different PCP. Network pediatricians can be chosen as a PCP for a child. (This is a PCP who specializes in treating children.) Female members may select a designated network obstetrician/gynecologist (OB/GYN) as their PCP.
- PCPs provide routine and preventive health care. They also can arrange and coordinate your care with other network providers.
- PCPs or their covering providers are available 24 hours a day.
- Select a PCP by writing the PCP’s name on your enrollment application or calling Member Services.
- You must obtain all primary care from your designated PCP.

Assignment of PCP for members enrolled in certain benefit packages: If you do not select a PCP within 15 days of your coverage effective date, the plan will assign an appropriate PCP to you. This assignment is based on your zip code and may also be based, in our judgment, on other relevant information we get from you and from other records. If you are assigned a PCP, we will tell you the PCP’s name and offer to help you schedule an appointment with the PCP. You must obtain all primary care from your assigned PCP. If you wish to change your assigned PCP, see “Changing Your PCP,” below.

PCPs are listed in the plan’s Provider Directory. You can search all providers in your provider network by going to our website at www.bmchp.org. (Simply click on the “Find a Provider” link.) Make sure to look up a PCP in the provider network that is listed on your Schedule of Benefits. You can also call Member Services at 1-855-833-8120 and we will send you a free printed Provider Directory. The most up-to-date version of the Provider Directory is on our website: www.bmchp.org. For help selecting a PCP, call Member Services.

Visit Your PCP: After enrolling, if you have not met your PCP, we recommend that you call your PCP. Introduce yourself as a new plan member and schedule an appointment. You should also ask your previous doctor to send your medical records to your new PCP. (Note: your previous doctor may charge you for copies.)

Changing Your PCP: You may change your PCP at any time, but no more than three times (if it is a voluntary change) in a benefit year. To change your PCP, select a new one from the Provider Directory. Then call Member Services. Tell Member Services that you want to change your PCP and obtain approval of the change. (If you do not obtain our approval, care you receive from the new PCP may not be covered.) PCP changes are effective the next working day. (Under certain circumstances, the change can be effective on the same day or on a later date.)

In certain cases, the plan will require you to change your PCP. If this happens, you must choose a new PCP by calling Member Services. This can happen if your PCP is no longer a network provider in your provider network. In this case, the plan will notify you in writing. We will do our best to give you notice at least 30 days before your PCP leaves the provider network. In some cases you may receive continued coverage of services from your prior PCP for at least 30 days after your PCP leaves the provider network. (See “Continuity of Care for Existing Members” later in this Chapter.)
Your PCP Provides and Arranges for Health Care:

- Whenever you need care, you should first call your PCP—except in an emergency.
- Your PCP will provide you with preventive care and primary care when you are sick or injured.
- Your PCP can arrange for you to see other network providers (for example, network specialists) for other types of care. Your PCP knows other network providers and is an excellent person to help you choose other network providers who can provide specialty services. Call your PCP for advice.
- Even if you go on your own (self-refer) to a network specialist for specialty care, we strongly recommend that you keep your PCP informed about self-referred care. This allows your PCP to have a full understanding of your medical needs and services. This helps to maintain the quality of your care.

When You Need Specialty Care: If you think you need specialty care, we encourage you to first call your PCP. Your PCP can tell you whether you need specialty care and can refer you to an appropriate network specialist. Or, you can self-refer by going to a network specialist on your own. But see the next paragraph about prior authorization requirements.

Prior Authorization for Specialists at Certain Network Hospitals: Please note that before you can visit specialists affiliated with certain network hospitals, your PCP or the specialist you want to see must get prior authorization from a plan authorized reviewer. (The network hospitals to which this rule applies are listed on our website at www.bmchp.org.) In such cases, the plan authorized reviewer will only approve your visit to specialists at these particular hospitals if the specialty care you need is not available from a network specialist affiliated with Boston Medical Center. (Note: no prior authorization is required for you to visit network specialists affiliated with the same network hospital as your PCP.)

The plan may change (add or delete) the list of network hospitals, referred to in the above paragraph, for which prior authorization is required. If we do so, we will post such changes on our website at www.bmchp.org.

- Before you visit a specialist, check with your PCP or the network specialist to make sure, if necessary, he or she has gotten prior authorization from a plan authorized reviewer.
- No prior authorization is required for you to go to any network obstetrician, gynecologist, certified nurse midwife or family practitioner who is affiliated with any network hospital for the following types of care:
  - Maternity care.
  - Routine annual gynecologic exam. This includes any follow-up obstetric or gynecological services determined to be medically necessary as a result of such exam.
  - Medically necessary evaluations and related health care services for acute or emergency gynecological conditions.
- You can look up physicians’ hospital affiliations on our website: www.bmchp.org.

Care from Non-Network Providers: The plan does not cover care you receive from non-network providers, except:

- in an emergency (see “Emergency Services,” below);
- for urgent care when you are outside the service area (see “Coverage for Urgent Care When You are Outside the Service Area,” below);
- certain specific continuity of care situations (see “Continuity of Care”, below); and
- in rare cases when no network provider has the professional expertise needed to provide the required service. In such case, your PCP or the plan may arrange for you to see a non-network provider. Your PCP must first get prior authorization from a plan authorized reviewer. (If you are authorized to see a non-network provider, your applicable cost-sharing does not change.) The plan authorized reviewer considers several important factors when evaluating a request to authorize care at a non-network provider. These include: your specific medical needs; the medical necessity of the requested covered service or provider; cost-effectiveness of the non-network options; quality; and access.

Care at Network Hospitals or Other Network Facilities: In the unlikely event you receive covered services from a non-network provider (such as an anesthesiologist or radiologist) while you are an inpatient in a network hospital or other network facility, the plan will pay for these covered services as if they had been provided by a network provider.
Plan Help Finding Network Providers: You may request assistance from the plan if you or your PCP has difficulty identifying network providers who can provide you with medically necessary services. If you ask us, we will identify and confirm the availability of these services directly. If medically necessary services are not available from network providers, we will arrange for non-network providers to provide these services to you.

If You Can't Reach Your PCP: Your PCP or covering provider is available to provide and arrange for care 24 hours a day. If your PCP cannot take your call right away, always leave a message with the office staff or answering service. Except in an emergency, wait a reasonable amount of time for someone to call you back. If you are unable to reach your PCP or the covering provider, call Member Services during regular business hours. You do not have to call your PCP before seeking emergency care. See “Emergency Services” later in this Chapter.

Canceling Provider Appointments: Sometimes you may need to cancel an appointment with your PCP or any provider. Always do so as far in advance of your appointment as possible. Providers may charge you for missed appointments. The plan does not pay for any missed appointment charges.

No Waiting Period or Pre-Existing Condition Limitations: There are no waiting periods or pre-existing condition limitations in the plan. All covered services are available to you as of your coverage effective date, unless you are an inpatient on your coverage effective date and you have not notified the plan that you are an inpatient.

The Provider Network:
Service Area: The service area is the geographical area in which network providers are located. Please visit the plan’s website at www.bmchp.org for a description of the cities and towns in the plan’s service area.

Your Provider Network: As a member, you must get all your care from providers who are in the provider network named in your Schedule of Benefits. (Exceptions apply – see “Care from Non-Network Providers” above.) BMCHP maintains several provider networks. Therefore, when using the provider search tool on our website (see next paragraph) or when requesting a paper copy of the plan’s Provider Directory, please be sure to check the correct provider network for the benefit package in which you are enrolled.

Provider Directory: The Provider Directory lists our network providers. These include PCPs, physician specialists, other health care professionals and hospitals. In the Provider Directory, you can also find information about providers, including contact information, office location, board certification status, specialty, languages spoken, handicap accessibility, hours of operation and, when applicable, hospital affiliation. The provider directory is available on our website at www.bmchp.org. A free paper copy of the Provider Directory is available by calling Member Services at 1-855-833-8120. Since it is frequently updated, the online directory is more current than a paper directory. You may also call Member Services for information about network providers.

Physician Profiling Information: Information about licensed physicians (such as: malpractice history, medical school and residency information) is available. Contact the Commonwealth of Massachusetts Board of Registration in Medicine at www.massmedboard.org.

Changes to Provider Network: Sometimes, providers in your provider network may change during the year. Changes can occur for a number of reasons: a provider may move outside of the service area; retire; or fail to continue to meet our credentialing or other contract requirements. Also, BMCHP and the provider might not reach agreement on a contract. This means that we cannot guarantee that any particular provider will continue to be a network provider during the entire time you are a member. If your PCP leaves the network, we will make every effort to notify you at least 30 days in advance. Member Services can help you select a new PCP.

Financial Compensation to Network Providers: BMCHP enters into contracts with network providers that may contain a variety of mutually-agreed upon methods of compensation. The Provider Directory indicates the method of payment for network providers. Our goal in compensating network providers is
to encourage and reward network providers to provide: preventive care in accordance with generally accepted guidelines; quality management of illness; and appropriate access to care. Regardless of how we pay network providers, we expect them to: use sound medical judgment when providing and arranging for care; provide only medically necessary care; and avoid unnecessary medical care that could be harmful and costly.

Nurse Practitioners and Certified Registered Nurse Anesthetists: The plan provides coverage on a non-discriminatory basis for covered services provided by a network: nurse practitioner; or a certified registered nurse anesthetist. This means the plan provides you with the same coverage whether the service was given to you by a network nurse practitioner or by another network provider. The covered services provided by these providers must be within the lawful scope of their license and/or authorization to practice.

Emergency Services:

What to Do in an Emergency: You are always covered for care in an emergency. You do not need prior authorization or a referral from your PCP. (This includes emergency mental health or substance use disorder services). In an emergency, whether you are inside or outside the service area: go to the nearest emergency facility; or call 911 or other local emergency number. The plan will not discourage you from using the local pre-hospital emergency medical services system, 911, or other local emergency number. No member will be denied coverage for medical and transportation expenses incurred as a result of an emergency.

Cost-Sharing:

- Cost-sharing may apply: for emergency care you get in an emergency room; or for observation services in a hospital setting without use of the emergency room. Please see your Schedule of Benefits for applicable cost-sharing.
- Cost-sharing applies even if you go to an emergency room for non-emergency care.
- Copayments for emergency services are waived if you are admitted as an inpatient immediately following receipt of emergency services in an emergency room. However, any applicable cost-sharing for inpatient hospital care will apply to your inpatient stay.
- If you get emergency covered services from a non-network provider, the plan will pay up to the allowed amount. You pay applicable cost-sharing and any difference between the provider’s charge and our payment.

Emergency Defined: An emergency means a medical condition, whether physical, behavioral, related to substance use disorder, or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that, in the absence of prompt medical attention, could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of a member or another person, or, in the case of a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any body organ or part; or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B). Examples of Emergencies: heart attack or suspected heart attack; stroke; shock; major blood loss; choking; severe head trauma; loss of consciousness; seizures; and convulsions.

Notice Following Emergency Care:

- If you receive emergency care at an emergency facility (whether in or out of the service area), but are not admitted to the hospital, you or someone acting on your behalf should call your PCP after receiving care. This helps your PCP to provide or arrange for any follow up care.
- If you receive emergency care at an emergency facility (whether in or out of the service area) AND you are admitted as an inpatient (hospitalized) to a non-network facility, you or someone acting on your behalf MUST call the plan within 2 working days of your admission. This is essential so that the plan can: manage and coordinate your care; and arrange for any medically appropriate transfer. (Note: notice by the provider of emergency services to your PCP, the plan or, in the case of emergency mental health or substance use disorder services, to Beacon, satisfies this notice requirement.)
Transfer: If you receive emergency care from a non-network provider (inside or out of the service area): continued services with that provider after the emergency condition has been treated and stabilized may not be covered if the plan determines, in coordination with your providers, that it is safe, appropriate and cost-effective for you to be transported to a network facility and you choose not to go to the network facility.

Coverage for Care When You Are Outside the Service Area:

- If you are outside the service area and you get hurt or sick, the plan will pay for medically necessary covered services for urgent care that you receive from non-network providers. (Please see “Emergency Services”, above, for coverage of emergency care when you are outside the service area.)
- We recommend that you call your PCP for guidance, when appropriate, prior to seeking urgent care. But you are not required to do so.
- You should seek urgent care at the nearest and most appropriate health care provider.
- Applicable member cost-sharing amounts apply.
- Urgent care is medically necessary care that is required to prevent serious deterioration of your health when you have an unforeseen illness or injury. Examples: care for broken bones or a high fever.

The plan will not cover the following types of care when you are outside the service area:

- Care you could have foreseen the need for before leaving the service area. This includes care for chronic medical conditions requiring ongoing medical treatment.
- Routine care or preventive care.
- Elective inpatient admissions, outpatient surgery or other covered services that can be safely delayed until you are in the service area.
- Follow-up care that can wait until you are in the service area.
- Routine maternity services for prenatal or postpartum care; or delivery (including postpartum care and care provided to the newborn) or problems with pregnancy beyond the 37th week of pregnancy or anytime after you have been told by your provider that you are at risk for early delivery.

Cost-Sharing:

- Applicable cost-sharing (such as deductibles and copayments) will apply for urgent care you get when you are outside the service area. Please see your Schedule of Benefits for applicable cost-sharing.
- If you get urgent care from a non-network provider, the plan will pay up to the allowed amount. You pay applicable cost-sharing and any difference between the provider’s charge and our payment.

Inpatient Hospital Care:

Inpatient Hospital Services: Except in an emergency, always call your PCP first before going to a hospital.

- If you need hospital care, your PCP will arrange for you to go to a network hospital.
- In rare instances when the hospital services you need are not available from any network hospital, your PCP may arrange for you to go to a non-network hospital. In such case your PCP must obtain prior authorization from a plan authorized reviewer.

Charges after the Discharge Hour: If you choose to stay as an inpatient after a physician has scheduled your discharge or determined that further inpatient services are no longer medically necessary, the plan will not pay for any costs incurred after that time.

Continuity of Care:

Continuity of Care for Existing Members:

- Disenrollment of PCP. If you are a member whose PCP leaves the network, we will use our best efforts to provide you with written notice at least 30 days prior to the date your PCP leaves. That notice will tell you how to choose a new PCP. Unless your PCP was disenrolled due to fraud or quality of care concerns, we will continue to pay for covered services from the disenrolled PCP, under the terms of this EOC, for at least 30 days after the disenrollment date.
- Disenrollment of PCP or Specialist: If you are a member whose PCP or specialist leaves the network (for reasons other than fraud or quality of care) and you are undergoing active treatment for a chronic
or acute medical condition with that provider, we will cover continued treatment with the PCP or treating specialist through the current period of active treatment, or for up to 90 calendar days (whichever is shorter).

- **Pregnancy.** If you are a female member in your second or third trimester of pregnancy and the network provider you are seeing in connection with your pregnancy is disenrolled from the plan (for reasons other than fraud or quality of care); you may continue to receive coverage for covered services provided by that provider, under the terms of this EOC, through your first postpartum visit.
- **Terminal Illness.** If you are a member with a terminal illness (having a life expectancy of 6 months or less) and the network provider you are seeing in connection with your illness is involuntarily disenrolled from the plan (for reasons other than fraud or quality of care); you may continue to receive coverage for covered services provided by that provider, under the terms of this EOC, until death.

**Continuity of Care for New Members:** If you are a new member, the plan will provide coverage for covered services provided by your existing non-network physician, non-network physician assistant or non-network nurse practitioner, under the terms of this EOC, as follows:

- For up to 30 days from your coverage effective date if:
  - No other health plan options offered by your group (if applicable) include this physician, physician assistant or nurse practitioner; and
  - This physician, physician assistant or nurse practitioner is providing you with an ongoing course of treatment or is your primary care provider.
- Through your first postpartum visit, if you are a new member in her second or third trimester of pregnancy.
- Until death, if you are a new member with a terminal illness (having a life expectancy of 6 months or less).

**Conditions for Coverage of Continuity of Care as Described in this Section:** Services provided by a disenrolled provider or non-network provider as described in this “Continuity of Care” section are covered only when: the member or provider obtains prior approval from the plan for the continued services; the services would otherwise be covered services under this EOC; and the provider agrees to:

- accept payment from the plan at the rates we pay network providers;
- accept such payment as payment in full and not charge you any more than you would have paid in cost-sharing if the provider was a network provider;
- comply with the plan’s quality standards;
- provide the plan with necessary medical information related to the care provided; and
- comply with the plan’s policies and procedures: these include procedures regarding obtaining prior authorization, and providing covered services pursuant to a treatment plan if any, approved by the plan.

**Concierge Services:** There may be some network providers who charge extra fees for special services or amenities. These may include: assistance with transportation to medical appointments; guaranteed non-medically necessary same day or next day appointments; and going with members to specialist visits. These special services are not covered services under the plan. The plan does not cover fees for such services. It is your choice whether to purchase and pay for these special services directly from your provider.

**Member Identification (ID) Cards:** We will give each member an ID card. Please look at it carefully. If any information is wrong, call Member Services. Your member ID card is important. It identifies your plan membership. Please carry it with you at all times. Always show your ID card to any provider before receiving services. If your card is lost or stolen, call Member Services for a new card. An ID card in itself is not enough to entitle you to plan benefits. To be entitled to plan benefits, you must be a properly enrolled member at the time you receive health care services.
CHAPTER 3. COVERED SERVICES

Introduction: This Chapter describes:
- covered services;
- what is not covered (exclusions); and
- certain limits or conditions on coverage.

Cost Sharing: See your Schedule of Benefits for information about: deductibles; copayments; coinsurance; and out-of-pocket maximums.

Note: Providers may refuse to provide covered services if you do not pay required cost-sharing.

Prior Authorization from Plan Authorized Reviewer: There are certain covered services – both inpatient and outpatient – that must be authorized (approved) in advance by a plan authorized reviewer. There are also specialists who may be affiliated with certain network hospitals for whom prior authorization must be obtained before you receive services from them. These requirements are known as “prior authorization.” Your network provider will request prior authorization from the plan on your behalf. The plan authorized reviewer will: review your request within legally set timeframes; and determine if the proposed service should be covered as medically necessary for you. The plan will then tell your provider and you if coverage for a proposed service has been approved or denied. To check on the status of a request or the outcome of a prior authorization decision:
- call your provider; or call the plan at 1-855-833-8120.

You should always check with your provider before you obtain services or supplies. Make sure he or she has obtained any required prior authorization.

If coverage for a service is denied as not medically necessary, your provider may discuss your case with a plan authorized reviewer. He or she may also seek reconsideration from the plan. If the denial is not reversed, you have appeal rights. See Chapter 6. (Your right to appeal does not depend on whether your provider sought reconsideration.)

Examples of covered services requiring prior authorization from the plan:
- High-tech imaging: CT/CTA, MRI/MRA, PET, and NCI/NPI (nuclear cardiac imaging).
- Covered non-emergency transportation. (See Ambulance Services in Chapter 3).
- Durable medical equipment and orthotics
- Prosthetics
- Medical formulas.
- Low protein food.
- Home health care.
- Hospice.
- Infertility treatment.
- Services to treat gender identity disorder and gender dysphoria.
- Mental health and substance use disorder outpatient services. Your provider must call Beacon for prior authorization.
- Non-emergency inpatient admissions.
- Nutritional counseling.
- Organ transplants.
- Outpatient rehabilitation therapies. (For example: physical, occupational and speech therapies).
- Certain prescription drugs from a pharmacy or that are given to you (by injection or infusion).
- Specialty care from certain network specialists. See Chapter 2 for more information.

These are examples only. Please check with your provider, or call the plan, for more information about specific services, supplies, and drugs subject to prior authorization. From time to time, the plan may change the services subject to prior authorization.

Basic Requirements for Coverage: To be covered services, all services and supplies must meet all of the following requirements:
- Described in this Chapter 3 as a covered service.
• Medically necessary.
• Received while you are a member of the plan.
• Provided by a network provider in your provider network, except as described in Chapter 2. See Chapter 2: “Care from Non-Network Providers.”
• In some cases, authorized in advance by a plan authorized reviewer. (Prior authorization.)
• Not listed as excluded in this EOC.
• Provided to treat an injury, illness or pregnancy; or for preventive care.
• Consistent with applicable state and federal law.

INPATIENT SERVICES:

Prior Authorization from Plan Authorized Reviewer: Certain inpatient covered services described below require prior authorization (approval) by a plan authorized reviewer. If the provider of the service does not obtain the prior authorization, the plan will not cover the service. Always check with your provider to make sure he or she has obtained necessary approval.

Inpatient Hospital Care: The plan covers acute hospital inpatient care. This is covered in a general or chronic disease hospital. Coverage is for as many days as medically necessary. This includes:
• Semi-private room and board. (Private room covered only when medically necessary).
• Anesthesia.
• Chemotherapy and radiation therapy.
• Doctor’s visits and specialist consults, while you are inpatient.
• Diagnostic tests (Examples: lab, x-ray and other imaging tests).
• Dialysis.
• Intensive/cardiac care.
• Lab and imaging services.
• Medications when you are an inpatient.
• Nursing care.
• Physical therapy.
• Occupational therapy.
• Speech therapy.
• Cardiac therapy.
• Respiratory therapy.
• Surgery. This includes the following:

  o Reconstructive Surgery and Procedures: The plan covers medically necessary reconstructive surgery and procedures. These are covered only when the services are required: to relieve pain; or to improve or restore bodily function that is impaired as a result of:
    • a birth defect;
    • accidental injury;
    • disease; or
    • a covered surgical procedure.

  The plan also covers the following post-mastectomy services:
  • Reconstruction of the breast affected by the mastectomy.
  • Surgery and reconstruction of the other breast to produce a symmetrical appearance.
  • Prostheses and treatment of physical complications of all stages of mastectomy. (This includes lymphedema.)

  Removal of breast implants is covered only when:
  • there is a medical complication related to an implant (such as a breast implant rupture); or
  • there is documented evidence of auto-immune disease.

  Related Exclusions: Cosmetic procedures, except for post-mastectomy coverage described in this section.
Human Organ Transplants: The plan covers:

- Bone marrow transplants. This includes for members diagnosed with breast cancer that has progressed to metastatic disease. Members must meet the criteria established by the Massachusetts DPH.
- Solid human organ transplants provided to members.
- Hematopoietic stem cell transplants provided to members.

You must be approved by the transplant facility as a candidate for the recommended transplant. Transplant services must also be: approved by a plan authorized reviewer; and provided at a network transplant facility. (Note: network transplant facilities may include facilities that are out of the service area. In such case, the plan will pay for related medically necessary transportation for the member.)

The plan covers the following services when the person receiving the organ transplant is a member:

- Care for the person receiving the organ.
- Donor search costs through established organ donor registries.
- The following charges incurred by the donor in donating the stem cells or organ to the member, but only to the extent these charges are not covered by the donor’s or any other health plan:
  - Evaluation and preparation of the donor.
  - Surgery and recovery services directly related to donating the organ to the member.

Related Exclusions:

- Donor charges of members who donate stem cells or solid organs to non-members.
- Experimental or investigational organ transplants.

Maternity Care: The plan covers:

- Hospital and delivery services for the mother. Note: The mother’s inpatient stay is covered for at least: 48 hours following a vaginal delivery; and 96 hours following a caesarean delivery. Decisions to reduce the mother and child’s inpatient stay are made only by the attending physician and mother (and not by the plan).
- Routine nursery charges for a healthy newborn.*
- Well newborn care.* This includes: pediatric care; routine circumcision furnished by a physician; and newborn hearing screening tests performed by a network provider before the newborn child (an infant under three months of age) is discharged from the hospital, or as provided by regulations of the Massachusetts DPH.
- One home visit by a network provider who is a: registered nurse; physician; or certified nurse midwife. Additional home visits by network providers when medically necessary. These home visits may include: parent education; assistance and training in breast or bottle feeding; and necessary and appropriate tests.

*Notes: If you are enrolled in a benefit package that does not allow subscribers to enroll newborns as dependents: the plan does not cover any costs (inpatient or outpatient) related to your newborn except routine nursery charges and well newborn care. See Chapter 4 for more information.

If you are enrolled in a benefit package that does allow you to enroll newborns as dependents: For newborns, the plan covers routine nursery charges and well newborn care. The newborn must be enrolled in the plan within 30 days of date of birth in order for the plan to cover other medically necessary services rendered to the newborn.

Note: You should not travel outside the service area:

- after your 37th week of pregnancy; or
- anytime after you have been told by your provider that you are at risk for early delivery.

There is no coverage for delivery (including postpartum care and care provided to the newborn) or problems with pregnancy outside the service area: after your 37th week of pregnancy; or anytime after being told by your provider that you are at risk for early delivery.
For Inpatient Mental Health and Substance Use Disorder Services: See “Mental Health and Substance Use Disorder Services” later in this Chapter 3.

Extended Care: The plan covers medically necessary care in an extended care facility up to any benefit limits in your Schedule of Benefits. An extended care facility is: a skilled nursing facility; rehabilitation hospital; or chronic hospital. You must need inpatient daily skilled nursing care or rehabilitative services. Coverage includes:
- semiprivate room and board;
- facility services; and
- use of durable medical equipment while you are in the facility.

Note: You may no longer need acute care hospital services but cannot be transferred to an extended care facility because a bed is not available. In such case, the plan may arrange for the hospital you are in to provide you with extended care services until such bed becomes available. These additional days in the acute hospital will be counted toward the applicable extended care benefit limits.

Related Exclusions to all Inpatient Care: The plan does not cover the following related to any inpatient admission:
- Personal items. Examples include: telephone; and television charges.
- Private duty nursing services.
- All charges over the semi-private room rate, except when a private room is medically necessary.
- Rest or custodial care.
- Charges after your hospital discharge.
- Charges after the date you are no longer a plan member.

OUTPATIENT SERVICES:

Prior Authorization from Plan Authorized Reviewer: Certain outpatient covered services require prior authorization (approval) by a plan authorized reviewer. If the provider of the service does not obtain the prior authorization, the plan will not cover the service. Always check with your provider to make sure he or she has obtained necessary approval.

Abortion: See Outpatient Surgery.

Allergy Services: The plan covers:
- Allergy testing.
- Allergy treatment.
- Allergy injections.
- Sensitivity tests. Limited to one per benefit year.
- Blood and pulmonary function tests. Limited to three per benefit year.

Ambulance Services: The plan covers:
- Ground ambulance transportation to the nearest medical facility for emergency medical care. (Air ambulance transportation is covered only when: a ground ambulance cannot be used to access the member; or when these forms of transport are medically necessary for your emergency medical condition.)
- Non-emergency ground ambulance or chair car transport to take the member from one inpatient facility to another inpatient facility for covered services.
- When medically necessary, non-emergency ground ambulance or chair car transport to take the member from an inpatient facility to a covered service.
- When medically necessary, non-emergency air ambulance or other air transport.

Related Exclusions:
- Transport to or from medical appointments (except when covered as described above).
- Transport by taxi or public transportation.
**Autism Spectrum Disorder Services:** See Mental Health and Substance Use Disorder later in this Chapter.

**Cardiac Rehabilitation:** The plan covers outpatient cardiac rehabilitation. This must meet the requirements of the Massachusetts DPH. Your first visit must be within 26 weeks of the date you were first diagnosed with cardiovascular disease or after a cardiac event. The plan covers:
- Outpatient convalescent phase of the rehab program following hospital discharge.
- Outpatient phase of the program that addresses: multiple risk reduction; adjustment to illness; and therapeutic exercise.

*Related Exclusions:*
- The program phase that maintains rehabilitated cardiovascular health.
- Fitness or health club fees.
- Exercise equipment.

**Chemotherapy and Radiation Therapy:** The plan covers outpatient chemotherapy and radiation therapy.

**Chiropractic Care:** See Spinal Manipulation.

**Cleft Lip and Cleft Palate:** The plan covers the following outpatient medical, dental, oral surgery and orthodontic treatment for members who are children under the age of 18 only when it is medically necessary and consequent to the treatment of cleft lip, cleft palate or both:

- Outpatient medical services including but not limited to:
  - Audiology services
  - Nutrition services
  - Speech therapy
  - Oral and facial surgery and related follow up care and surgical management
- Outpatient dental and orthodontic services including but not limited to:
  - Preventative and restorative services to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy.
  - Orthodontic treatment and management

*Prior Authorization:* Some services for the treatment of cleft lip and cleft palate require prior authorization. Always check with your provider to make sure he or she has obtained necessary plan approval.

*Related Exclusions:*
- Cosmetic procedures except when needed to improve or restore physiologic function that is impaired as a result of cleft lip, cleft palate or both.
- Dental or orthodontic treatment not related to the management of the congenital conditions of cleft lip and cleft palate.

**Clinical Trials:** The plan covers services for members enrolled in a qualified clinical trial or approved clinical trial for treatment for any form of cancer or other life-threatening disease or condition. Coverage will be provided in accordance with the terms and conditions in MA law (M.G.L. ch. 175, section 110L) and/or the Affordable Care Act (42 USC, section 300gg-8). The following services are covered:
- 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 reasonable cost of an investigational drug or device that has been approved for use in the clinical trial; however, coverage is only to the extent the drug or device is not paid for by its distributor, manufacturer or the provider.
Dental Services: The plan covers only the following dental services:

- **Emergency Dental Services:** The plan covers the following emergency dental services only when: there is a traumatic injury to sound, natural and permanent teeth caused by a source external to the mouth; and the emergency dental services are provided by a physician in a hospital emergency room or operating room within 48 hours following the injury:
  - X-rays; and
  - emergency oral surgery related to the repair of damaged tissues and/or the repositioning of displaced or fractured teeth.

- **Inpatient or Outpatient Surgery for Non-Covered Dental Services:** The plan covers facility charges (and related medical charges, such as radiology, lab and anesthesia) only when it is medically necessary, due to your having a serious non-dental medical condition, for you to be admitted:
  - to a network hospital;
  - to a surgical day care unit of a network hospital; or
  - to a network ambulatory surgical facility as an outpatient;
in order for you to receive non-covered dental services. The plan does not cover the dental services.

Examples of serious non-dental medical conditions include: hemophilia and heart disease.

- **Cleft Lip and Cleft Palate:** The plan covers medically necessary dental (including preventative and restorative dentistry) and orthodontic services for the treatment of cleft lip and cleft palate. Please see Cleft Lip and Cleft Palate earlier in this Chapter 3 for more details.

- **Pediatric Dental:** This plan DOES include coverage of pediatric dental services as per the federal Patient Protection and Affordable Care Act for members age 21 and under. Coverage is provided for the pediatric dental services described below. Cost-sharing applies to Type II, Type III and Type IV services. Deductible applies only to Type II and Type III services. Type I services are covered in full. There is some coverage for orthodontia treatment as noted in Type IV, below. Coverage is described and includes the following:

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Diabetes Treatment: The plan covers the following for members with diabetes if these are medically necessary to diagnose or treat: insulin-dependent; insulin-using; non-insulin dependent; or gestational diabetes.

- Diabetes outpatient self-management training and educational services. This includes medical nutrition therapy. These must be provided by a network provider who is a certified diabetes provider.
- Podiatry services to treat podiatric conditions for members diagnosed with diabetes, including: diagnostic lab tests and X-rays; surgery and necessary postoperative care; routine foot care (such as trimming of corns, nails or other hygienic care); and other medically necessary foot care.
- Under the plan’s lab benefit, the plan covers: diabetes lab tests, including glycosylated hemoglobin, or HbA1c, tests; and urinary protein/microalbumin and lipid profiles.
- Under the plan’s durable medical equipment benefit, the plan covers: insulin pumps and insulin pump supplies; insulin needles and syringes; diabetic test strips and lancets; blood glucose monitors for home use; voice-synthesizers and visual magnifying aids when medically necessary for home use for the legally blind.
- Under the plan’s prosthetics benefit, the plan covers: therapeutic and molded shoes and shoe inserts for severe diabetic foot disease. Shoes/shoe inserts must be: prescribed by a network podiatrist or other qualified doctor; and furnished by a network podiatrist, orthotist, prosthetist or pedorthist.
- Under the plan’s prescription drug benefit, the plan covers: prescribed oral diabetes medications that influence blood sugar levels; insulin; insulin needles and syringes; insulin pens; lancets; and blood glucose, urine glucose, and ketone monitoring strips.

Note regarding certain diabetes supplies: When obtained from a network pharmacy, certain diabetes supplies are covered under your prescription drug benefit; when obtained from a network DME provider, these supplies are covered under your durable medical equipment benefit. Examples are: insulin needles and syringes; and diabetic test strips and lancets.

Dialysis: The plan covers the following:

- Outpatient kidney dialysis in a network: hospital; or free-standing dialysis facility.
- Home dialysis. This includes non-durable medical supplies such as: dialysis membrane and solution; tubing and drugs needed during dialysis; and the cost to install, maintain or fix dialysis equipment. The plan decides whether to rent or buy the equipment.

If you are traveling outside the service area, the plan covers dialysis for up to one month per benefit year. You must first make advance arrangements with your network provider; and your network provider must obtain prior approval from a plan authorized reviewer.

When federal law permits Medicare to be the primary payer, you must apply for Medicare. You must also pay any Medicare premium. When Medicare is primary (or would be primary if you had enrolled in a timely manner): the plan will cover only those costs that exceed what would be payable by Medicare.

Related Exclusions to home dialysis:

- Costs to get or supply power, water or waste disposal systems.
- Costs of a person to help with the dialysis.
- Home hemodialysis.

Durable Medical Equipment and Orthotics (DME): The plan covers medically necessary DME. The DME must be prescribed by a network physician. The plan will decide whether to rent or buy the DME. The DME must be purchased or rented from a network provider.

DME is defined as devices or instruments of a durable nature that must be:

- able to withstand repeated use;
- reasonable and necessary to sustain a minimum threshold of independent daily living;
- used primarily to serve a medical purpose;
- not generally useful in the absence of disease or injury;
- able to be used in the home; and
- medically necessary for you.
Coverage for DME is available only for:

- The least costly DME adequate to allow you to engage in activities of daily living. If the plan decides that you chose DME that costs more than the least costly DME adequate to allow you to engage in activities of daily living, the plan will pay only for those costs that would have been paid for the least costly DME that meets your needs. In this case, you will have to pay the provider’s charges that are more than the plan’s allowed amount.
- One item of each type of equipment that meets your needs. (No back up items or items that serve a duplicate purpose are covered.)
- Repair and maintenance of covered DME.

The following are examples of covered and non-coverage DME: (Please call Member Services for questions about whether a particular piece of DME is covered.)

**Covered DME includes the following:**

- Wheelchairs.
- Crutches, canes, walkers.
- Respiratory and oxygen equipment.
- Hospital beds.
- Insulin pumps and insulin pump supplies; insulin needles and syringes; insulin test strips and lancets; blood glucose monitors for home use; voice-synthesizers and visual magnifying aids when medically necessary for home use for the legally blind.
- Certain types of braces.
- Non-foot or non-shoe orthotics.
- Breast pumps and related supplies (covered under the “Preventive Health Services” benefit, below)

**Note regarding certain diabetes supplies:** When obtained from a network pharmacy, certain diabetes supplies are covered under your prescription drug benefit; when obtained from a network DME provider, these supplies are covered under your DME benefit. Examples are: insulin needles and syringes; and diabetic test strips and lancets.

**Related Exclusions:**

- Dentures.
- Comfort or convenience items.
- Heating pads, hot water bottles.
- Foot and shoe orthotics; arch supports; shoe inserts; or fittings, casting and other services related to devices for the feet (except for members with severe diabetic foot disease).
- Bed pans and bed rails.
- Home improvements
- Home adaptation equipment.
- Exercise equipment.
- Equipment for sports or employment purposes.
- Wigs (or hair pieces) for hair loss due to: male or female pattern baldness; or natural or premature aging.
- For members over age 21 years of age: hearing aid devices; ear molds; impressions; batteries; accessories; and instruction in use and care of a hearing aid.

**Early Intervention Services:** The plan covers early intervention services provided by a network provider. These services must be an early intervention program meeting the standards of the Massachusetts DPH. This benefit is only for members through the age of 2 who meet established criteria. There is no cost-sharing. Early intervention services include the following:

- Physical therapy.
- Speech therapy.
- Occupational therapy.
- Nursing care.
- Psychological counseling.
**Note:** Benefit limits applicable to rehabilitation therapies do not apply to early intervention services.

**Emergency Services:** The plan covers emergency services in an emergency room.
- You are always covered for medical care in an emergency. You do not need prior authorization or a referral from your PCP. In an emergency, you should: go to the nearest emergency facility; or call 911 or other local emergency number.
- The plan provides coverage for post-stabilization services. These are covered services that are needed to stabilize your condition following an emergency until such time as your treating physician determines you are sufficiently stabilized for transfer or discharge.

**Cost-Sharing:** See your Schedule of Benefits for information about specific cost-sharing amounts.
- Cost-sharing may apply: for emergency care you get in an emergency room; or for observation services in a hospital setting without use of the emergency room. Please see your Schedule of Benefits for applicable cost-sharing.
- Cost-sharing applies even if you go to an emergency room for non-emergency care.
- Copayments for emergency services, if any, are waived if you are admitted as an inpatient immediately following receipt of emergency services in an emergency room. However, any applicable cost-sharing for inpatient hospital care will apply to your inpatient stay.
- If you get emergency covered services from a non-network provider, the plan will pay up to the allowed amount. You pay applicable cost-sharing and any difference between the provider’s charge and our payment.

**Emergency Defined:** See Appendix A for the definition of emergency.

**Notice to PCP or Plan:** If you receive emergency care at an emergency facility (whether inside or outside the service area), but are not admitted to the hospital, you or someone acting on your behalf should call your PCP after receiving care. This helps your PCP to provide or arrange for any follow up care.

If you receive emergency care at an emergency facility (whether inside or outside the service area) **AND** you are admitted as an inpatient (hospitalized) to a non-network facility; you or someone acting on your behalf **MUST** call the plan within 2 working days of admission. This is essential so that the plan can: manage and coordinate your care; and arrange for any medically appropriate transfer. (Note: notice by the provider of emergency services to your PCP, the plan or, in the case of emergency mental health or substance use disorder services, to Beacon, satisfies your requirement to notify the plan.

**Transfer:** Following emergency care, if you are admitted to a facility that is not a network provider, and your PCP determines that transfer is appropriate, you will be transferred to a network facility. The plan will not pay for inpatient care provided in the facility to which you were first admitted after your PCP determined that a transfer is medically appropriate and transfer arrangements have been made.

**Family Planning Services:** The plan covers the following outpatient family planning services when received from a network: physician (PCP, obstetrician or gynecologist); nurse practitioner; or certified nurse midwife:
- Routine medical exams.
- Medical consults.
- Diagnostic tests.
- Pregnancy testing.
- Birth control counseling.
- Genetic testing and related counseling: for certain genetically linked inheritable disorders, when the results of the testing will directly affect the care you receive. The member must either have a direct risk factor for, or have symptoms of, the disorder.
- Prescription and non-prescription contraceptives when given to you by a network provider during an office visit. Examples are: implantable contraceptives; intrauterine devices; diaphragms; cervical caps; injectable birth control drugs; and other medically necessary contraceptive devices that have been approved by the U.S. Food and Drug Administration.

**Notes:** Many family planning services are covered as “Preventive Health Services”, including prescription contraceptives such as: birth control pills and patches. See “Preventive Health Services” below.
For coverage of pregnancy terminations (abortions) and male voluntary sterilization: see “Outpatient Surgery” later in this Chapter. For coverage of female voluntary sterilization: see “Preventive Health Services” later in this Chapter. For coverage of infertility services: see “Infertility Services” later in this Chapter.

**Related Exclusions:**
- Reversal of voluntary sterilization.
- Services or fees related to using a surrogate to achieve pregnancy.
- Birth control that, by law, does not require a prescription. (Exception: when it is given to you by a network provider during an office visit).

**Gender Reassignment or Sex Change Services:** The plan provides coverage for medically necessary gender identity-and gender dysphoria-related health care services. Services are subject to prior authorization by the plan.

**Hearing Aids for Children:** The plan provides coverage towards the cost of hearing aids for members 21 years of age or younger. Coverage includes all related services prescribed by a licensed audiologist or hearing instrument specialist, including the initial hearing aid evaluation, fitting and adjustments, and supplies, including ear molds. Hearing aid batteries and cleaning fluid are not covered. Benefit limits apply. See your Schedule of Benefits for the benefit limit. Once you reach your benefit limit, no more benefits will be provided toward the cost of hearing aids.

**Hearing (Audiology) Examinations:** The plan covers exams and evaluations performed by a PCP or a network hearing specialist.

**Home Health Care:** The plan covers the home health care services listed below when:
- the member is homebound for medical reasons;
  - Homebound means that your medical condition normally prevents you from leaving the home; or that leaving your home requires a substantial effort.
- your PCP orders a home health care services plan that includes part time skilled nursing care as an essential part of your treatment; and
- there is a defined medical goal set by your PCP that he or she reasonably expects you will meet.

When you qualify for home health care, the plan will cover:
- Part time skilled nursing visits for as many visits as medically necessary.
- Part time physical, occupational and speech therapy, when these services: are a medically necessary component of skilled nursing; and they are needed to restore function lost or impaired due to your illness or injury.
- Medical social work.
- Nutritional consult.
- The medically necessary services of a part time home health aide while you are receiving home skilled nursing or rehabilitation therapies.
- Home visits by a network physician.
- Inhalation therapy.
- Home infusion therapy.
- Total parenteral nutritional therapy.

In addition, under the plan’s DME benefit, DME is covered when determined to be a medically necessary component of nursing and physical therapy services. See your Schedule of Benefits for DME cost-sharing.
**Related Exclusions:**
- Custodial care.
- Housekeeping services.
- Household repairs.
- Meals.
- Respite care.
- Private duty nursing.
- Personal care attendants.
- Homemakers.

**Hospice Services:** The plan covers the hospice services, in accordance with MA law, described below. Coverage is for members who are terminally ill. (Terminally ill means having a life expectancy of six months or less as certified by a network physician.)

Hospice services are a coordinated licensed program of services provided during the life of a terminally ill member. The member and his/her physician must agree to a plan of care that stresses pain control and symptom relief rather than treatment aimed at curing the member’s condition. Services can be provided:
- in a home setting;
- on an outpatient basis; or
- on a short-term inpatient basis. (This is only when medically necessary to control pain and manage acute and severe clinical problems that cannot, for medical reasons, be managed in a home setting.)

Covered services are provided in accordance with MA law, as follows:
- Physician services. (These are covered when the condition or diagnosis is unrelated to the condition or diagnosis for which you are receiving hospice care.)
- Skilled nursing care.
- Social work services.
- Medically necessary home health aid visits.
- Respite care. (This care is furnished to the hospice patient in order to relieve the family or primary care person from care-giving functions.)
- Volunteer services.
- Counseling services. (Bereavement counseling for the member’s family is covered for up to one year following the member’s death.)
- Private duty nursing.
- Personal care attendant services.

In addition:
- DME is covered under the plan’s DME benefit.
- Prescription drugs are covered under the plan’s prescription drug benefit.

**House Calls:** The plan covers house calls when medically necessary. Providers include PCPs, nurse practitioners and physicians’ assistants. House calls are subject to the applicable office visit cost-sharing. Your PCP must arrange for house calls.

**Immunizations:** The plan covers:
- Routine preventive immunizations. (See Preventive Health Services benefit).
- Medically necessary immunizations.

**Infertility Services for Massachusetts Residents:** The plan covers the diagnosis and treatment of infertility. Services must be provided by network providers in accordance with MA law.

“Infertility” is defined as: the condition of an individual who is unable to conceive or produce conception during a period of:
- 1 year if the female is age 35 or younger; or
- 6 months if the female is over the age of 35.
For purposes of meeting the criteria for infertility: if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the 1 year or 6 month period, as applicable.

Infertility services are covered services only for members who are diagnosed with infertility and:

- who are MA residents;
- who meet the plan’s clinical review criteria for coverage of infertility services, which are based on the member’s medical history, diagnostic testing and medical evaluations;
- who meet the eligibility requirements of network infertility services providers; and
- with respect to the procurement and processing of donor eggs, sperm or inseminated eggs, or banking of donor sperm or embryos: to the extent the costs of such services are not covered by the donor’s health insurance or other health coverage and the member is in active infertility treatment.

The plan covers the following medically necessary infertility services:

- The following services and supplies provided in connection with an infertility evaluation and/or treatment:
  - diagnostic tests and procedures;
  - artificial insemination (intracervical or intrauterine) when done with non-donor (partner) sperm; and/or
  - procurement, processing, and long-term (longer than 90 days) banking of sperm when associated with active infertility treatment.

- The following procedures when approved in advance by a plan authorized reviewer in accordance with the plan’s clinical review criteria:
  - artificial insemination (intracervical or intrauterine) when done with donor sperm* and/or gonadotropins; and
  - procurement and processing of eggs or inseminated eggs and banking of embryos when associated with active infertility treatment.
  *Donor sperm is only covered when: the partner has a male factor infertility diagnosis; or donor sperm is being used as an alternative to Pre-implantation Genetic Diagnosis (PGD) when a couple meets the criteria for PGD.

- The following “assisted reproductive technology” (ART) procedures* when approved in advance by a plan authorized reviewer in accordance with the plan’s clinical review criteria:
  - In Vitro Fertilization and Embryo Transfer (IVF-ET).
  - Gamete Intra-Fallopian Transfer (GIFT).
  - Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor infertility.
  - Zygote Intra-Fallopian Transfer (ZIFT).
  - Frozen Embryo Transfer (FET).
  - Donor Oocyte (DO).
  - Cryopreservation of eggs.
  - Assisted hatching.
  *ART procedures include: diagnostic evaluation; testing; ovarian stimulation; egg retrieval; procurement and processing of sperm and eggs or inseminated eggs; transfer of embryos; and banking of extra embryos when associated with active infertility treatment.

- Under your prescription drug benefit: oral and injectable drugs used in the treatment of covered infertility services are covered: when the member has been approved for covered infertility treatment; and when obtained from a network pharmacy. See your Schedule of Benefits for applicable cost-sharing.

Related Exclusions:
- Infertility services for any member who is not a MA resident.
• Any experimental infertility procedure. This is defined by applicable MA regulation.
• Surrogacy/gestational carrier.
• Reversal of voluntary sterilization.

**Laboratory Tests, Radiology and other Outpatient Diagnostic Procedures:** The plan covers the following outpatient services to diagnose illness, injury or pregnancy. Some tests are subject to prior authorization by a plan authorized reviewer.

- Diagnostic laboratory tests.
  - Examples: Glycosylated hemoglobin (HgbA1C) tests; urinary protein/microalbumin tests; and lipid profiles to diagnose and treat diabetes.
- Diagnostic X-ray and other imaging tests.
  - Example: fluoroscopic tests.
- Diagnostic: CT/CTA scans; MRI/MRA; PET scans; and NCI/NPI (nuclear cardiac imaging). **Note:** Prior authorization is required for these tests.
- Human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish bone marrow transplant donor suitability. This includes testing for A, B or DR antigens, or any combination, in accordance with Massachusetts DPH guidelines.

**Low Protein Foods:** The plan covers food products modified to be low-protein when: ordered by a physician; and medically necessary to treat inherited diseases of amino and organic acids.

**Maternity Services-Outpatient:** The plan covers the following outpatient maternity services:

- Prenatal exams and tests: Routine outpatient prenatal care, including evaluation and progress screening; physical exams; and recording of weight and blood pressure monitoring.
- Postpartum exams and tests: Routine outpatient postpartum care for the mother. This includes lactation consultations.
- Childbirth classes.

You must obtain outpatient maternity care from a network provider. Your network provider must make arrangements for inpatient care. (See “Inpatient Hospital Care” earlier in this Chapter.)

**Note:** Some services above are considered Preventive Health Services. Please see “Preventive Health Services” later in this Chapter for more information.

**Medical Formulas:** The plan covers the following to the extent required by MA law:

- Non-prescription enteral formulas, ordered by a physician for home use, 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.
- Prescription formulas for the treatment of: phenylketonuria; tyrosinemia; homocystinuria; maple syrup urine disease; propionic academia or methylmalonic academia in infants and children; or to protect the unborn fetuses of pregnant women with phenylketonuria.

**Medical Supplies:** The plan covers the cost of certain types of medical supplies. You must obtain these from a network provider. Medical supplies include:

- Ostomy supplies;
- Tracheostomy supplies;
- Catheter supplies;
- Oxygen supplies; and
- Supplies for insulin pumps.

**Notes:** Call Member Services for more information on whether:

- a particular medical supply is a covered service; and
- a particular medical supply is covered under the prescription drug benefit. (See “Prescription Drugs” later in this Chapter.)

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**Mental Health and Substance Use Disorder Services (Inpatient, Intermediate and Outpatient):** The plan contracts with Beacon Health Strategies to manage all mental health and substance use disorder services for members.

**How to Get Care:** If you need mental health or substance use disorder services, you may do any of the following:

- Go directly to a network provider who provides mental health or substance use disorder services.
- Call the plan’s toll-free mental health/substance use disorder telephone line – staffed by Beacon—at 1-877-957-5600 for help finding a network provider 24 hours a day.
- Call your PCP for help finding a network provider.
- Visit Beacon’s website (www.beaconhealthstrategies.com) or follow the link on the plan’s website (www.bmchp.org) to look up network providers.

**In an emergency:**
- go to the nearest emergency services provider or emergency medical facility; or
- call 911 or local number for emergency services.

**Prior Authorization:**
- Coverage for certain mental health and substance use disorder services is subject to prior authorization by a plan authorized reviewer.
- Always check with your provider to make sure he or she has obtained necessary approval from Beacon.
- Any decision that a requested mental health or substance use disorder services is not medically necessary will be made by a licensed mental health professional.

**Benefits:** The plan covers medically necessary outpatient, inpatient and intermediate mental health and substance use disorder services to diagnose and treat mental disorders. This includes:

- Biologically-based mental disorders, including: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia; panic disorder; obsessive-compulsive disorder; delirium and dementia; affective disorders; eating disorders; post-traumatic stress disorder; substance use disorders; autism; and other psychotic disorders or other biologically–based mental disorders.
  - **Note regarding autism spectrum disorder (ASD):** The plan provides coverage for ASD in accordance with MA law, including the following:
    - ASD includes any of the pervasive developmental disorders (as defined by the most recent edition of the DSM), including autistic disorder; Asperger’s disorder; and pervasive developmental disorders not otherwise specified.
    - Diagnosis of ASD includes: medically necessary assessments; evaluations (including neuropsychological evaluations); genetic testing; or other tests to diagnose whether a member has an ASD.
    - Treatment for ASD includes: habilitative or rehabilitative care (including applied behavioral analysis*); pharmacy care (under the Prescription Drug benefit); psychiatric care (direct or consultative services provided by a licensed psychiatrist); psychological care (direct or consultative services provided by a licensed psychologist); and therapeutic care (services provided by licensed or certified: speech therapists, occupational therapists, physical therapists or social workers). Benefit limits applicable to the Rehabilitation Therapies benefit do not apply to therapeutic care services provided to members with ASD.
    - Services must be rendered by network autism services providers (providers who treat ASDs). These include board certified behavior analysts**; psychiatrists; psychologists; licensed or certified: speech therapists, occupational therapists, physical therapists and social workers; and pharmacies. However, in the event the plan is unable to provide adequate access to network ASD providers, members should call Beacon at 1-877-957-5600 to arrange for out-of-network ASD services.

*Applied behavioral analysis is defined as: the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially
significant improvement in human behavior. This includes the use of direct observation, measurement and functional analysis of the relationship between environment and behavior. **Defined as a behavioral analyst credentialed by the behavior analyst certification board as a board certified behavior analyst.**

- Rape-related mental or emotional disorders to victims of rape or victims of an assault with intent to commit rape.
- For members who are under the age of 19: non-biologically based mental, behavioral or emotional mental disorders, which substantially interfere with or substantially limit the functioning and social interactions of such child or adolescent; provided, that the interference or limitation is documented by and the referral for such diagnosis and treatment is made by the PCP, primary pediatrician or a licensed mental health professional of such a child or adolescent, or is evidenced by conduct, including but not limited to: (1) an inability to attend school as a result of such a disorder; (2) the need to hospitalize the child or adolescent as a result of such a disorder; (3) a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others.

Note: The plan will continue to provide such benefits to any adolescent who is engaged in an ongoing course of treatment beyond their 19th birthday until:
- the course of treatment, as specified in the treatment plan, is completed, and
- while the benefit contract under which such benefits first became available remains in effect, or subject to a subsequent benefits contract which is in effect.

- All other non-biologically based mental disorders.

Outpatient Mental Health and Substance Use Disorder Services:

- The plan covers medically necessary outpatient services to diagnose and treat mental disorders. (Services include ambulatory detoxification and methadone maintenance treatment.)
- Outpatient services may be provided in a network: licensed hospital; a mental health or substance use disorder clinic licensed by DPH; a public community mental health center; a professional office; or home-based services.
- The services are available from any of the following network licensed professionals acting within the scope of his/her license:
  - Licensed mental health counselors.
  - Licensed independent clinical social workers.
  - Licensed psychiatric nurses who are certified as clinical specialists in psychiatric and mental health nursing.
  - Licensed marriage and family therapists
  - Psychiatrists.
  - Psychologists.

Biologically-based and non-biologically based outpatient services are provided without annual, lifetime or visit/unit/day limits.

Inpatient Mental Health and Substance Use Disorder Services:

- The plan covers medically necessary inpatient mental health and substance use disorder services for mental disorders.
- Inpatient services for mental disorders are provided in a network: general hospital; mental health hospital; or a substance abuse facility.
- Inpatient services are provided without annual, lifetime or visit/unit/day limits.

Intermediate Mental Health and Substance Use Disorder Services:

- The plan covers medically necessary intermediate services for mental disorders.
- Intermediate services are: a range of non-inpatient services that provide more intensive services than outpatient services and less intensive than inpatient services.
- Services are provided without annual, lifetime or visit/unit/day limits.
- Examples include:
  - Day treatment programs.
  - Partial hospital programs.
  - Intensive outpatient programs.
Crisis stabilization.
Clinical stabilization services
In-home therapy services, such as family stabilization (FST).
Acute residential treatment, such as community based acute treatment.
Clinically managed detoxification services.
Level III community based detoxification.

Medication-Assisted Treatment (MAT) and Associated Services
- Medication-Assisted Treatment visits include, but are not limited to, counseling and drug screening

Opioid Antagonist Medication
- Coverage is provided for opioid antagonist medication approved for use in a take-home setting or by a health care professional

Other Related Services: The plan covers:
- Medication management services.
- Neuropsychological assessment and psychological testing.

Smoking and Tobacco Cessation: The plan covers individual and group counseling services for members who smoke or use tobacco products. Also covered are related prescription drugs. See the “Prescription Drug” benefit later in this Chapter. For information about this benefit, call Member Services at 1-855-833-8120.

Related Exclusions:
- Custodial care.
- Psychoanalysis.
- Hypnotherapy.
- Massage and relaxation therapies.
- Developmental testing.
- Services for problems of school performance.
- Educational services or testing services.
- Mental health services provided to a member who is in jail, a house of correction, prison or custodial facility.
- Mental health services provided by the Massachusetts DPH.
- The following ASD services are excluded:
  - ASD services provided under:
    - an individualized family service plan (ISFP);
    - an individualized education program (IEP); or
    - an individualized service plan (ISP).
  - ASD services provided by school personnel.

Newborn Infants and Adoptive Children Services: The plan covers medically necessary newborn care for newborns and adoptive children properly enrolled in the plan. This includes medically necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, or premature birth. See “Maternity Care” earlier in this Chapter; and see Chapter 4 “Newborn and Adoptive Children – Enrollment and Coverage” for more information about enrollment and coverage of newborns and adoptive children.

Nutritional Counseling: The plan covers nutrition-related diagnostic, therapeutic and counseling services furnished by a registered dietician or nutritional professional for the purpose of disease management. Nutritional counseling includes an initial assessment of nutritional status followed by additional planned visits for dietary interventions to treat medical illness.

Orthotics: See Durable Medical Equipment earlier in this Chapter.
Outpatient Office Visits for Medical Care: The plan covers outpatient PCP and specialist office visits to evaluate and treat illness or injury. Services include:

- Medically necessary (non-routine) immunizations.
- Pediatric specialty care by network providers with expertise in specialty pediatrics. (See Mental Health and Substance Use Disorder Services for mental health and substance use disorder services for children and adolescents.)

Note: Some outpatient office visit services are considered Preventive Health Services. Please see “Preventive Health Services” later in this Chapter for more information.

Outpatient Surgery: The plan covers outpatient surgery:

- that is done under anesthesia in an operating room of a facility licensed to perform surgery; and
- where you are expected to be discharged the same day.

This coverage includes:

- Voluntary termination of pregnancy (abortions). The plan provides coverage for all abortion services that are legally permitted under applicable law. When applicable, in accordance with federal law, a separate premium is charged for coverage of the abortion services for which federal funding is prohibited.
- Male voluntary sterilizations (See “Preventive Health Services,” below, for female voluntary sterilization.)
- Diagnostic procedures. Examples: a colonoscopy or endoscopy.

Podiatry Services: The plan covers the following:

- For diabetic members: all podiatry (foot) care whether routine or non-routine is covered.
- For all other members: the plan only covers non-routine medically necessary podiatry (foot) care by a network provider, including a network podiatrist. Examples: treatment for hammertoe and osteoarthritis. This does not include routine foot care. (Examples of routine foot care: trimming of corns, nails or other hygienic care).

Prescription Drugs: The plan’s formulary is a list of prescription drugs that indicates coverage status, cost-sharing, and any limitations, restrictions or exclusions. Formulary updates are made every other month or more frequently if necessary. The online formulary is updated as changes are made. Members who may be affected by formulary changes are notified via mail, unless the change is beneficial to the member. Go to the plan’s website (www.bmchp.org) or call Member Services at 1-855-833-8120 to find out whether a drug is covered or excluded.

Conditions of Coverage: The plan covers prescription drugs listed on the plan’s formulary, when they are provided in accordance with the plan’s Pharmacy Programs and when they meet all of the following rules described below. (Note: this includes the requirement that coverage for certain drugs is subject to prior authorization (approval) by a plan authorized reviewer. Always check with your provider to make sure he or she has obtained necessary plan approval.)

- The drug by law requires a prescription.
- The drug is prescribed by a provider licensed to prescribe medications.
- The prescription meets all legal requirements for a prescription.
- The prescription is filled by a network pharmacy (except in an emergency, or for urgent care when you are temporarily traveling outside the service area).
- The prescribed drug is medically necessary.
- The drug is being prescribed to treat an illness, injury, or pregnancy; or for preventive care purposes.

Cost-Sharing: See your Schedule of Benefits for prescription drug cost-sharing.

Where to get your prescription drugs: Take your prescription or refill to any network pharmacy. Bring your ID card. Pay the applicable cost-sharing.

- Network pharmacies: includes many retail pharmacies in Massachusetts. For a list of network pharmacies, see the Pharmacy Directory on our website at www.bmchp.org, or call Member Services.
- Specialty pharmacy providers: For certain drugs, the plan contracts with one or more specialty pharmacy providers. (See below under “Pharmacy Programs” for more information about specialty pharmacy providers.)
How to obtain Mail Order Drugs: The plan contracts with EnvisionPharmacies for mail order drug services. Before you can use the mail order drug program, you must have filled a 30-day supply of each medication, two times at a retail pharmacy within the previous 3 months. Only certain maintenance drugs are available through mail order. To use the mail order service you must first enroll with EnvisionPharmacies. To enroll in this service and begin getting medications in the mail you may must either contact EnvisionPharmacies by phone at 866-909-5170 or complete the mail order enrollment form that was included in your member welcome packet and is also available on the EnvisionPharmacies website. Your prescribing provider may also call EnvisionPharmacies at 1-866-909-5170 or fax your prescription to them at 1-866-909-5171. Once you have enrolled, you can refill prescriptions by mail, phone, or online at www.envisionpharmacies.com.

- Non-network pharmacies: If you have to fill a prescription at a non-network pharmacy due to an emergency or for urgent care when outside the service area, you will have to pay for your prescription and seek reimbursement from the plan. The plan will pay up to the allowed amount for eligible claims minus your cost-sharing. (See Chapter 7 – “Bills from Providers” or call Member Services for information about how to seek plan reimbursement.)

What is covered: Subject to all of the Conditions of Coverage described earlier in this section, the plan covers the following prescription drugs and supplies:

- Prescribed drugs that by law require a prescription (unless listed under “What is not covered,” below).
- Select drugs that do not require a prescription by law (“over-the-counter” drugs), if any, that are listed on the plan’s formulary as a covered drug. To find out which over-the-counter drugs are covered, go to www.bmchp.org.
- Hormone replacement therapy for peri-and post-menopausal women (HRT).
- Oral and other forms of prescription drug contraceptives (birth control drugs). See “Preventive Health Services” below.
- Drugs to stop smoking and treat tobacco addiction. These are covered only when your provider has given you a prescription that meets all legal requirements for a prescription. Please check the plan’s formulary for coverage information on these drugs.
- Hypodermic syringes or needles when medically necessary.
- Insulin; insulin pens, insulin needles and syringes; blood glucose, urine glucose and ketone monitoring strips; lancets; and oral diabetes medications only when your provider has given you a prescription that meets all legal requirements for a prescription.
- Off-label use of FDA-approved prescription drugs for the treatment of cancer or HIV/AIDS that have not been approved by the FDA for that indication. These drugs must be recognized for such treatment: in one of the standard reference compendia, in the medical literature, or by the Massachusetts Commissioner of Insurance.
- Certain compounded medications: as long as one or more agents within the compound by law requires a prescription.
- Certain injectable, inhaled, infused or oral medications given in a physician’s office or self-administered.
- Oral and injectable drug therapies used in the treatment of covered infertility services. (See Chapter 3-Outpatient Services/Infertility Services.) These are covered only when the member has been approved for covered infertility treatment.
- Orally administered anti-cancer medications used to kill or slow the growth of cancerous cells.
- Opioid Antagonist Medications
- Medication-Assisted Treatment (MAT) Medications

What is not covered: The plan does not cover the following under the prescription drug benefit:

- Over-the-counter drugs that are not listed on the plan’s formulary as covered. To find out which over-the-counter drugs are covered, go to www.bmchp.org.
- Prescriptions that were written by a non-network provider, except: in an emergency: or in an urgent care setting when you are outside the service area.
- Drugs that are not prescribed to: treat an illness, injury, or pregnancy, or for preventive care purposes.
- Drugs that the plan specifically excludes, for example:
  - Experimental or investigational drugs.
  - Drugs that have not been approved by the U.S. Food and Drug Administration (“FDA”). This includes herbal and/or alternative drugs and medical foods that require a prescription. These
include, but are not limited to: Atopiclair®; Udamin®/Udamin SP®; and Foltix®.

- Drugs used primarily for cosmetic purposes. These include: Rogaine®; Avage®; Propecia®; Renova®; Vaniqa®; TriLuma®; all topical hydroquinone products; Benoquin®; and Solage®.
- Drugs for the treatment of sexual dysfunction. These include: Viagra®; Cialis®; Levitra®; Yohimbine; Caverject®; Edex®; and Muse®.
- Dietary and nutritional supplements.
- Drugs that have been deemed less-than-effective by the FDA, i.e. DESI drugs. These include: Midrin®; Duradrin®; Estratest®; and hydrocortisone rectal suppositories. For a complete list of DESI drugs please visit: http://www.cms.hhs.gov/MedicaidDrugRebateProgram/12_LTEIRSDrugs.asp
- Brand name prescription drugs used primarily for the treatment of the symptoms of a cough or cold.
- Convenience packaged drugs that contain topical medications and/or medical supplies. (For example: topical rinses, alcohol pads, and combs.)

- Prescription drugs related to non-covered dental services.
- Drugs prescribed as part of a course of treatment that the plan does not cover.
- Delivery, shipping and handling costs related to delivering drugs to you.
- Prescriptions filled at non-network pharmacies, except in cases of: emergency care; or urgent care when you are outside the service area.
- Compounded medications, if no active ingredients by law require a prescription.
- Compounded medication and non-compounded medication flavoring.
- Immunizing agents; toxoids; blood; and blood products. (Note: these may be covered under your outpatient or inpatient benefits.)
- Certain medical devices. (Note: these may be covered under the Durable Medical Equipment benefit.)

Pharmacy Programs: The plan has several Pharmacy Programs. These Programs seek to ensure that members are provided safe, clinically appropriate and cost-effective drugs. The drugs subject to these programs are listed on the plan’s formulary and may change from time to time. To find out what drugs are subject to any of these Programs, check the plan’s formulary at www.bmchp.org or call Member Services.

The following is a description of these Programs:

- **Prior Authorization:** In the case of certain drugs, the plan requires your physician to obtain prior authorization from a plan authorized reviewer before prescribing the drug. The drugs subject to prior authorization include: certain very expensive drugs; brand name drugs when a generic equivalent is available; and new-to-market drugs that have not yet been reviewed by the plan for coverage.
- **Quantity Limits:** The plan limits the quantity of certain drugs that you can be provided in a given period of time. This is done for safety, cost and/or clinical reasons.
- **Step Therapy:** This Program requires providers to use certain designated “first line” therapies or drugs prior to prescribing certain other drugs. Example: the use of generic antidepressants before prescribing brand name antidepressants.
- **Specialty Pharmacy Providers:** The plan has contracts with network specialty pharmacies to provide certain specialized drugs. You must obtain these drugs from one of our network specialty pharmacies.
- **Mandatory Generic Substitution Program:** This Program requires that members first try the equivalent “AB-rated” generic version of a brand drug before its brand counterpart would be covered. A provider can submit an exception request when the brand drug is medically necessary.

**EXCEPTION REQUESTS:** If your physician believes it is medically necessary for you to take a prescription drug that is restricted by any of the Pharmacy Programs above, he or she should contact the plan and request an exception from a plan authorized reviewer. The plan will consider if the drug is medically necessary for you. If so, it will make an exception and cover the drug. For more information, call Member Services.

**Pharmacy Benefit Manager:** The plan contracts with a separate organization, known as a pharmacy benefit manager, to administer its prescription drug benefit. See the Address and Telephone Directory in the front of this EOC for more information.
Preventive Health Services: The plan covers preventive health services. These are services to prevent disease or injury rather than diagnose or treat a complaint or symptom. These services are provided by your PCP, network obstetrician or other qualified network providers. To be covered, all preventive health services must be provided: in accordance with the plan’s medical policy guidelines; and with applicable laws and regulations.

The following is a summary of covered preventive health services. A complete listing of all preventive health services covered by the plan under the federal Affordable Care Act (ACA) can be found at www.healthcare.gov or on www.bmchp.org.

- **Preventive health care services for members who are children:**
  - Physical exam, history, measurements, sensory screening, neuropsychiatric evaluation and developmental screening, and assessment at the following intervals:
    - Six times during the child’s first year after birth.
    - Three times during the second year of life (age one to age two).
    - Annually from age two through age five (until age 6).
  - Hereditary and metabolic screening at birth.
  - Newborn hearing screening test prior to discharge from the hospital or birthing center.
  - Immunizations; tuberculin tests; hematocrit; hemoglobin; blood lead screening; or other appropriate blood tests and urinalysis as recommended by the physician.
  - Routine physical exams for children age 6 and older.
  - Routine eye exams up to the benefit limit. See your Schedule of Benefits.

- **Preventive health care services for adults:**
  - Routine medical exams (once per benefit year); and related routine lab tests and x-rays.
  - Routine hearing exams and screenings.
  - Routine preventive immunizations as recommended by the Advisory Committee on Immunization Practices.
  - Routine preventive screening tests and procedures. (Example: screening colonoscopies). (In some cases, if these procedures are accompanied by treatment/surgery, they become subject to applicable cost-sharing.)
  - Nutritional counseling and health education.
  - Routine eye exams up to the benefit limit. See your Schedule of Benefits.

- **Preventive health care services for women, including pregnant women:**
  - Routine gynecological exam. This includes a routine cytologic (Pap smear) screening once per benefit year. You must see a network: physician (PCP, obstetrician or gynecologist); nurse practitioner; or certified nurse midwife.
  - Prenatal care.
  - Baseline mammograms for women between the ages of 35 and 40; and routine annual screening mammograms once per benefit year for women age 40 and older.
  - Laboratory tests associated with routine maternity care.
  - Voluntary sterilization procedures.
  - Breast pumps and related supplies.
  - Lactation counseling and support from a trained network provider.
  - Prescription drug contraceptives.

- **Other preventive health services, screenings and counseling, as required by the Affordable Care Act (ACA).**

**Cost Sharing:** There is no cost-sharing for covered preventive health services.

Note: In the course of receiving certain preventive health services, you may also receive other covered services that require separate cost-sharing. Also, any medically necessary follow up care as a result of preventive health services is subject to applicable cost-sharing.

**Related Exclusions:** Exams needed to take part in school, camp and sports activities; or exams required by employers, courts or other third parties; unless these exams are furnished as part of a covered routine exam.
Prosthetic Devices: The plan covers medically necessary prosthetic devices when prescribed by a network physician. The plan will decide whether to rent or buy the prostheses. The prostheses must be purchased or rented from a network provider.

Prosthetic devices are devices of a durable nature that must be:
- able to withstand repeated use;
- reasonable and necessary to sustain a minimum threshold of independent daily living;
- made primarily to serve a medical purpose;
- not generally useful in the absence of disease or injury;
- able to be used in the home;
- medically necessary for you; and
- used to replace the function of a missing body part and made to be fitted to your body as an external substitute.

Coverage for prosthetics is available only for:
- The least costly device adequate to allow you to engage in activities of daily living. If the plan decides that you chose a prosthetic that costs more than the least costly prosthetic adequate to allow you to engage in activities of daily living, the plan will pay only for those costs that would have been paid for the least costly device that meets your needs. In this case, you will have to pay the provider’s charges that are more than the amount the plan pays.
- One item of each type of prosthetic device that meets your needs is covered. No back up items or items that serve a duplicate purpose are covered.
- Repair and maintenance of covered equipment.

Examples of covered prosthetics:
- Breast prostheses. These include replacements and mastectomy bras.
- Prosthetic arms, legs and eyes.
- Therapeutic and molded shoes and shoe inserts for severe diabetic foot disease. (See Diabetes benefit, above.)
- Wigs prescribed by a network physician, when the member has hair loss due to: treatment for any form of cancer or leukemia; alopecia areata; alopecia totalis; or permanent loss of scalp hair due to injury (such as from burns or other traumatic injury).

Related Exclusions:
- Electronic and myoelectric artificial limbs.
- Wigs when hair loss is due to male or female pattern baldness; or natural or premature aging.

Radiology Services: See Laboratory Tests, Radiology and Other Diagnostic Procedures.

Rehabilitation Therapies (Outpatient) – Short Term Physical, Occupational and Pulmonary Therapies: The plan covers medically necessary outpatient short term physical, occupational, and pulmonary therapy services for rehabilitative and habilitative purposes. These services must be provided:
- to restore function lost or impaired as a result of an accidental injury or an illness;
- when needed to improve your ability to perform activities of daily living; and
- when your PCP and the plan determine that such therapy is likely to result in significant improvement in your condition within the period of time benefits are covered.

Benefit Limits: Rehabilitation and Habilitative therapies are covered up to the benefit limit in your Schedule of Benefits. These benefit limits do not apply when these services are provided to members:
- receiving early intervention services – see Early Intervention Services, above; or
- with autism spectrum disorder (ASD)-see Mental Health and Substance Use Disorder Services, above.

Prior Authorization: Coverage for rehabilitation therapies requires prior authorization by a plan authorized reviewer. Always check with your provider to make sure he or she has obtained necessary plan approval.
Related Exclusions:
• Educational services or testing, or services to address school performance.
• Vocational rehabilitation.
• Massage therapy.
• Sensory integrative testing (including praxis).
• Diagnosis or treatment of speech, language or hearing disorders in a school-based setting.

Second Opinions: The plan covers second opinions by network providers about the necessity of a covered service that a network provider has recommended for you. Second opinions from non-network providers are covered only when the specific expertise requested is not available from network providers. When surgery is being considered, the plan will cover third surgical opinions when the first and second opinions differ.

Speech-Language and Hearing Disorder Services: The plan covers diagnosis and treatment of speech, hearing and language disorders. These are covered to the extent medically necessary when provided by network speech-language pathologists and audiologists.

Related Exclusions: Diagnosis or treatment of speech, language and hearing disorders in a school-based setting.

Spinal Manipulation: The plan covers manual manipulation of the spine.

Temporomandibular Joint (TMJ) Disorder: The plan covers treatment of TMJ disorders only when the disorders are caused by or result in a specific medical condition. TMJ syndrome is not considered a specific medical condition. Examples of such specific medical conditions are: jaw fractures; jaw dislocations, or degenerative arthritis. The medical condition must be proven to exist by diagnostic x-rays or other generally accepted diagnostic procedures.

Note: Coverage for TMJ disorder may require prior authorization by a plan authorized reviewer. Always check with your provider to make sure he or she has obtained necessary plan approval.

Related Exclusions:
• Treatment of TMJ disorders that are not proven to be caused by or to result in a specific medical condition.
• Treatment for TMJ syndrome.
• Appliances, other than a mandibular orthopedic repositioning appliance (MORA).
• Services, procedures or supplies to adjust the height of teeth or in any other way restore occlusion. Examples include: crowns, bridges or braces.

Vision Services: The plan covers:
• Routine eye exams: Routine eye exams are covered up to the benefit limit. See your Schedule of Benefits.
• Non-routine eye exams and treatment: The plan covers non-routine eye exams. (This includes diabetic retinal eye exams.) You must use a network provider who is an eye doctor. These are optometrists or ophthalmologists. Non-routine eye exams are for detection, treatment and management of eye conditions that produce symptoms that, if left untreated, may result in loss of vision.
• Medically necessary vision therapy only for: accommodative insufficiency; amblyopia; convergence insufficiency; and esotropia acquired (prior to surgery).
• Contact lenses or eyeglasses (one pair per prescription change) if one of the following conditions exists: postoperative cataract extraction; keratoconus; anisometropia of more than 3.00D; or more than 7.00D of myopia or hyperopia.
• Pediatric Vision Service – For members age 21 and under, in addition to the routine eye exam noted above, the plan covers one (1) pair of eyeglasses, including frames and lenses, or contact lenses per calendar year.
  o Services include:
- Lenses: single vision, conventional (lined) 0 bifocal, conventional (lined) trifocal, lenticular all lens powers,
- fashion and gradient tinting,
- ultraviolet protective coating,
- oversized and glass-grey #3 prescription sunglass lenses.
- Polycarbonate lenses are covered for children, monocular patients and patients with prescriptions greater than or equal to +/- 6.00 diopters.
- All lenses include scratch resistant coating.

Related Exclusions:
- Vision therapy for certain diagnoses where there is not adequate authoritative evidence of effectiveness.
- Glasses, frames and contact lenses are excluded, except as specifically listed in this section as a covered Vision Service.

EXCLUSIONS FROM COVERED SERVICES:

The plan does not cover the following services, regardless of the setting:

Note: when the word “services” is used in this section on Exclusions from Covered Services, it means any of the following: services, treatments, procedures, tests, devices, supplies, equipment or medications.

- Services not described as a covered service in this EOC.
- Services related to or furnished along with a non-covered service, except as otherwise expressly stated in Chapter 3-Covered Services. This includes costs for: professional fees; medical equipment; drugs; and facility charges.
- Services that are not medically necessary. The only exceptions are: voluntary termination of pregnancy; voluntary sterilization; prescription birth control drugs used for contraception; and covered preventive health services.
- Services provided: for your comfort or convenience; as a duplicate or back-up item; or personal or environmental comfort. All comfort or convenience items considered to be so by the Centers for Medicare and Medicaid Services (CMS) are excluded. Examples of excluded items include: bedboards; bathtub lifts; bath/shower chair; overbed tables; adjust-a-beds; telephone arms; hot tubs; and water beds.
- Services: to accommodate your religious preference; to improve athletic performance; to promote a desired lifestyle; or to improve your appearance or your feelings about your appearance.
- Services received outside the service area except as specifically described in this EOC.
- Services provided by non-network providers, except as specifically allowed in this EOC.
- Services that do not conform to the plan’s clinical review criteria and guidelines.
- Services for which there is a less intensive level of service or more cost-effective alternative that can be safely and effectively provided, or if the service can be safely and effectively provided to you in a less intensive setting.
- Services that you received when you were not enrolled as a member under this plan. This includes before your plan membership began and after your plan membership ends.
- Charges for services you receive after you choose to stay in a hospital or facility beyond the discharge time determined by the plan.
- Acupuncture; biofeedback (except for the treatment of urinary incontinence); hypnotherapy; TENS units or other neuromuscular stimulators and related supplies; electrolysis; relaxation therapies; massage therapies; myotherapy; holistic treatments; treatment at sports medicine clinics; services by a personal trainer; and any diagnostic services related to any of these programs, services or procedures.
- Chiropractic and Related Services: Chiropractic services, other than manual manipulation of the spine (up to the applicable benefit limits). Excluded services include treatment with or purchase of TENS units or other neuromuscular stimulators and related supplies.
- Claim Fees: A provider’s charges to file a claim.
- Cognitive rehabilitation programs; cognitive retraining programs; and diagnostic services related to these programs.
- Complementary or Alternative Medicine: This includes the following:
• acupuncture;
• Ayurveda;
• biofeedback (except for medically necessary treatment of urinary incontinence);
• craniosacral therapy;
• homeopathic, holistic and naturopathic treatments;
• hippotherapy;
• hypnotherapy; meditation; prayer; mental healing;
• massage;
• myotherapy;
• pulsed or magnetic fields;
• electromagnetic or alternating-current or direct-current fields including TENS units and related supplies and electrolysis;
• Reiki; reflexology; relaxation therapies; therapeutic touch;
• therapies that use creative outlets such as art, music, dance, or yoga;
• pet therapy;
• treatment at sports medicine clinics;
• services by a personal trainer; and
• any diagnostic services related to any of the above programs, services or procedures.

Concierge Services: Any fees charged by a provider for so-called “concierge services.” These are fees charged: as a condition of selecting or using the services of the provider; or fees for amenities offered by the provider.

Cosmetic Services/Cosmetic Surgery: These are services given solely for the purpose of making you look better, whether or not these services are meant to make you feel better about yourself or treat your mental condition. Examples of non-covered services are:
• injection of collagen or other bulking agents to enhance appearance;
• thigh, leg, hip or buttock lift procedures;
• blepharoplasty, unless it is medically necessary to prevent vision occlusion;
• facelift surgery or rhytidectomy;
• abdominal liposuction or suction assisted lipectomy of the abdomen;
• abdominoplasty; partial abdominoplasty; or
• repair of diastasis recti.

Dermabrasion or other procedures to plane the skin; acne related services, such as the removal of acne cysts or injections to raise acne scars; electrolysis; wigs (except when expressly covered – see Chapter 3); hair removal, hair transplants or hair restoration; rhinoplasty (except as part of a medically necessary reconstructive surgery); liposuction; brachioplasty; treatment of spider veins; treatment of melasma; tattooing or reversal of tattooing; reversal of inverted nipples; body piercing; or removal or destruction of skin tags.

Custodial care; long term care; or care in a rest home.

Dental Services: The plan does not pay for any dental services, except:
• the emergency dental and pediatric dental services specifically set forth in Chapter 3 under Outpatient Services – Dental Services; and
• those dental and orthodontic services specifically related to the treatment of Cleft Lip, Cleft Palate or both as set forth in Chapter 3.

Dental services are any service provided by a licensed dentist involving the diagnosis or treatment of any disease, pain, injury, deformity or other condition of the human teeth, alveolar process, gums, jaw or associated structures of the mouth. The plan also does not pay for splints or oral appliances.

Equipment that does not meet the definition of “durable medical equipment” in Chapter 3. Example: equipment that is used primarily and customarily for anonmedical purpose—even if such equipment has a medically related use.

Devices and Clothing, such as the following:
• Devices such as: air conditioners; car seats; arch supports; bath seats; bed pans; chair lifts; computers; computerized communication devices; computer software; dentures; dental appliances; elevators; heating pads; hot water bottles; room humidifiers; air purifiers; medical bracelets; door alarms; raised toilet seats; bedding (such as dust mite covers); disposable supplies (such as sheets, bags, gloves, diapers, under pads, alcohol wipes and elastic stockings); sports-related braces; enuresis alarms; reachers; shoe horns; foot and shoe orthotics; shoe inserts (except for therapeutic and molded shoes and shoe inserts for members with severe diabetic foot disease).
Special clothing, except for: gradient pressure support aids for lymphedema or venous disease; clothing needed to wear a covered device (for example, mastectomy bras and stump socks); and therapeutic/molded shoes for members with severe diabetic foot disease.

Non-rigid appliances and supplies, such as: elastic stockings; garter belts; arch supports; corsets; and corrective shoes.

Safety equipment, such as: safe beds; crib enclosures; chest harness/seat belts; alert emergency response systems; and bath/shower grab bars.

Self-help devices that are not primarily medical items, such as: sauna baths, elevators, stair lifts, ramps, and special telephone or communication devices.

Self-monitoring devices, except if the plan decides that a device would give a member having certain symptoms the ability to detect or stop the onset of a sudden life-threatening condition.

Electronic and myoelectric artificial limbs.

Replacement or repair of durable medical equipment or prosthetic devices due to: loss; intentional damage; negligence; or theft.

Hospital-grade breast pumps.

Exercise and hygienic equipment. Examples: exercycles; treadmills; bidet toilet seats; bathtub seats; and hand held shower devices.

Physician’s equipment. Examples: blood pressure cuffs; and stethoscopes.

Assistive technology and adaptive equipment. Examples: communication boards and computers; supine boards; prone standers; gait trainers; and other such equipment not intended for use in the home.

Cryotherapy (i.e. Game Ready).

Hot/cold compression therapy.

Polar packs.

- Drugs that are described as not covered in Chapter 3 under “Prescription Drugs.”
- Educational-Related Services: Examinations, evaluations or services for educational or developmental purposes. These include: physical therapy; speech therapy; and occupational therapy. Also excluded are services to treat learning disabilities, behavior problems and developmental delays and services to treat speech, hearing and language disorders in a school-based setting.
- Experimental or investigational treatments; or services related to these treatments. If a service is an experimental or investigational treatment, the plan will not pay for that treatment or any related services that are provided to the member for the purpose of furnishing the experimental or investigational treatment. Exception: the plan will cover costs of clinical trials as specifically set forth in Chapter 3 – Covered Services.
- Government Program Benefits: Services for which you have the right to benefits under government programs. Examples: the Veterans Administration for illness or injury related to military service; schools; and other programs set up by local, state, federal or foreign laws or regulations that provide or pay for health care services or that require care or treatment to be provided in a public facility. No coverage is provided if you could have received governmental benefits by applying for them on time.
- Harvesting of a human organ transplant donor’s organ or stem cells when the recipient is not a member.
- For members over age 21 years of age: hearing aids or hearing aid supplies.
- Hearing aid batteries or cleaning fluid.
- Infertility services: The following are not covered:
  - Infertility services for any member who is not a Massachusetts resident.
  - Infertility services for members who are not “infertile” as defined under the Infertility Services section in Chapter 3.
  - Reversal of voluntary sterilization.
  - Infertility treatment needed as a result of prior voluntary sterilization, unless: the diagnosis of infertility is unrelated to a previous sterilization procedure; and if for a female, the diagnostic testing provides at least one patent fallopian tube; and if for a male, the sperm count meets the definition of normal as set forth in the plan’s clinical review criteria.
  - Long term (longer than 90 days) sperm or embryo cryopreservation unless the member is in active infertility treatment.
  - Costs associated with donor recruitment, testing and compensation.
  - Donor sperm and associated laboratory services in the absence of diagnosed male factor infertility in the partner.
  - Infertility services necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization.
• Drugs for anonymous or designated egg donors that are directly related to a stimulated Assisted Reproductive Technology (ART) cycle, unless the ART service has been approved by a plan authorized reviewer, is provided at a network infertility services provider; and the member is the sole recipient of the donor’s eggs.
• Surrogacy/gestational carrier-related costs: this means all procedures and costs incurred by a fertile woman to achieve a pregnancy as a surrogate or gestational carrier for an infertile member.
• Experimental or investigational infertility procedures.

Maternity Services: Services or costs associated with planned home births. When you are outside the service area, the plan will not cover:
• routine maternity services for prenatal or postpartum care; or
• delivery (including postpartum care and care provided to the newborn) or problems with pregnancy beyond the 37th week of pregnancy or any time after you have been told by your provider that you are at risk for early delivery. See Chapter 3: Inpatient Services/Maternity Care.

Non-Members: Services for non-members, except as specifically described in this Chapter 3 under “Human Organ Transplants” or under “Hospice Services.”

Medical Record Fees: Fees charged by providers for copies of your medical records.

The following mental health/substance use disorder-related services are excluded:

• psychoanalysis;
• pastoral counseling;
• interactive individual psychotherapy;
• family psychotherapy (without member present); or multiple-family group therapy;
• narcosynthesis; individual psychophysiological therapy incorporating biofeedback;
• hypnotherapy;
• massage and relaxation therapies;
• psychiatric evaluation of records and reports;
• developmental testing;
• neurobehavioral status exams administered/interpreted by physicians and computer;
• neuropsychological rehabilitation;
• behavioral health hotline service;
• assertive community treatment;
• mental health clubhouse services; halfway house services; and mental health or substance use disorder services provided to members who are in jail, prison, a house of correction or custodial facility;
• alcohol or drug testing for legal or other purposes unrelated to medical necessity;
• mental health or substance use disorder services provided by the Department of Mental Health;
• long term residential treatment;
• custodial care;
• programs in which the member has a pre-defined duration of care without the plan’s ability to conduct concurrent determinations of continued medical necessity; and
• programs that only provide meetings or activities that are not based on individualized treatment plans; programs that focus solely on improvement in interpersonal or other skills rather than treatment directed toward symptom reduction and functional recovery related to lessening of specific psychiatric symptoms or syndromes; and tuition-based programs that offer educational, vocational, recreational or personal development activities, such as a therapeutic school, camp or wilderness program.

Missed or Cancelled Appointment Charges: Charges by providers for missed or cancelled appointments.

Personal Comfort Items: Items that are primarily for your, or another person’s, personal comfort or convenience. Examples are telephones, radios, televisions and personal care items.

Routine podiatric services and related durable medical equipment and medical supplies (except for members with diabetes – see “Diabetes” benefit in this Chapter 3). Exclusions include but are not limited to: routine foot care (trimming of corns, nails or other hygienic care); foot and shoe orthotics; arch supports; shoe inserts; fittings, casting and other services related to devices for the feet; or orthopedic or corrective shoes that are not part of a covered leg brace.

Pre-implantation genetic diagnosis – except as specifically allowed under Infertility Services.

Private Room Charges: Charges greater than the rate for a semi-private room (except when a private room is medically necessary).

Private duty nursing (except as part of the Hospice benefit); and personal care attendants.
• Refractive eye surgery (including laser surgery, radial keratotomy and orthokeratology).
• Respite care, except when provided as part of a licensed hospice program.
• Safety items used in the absence of a disease or medical condition, such as: door alarms; and protective beds or bedding.
• Sensory integrative praxis tests.
• Services for which you are not legally obligated to pay; or services for which no charge would be made in the absence of health insurance.
• Services Furnished to You by Immediate Family: Services given to you by your immediate family (by blood or marriage) or anyone who ordinarily lives with you.
  • “Immediate family” means: spouse or spouse equivalent; parent; child; brother; sister; stepparent; stepchild; stepbrother or stepsister; father-in-law; mother-in-law; daughter-in-law; brother-in-law; sister-in-law; grandparent; or grandchild.
• Third Party Required Treatment: Services required by a third party that are not otherwise medically necessary.
  • Examples of third parties include: an employer; insurance company; licensing organization/agency; school; or court.
  • Examples of services include: exams and tests required for recreational activities or employment; court-ordered exams; vocational evaluations on job adaptability; vocational rehabilitation; job placement; or therapy to restore function for a specific occupation. Also excluded are: tests to establish paternity; tests for forensic purposes; and post-mortem exams and tests.
• Snoring: Services to treat or reduce snoring. Examples include: laser-assisted uvulopalatoplasty; somnoplasty; snore guards; and any other snoring-related appliances.
• Taxes: A provider’s charge for taxes; or sales tax related to any product delivered or given to a member.
• Services to treat TMJ (temporomandibular joint) syndrome; all TMJ-related appliances, other than a mandibular orthopedic repositioning appliance (MORA); services, procedures or supplies to adjust the height of teeth or in any other way restore occlusion, such as crowns, bridges or braces; and treatment of TMJ disorders that are not proven to be caused by or to result in a specific medical condition.
• Transportation and Lodging: Transportation (other than as described under “Ambulance Services” or “Human Organ Transplants” in Chapter 3) or lodging related to receiving any medical service.
• The following vision-related items and services:
  • Vision therapy for certain diagnoses where there is not adequate authoritative evidence of effectiveness.
  • Glasses, frames and contact lenses, except as specifically listed as covered under the Vision Services benefit.
• Weight – Related Services/Equipment: Commercial diet plans; weight loss or weight control programs and clinics (except those related to covered bariatric surgery or programs); and any services in connection with such plans or programs; and exercise equipment.
• Workers’ Compensation: Care for conditions for which benefits are available under a workers’ compensation plan or an employer under state or federal law.
CHAPTER 4. ELIGIBILITY, ENROLLMENT, TERMINATION AND PREMIUM PAYMENTS

The BMC HealthNet Plan Qualified Health Plan: is a health plan for individuals, group members, and, if applicable, their eligible dependents.

Eligibility: The Health Connector and plan establish eligibility rules for subscribers and dependents in accordance with state and federal laws. Subscribers and their eligible dependents must meet these eligibility rules in order to be enrolled in the plan through the Health Connector.

Please contact the Health Connector for more information about eligibility. The plan and the Health Connector may require reasonable verification of eligibility from time to time. Social security numbers are not required to obtain coverage under an individual contract.

If you meet the applicable eligibility rules, we will accept you into the plan upon referral from the Health Connector. You may continue to be enrolled in the plan for as long as you continue to meet eligibility rules and applicable premium is paid. When we receive notice of your enrollment from the Health Connector, we will send you an ID card and other information about the plan.

Acceptance into the plan is never based on: your income; physical or mental condition; age; occupation; claims experience; duration of coverage; medical condition; gender; sexual orientation; religion; physical or mental disability; ethnicity or race; previous status as a member; pre-existing conditions; or actual or expected health condition.

We do not use the results of genetic testing in making decisions about enrollment, eligibility, renewal, payment or coverage of healthcare services. Also, we do not consider any history of domestic abuse or actual or suspected exposure to diethylstilbestrol (DES) in making these decisions.

Once you are properly enrolled in the plan, we will pay for covered services that are given to you on or after your coverage effective date. (There are no waiting periods or pre-existing condition limits or exclusions.) The plan does not pay for any services you received prior to your coverage effective date with the plan.

Coverage Effective Dates for Subscribers and Dependents: The Health Connector establishes coverage effective dates for new subscribers and eligible dependents, in accordance with state and federal law. Please contact the Health Connector for more information.

- Individuals who do not meet the requirements to enroll outside of the annual open enrollment period may seek an enrollment waiver. A waiver permits enrollment outside the open enrollment period. Contact the Health Connector or the Office of Patient Protection for more information about enrollment waivers.

This section applies to those benefit packages that allow subscribers to enroll newborns and adopted children under the age of 19 as dependents. Contact the Health Connector for eligibility information.

Newborn and Adoptive Children – Enrollment and Coverage:

- A newborn infant of a member is eligible for coverage under the plan from the moment of birth as required by Massachusetts law.
  - The subscriber must properly enroll the newborn in the plan within 30 days of the newborn’s birth for the newborn to be covered from birth. Otherwise, the subscriber must wait until the next open enrollment period to enroll the child.
  - If the subscriber does not enroll a newborn within 30 days of the newborn’s birth, the plan will only cover the costs of routine nursery charges and well newborn care. (See Chapter 3 – Inpatient Services/Maternity Care.) Any other charges for services to the newborn will not be covered.

- The subscriber must enroll an adoptive child within 30 days after: the date of filing a petition to adopt the child; or the date the child is placed with the subscriber for the purpose of adoption. Otherwise, the subscriber must wait until the next open enrollment period to enroll an adoptive child.

- Choose a PCP for your newborn or adoptive child within 48 hours: after the newborn’s birth, or after the date of adoption or placement for adoption. This PCP can manage your child’s care from the time of birth or adoption.
• Contact the Health Connector for further information about enrollment of a newborn or an adoptive child.

• This section applies to those benefit packages that do NOT allow subscribers to enroll newborns or adoptive children under the age of 19 as dependents. Contact the Health Connector for eligibility information.

Newborn and Adoptive Children – Enrollment and Coverage:
• If you are enrolled in a benefit package that does not allow you to add newborns as dependents, and you have a newborn, you cannot enroll your newborn in this plan. The plan does not cover any health care costs (inpatient or outpatient) related to the newborn except for routine nursery charges and well newborn care. Your newborn baby may be eligible for coverage under MassHealth. For information about MassHealth eligibility for your newborn, call Member Services or the Health Connector. 
• If you adopt a child under the age of 19, you cannot enroll your adoptive child in this plan. Adoptive children may be eligible for coverage under MassHealth. For information about MassHealth eligibility for your adoptive child, call Member Services or the Health Connector.

Change in Eligibility Status: It is the subscriber’s responsibility to notify the Health Connector of all changes that may affect your or your dependents’ eligibility under the plan or the amount of premium you pay. Notification must occur within 30 days of the event. These include the following:

- Having a baby or adopting a child.
- The marriage of a dependent.
- Address changes.
- Moving out of the plan’s service area.
- Job changes.
- Changes in marital status.
- Death of a member.
- Enrollment in a state or federal health insurance program such as Medicaid or Medicare.
- When you or a dependent no longer meets the Connector’s or plan’s eligibility rules.

Note: Changes in dependents covered by the plan may result in a change to the premium that must be paid.

The Health Connector and the plan need your current address and phone number so we can send you important information about benefits and services. To report eligibility, address or phone number changes, please contact:

Qualified Health Plan Program Customer Service Center
1-877-MA-ENROLL or 1-877-623-6765; Monday through Friday from 8:00 a.m. to 5:00 p.m.
For persons with total or partial hearing loss, call TTY: 1-877-623-7773.

If Hospitalized When Membership Begins: If you are an inpatient on your coverage effective date, you will be covered by the plan under this EOC as of your coverage effective date as long as you call the plan and allow us to manage your care. This may include a transfer to a network hospital, if medically appropriate.

Coverage for Members Who Live Outside the Service Area: If you are a properly enrolled member who lives outside the service area in accordance with the Health Connector’s and plan’s eligibility rules: you must still comply with all plan rules regarding use of network providers for your care. Outside the service area you are only entitled to coverage for emergency and urgent care; you may come into the service area at any time to obtain full coverage for covered services from network providers in the service area. All cost-sharing and other payment rules apply to services received outside the service area.

Premium Payments. Individuals and groups are required to pay applicable monthly premiums. You will be told the premium amount and due date. Premium must be sent by the due date stated on the bill. Only members for whom applicable premium has been received are entitled to covered services. In the event an individual or group is late (delinquent) in paying required premium, the plan, in accordance with applicable state and federal law, may suspend payment of claims and/or prior authorization of services until full premium payment is received.
Notes:

- The amount of premium an individual or group is required to pay may change during the term of this EOC. You will be notified of any changes in premium.
- The plan will send subscribers an annual notice stating the premium that must be paid.

Termination of Plan Coverage: The Health Connector determines when your enrollment is to be terminated. All terminations are done in accordance with federal and state law. Your enrollment in the plan can be terminated if:

- You are an individual who has not paid the required premium, or you are a group member and your group has not paid the required premium.
- You commit an act of physical or verbal abuse unrelated to your physical or mental condition which poses a threat to any provider, any other member, or to the plan or a plan employee.
- You fail to comply with our or the Health Connector’s reasonable request for information.
- You commit an act of intentional misrepresentation or fraud related to: coverage; obtaining health care services; or payment for such services. Examples: obtaining or trying to obtain benefits under this EOC for a person who is not a member; or misrepresenting your eligibility for enrollment under the plan. Termination may be retroactive: to your effective date; the date of the fraud or misrepresentation; or to another date determined by the plan.
- You fail to comply in a material manner with the plan’s rules under this EOC or, for individuals, with the individual contract. For groups, this includes the group’s failure to meet requirements related to group premium contributions; or that the group is not actively engaged in business.
- You fail to continue to meet the Health Connector’s or plan’s eligibility rules, including applicable residency or work location requirements.
- An individual or a group chooses to end coverage by notifying the Health Connector.

Effective Date of Termination: The Health Connector will notify you of the date your coverage under the plan ends.

Benefits after termination: The plan will not pay for services, supplies or drugs you receive after your coverage ends, even if:

- you were receiving inpatient or outpatient care before your coverage ended; or
- you had a medical condition (known or unknown), including pregnancy, that requires medical care after your coverage ends.

Health Connector Termination of Group for Non-Payment of Premium:

- Any group that does not pay its monthly premium in full by the 55th calendar day following the first day of the coverage month for which premium payment was due is subject to termination of its group contract.
- Coverage for all group members (subscribers and dependents) will end on the 60th calendar day after the first day of the coverage month for which premium payment was due and not paid in full.
- Termination is retroactive to the last day of the coverage month for which premium was paid.
- The Health Connector will send written notice to each subscriber (at his or her last known address) about the group’s termination due to nonpayment of premium. The notice will include the effective date of the termination of the group contract and information about your continuation of coverage options.
- Unless a subscriber elects the continuation of coverage option and makes the required premium payment, the subscriber is responsible for all claims for services received after the effective date of termination (which can be up to 60 days back).

Voluntary and Involuntary Disenrollment Rates for Members: The plan will annually notify you of the voluntary and involuntary member disenrollment rate.

Questions about Eligibility, Enrollment and Termination: Please contact the Health Connector:
Commonwealth Health Insurance Connector Authority – Qualified Health Care Program
P.O. Box 120089, Boston, MA 02112-9914
Telephone: 1-877-MA-ENROLL (1-877-623-6765)
For persons with total or partial hearing loss, please call TTY: 877-623-7773
Hours of Operation: 8 a.m. – 6 p.m. Monday through Friday
Website: www.mahealthconnector.org
CHAPTER 5: CONTINUATION OF GROUP COVERAGE

Continuation of Group Coverage Under Federal Law (COBRA): Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), group members may be eligible to continue coverage under the group contract if: you were enrolled in a group which has 20 or more eligible employees; you experience a qualifying event which would cause you to lose coverage under your group; and you elect coverage as provided under COBRA. Below is a brief summary of COBRA continuation coverage.

- **Qualifying Events:** Qualifying events that may entitle you to COBRA continued coverage are as follows:
  - Termination of the subscriber’s employment (for reasons other than gross misconduct).
  - Reduction in the subscriber’s work hours.
  - The subscriber’s divorce or legal separation.
  - Death of the subscriber.
  - The subscriber’s entitlement to Medicare.
  - Loss of status as an eligible dependent.

- **Period of Continued Coverage Under COBRA:** The period of continued group coverage begins with the date of your qualifying event. The length of this continued group coverage will be up to 36 months from that qualifying event. This is true except for termination of the subscriber’s employment or the reduction in the subscriber’s work hours, in which cases continued group coverage is available for only 18 months, or, if you are qualified for disability under Title II or XVI of the Social Security Act, up to 29 months. COBRA coverage will end at the end of the maximum period of coverage; however, coverage may end earlier if: premium is not paid on time; your group ceases to maintain any group health plan; the group terminates its group contract with the Health Connector (in which case your coverage may continue under another health plan); or for other reasons such as the end of disability, or becoming eligible for or obtaining other dependent.

- **Cost of Coverage:** In most cases, you are responsible for payment of 102% of the cost of coverage.

- **Continued Coverage for Disabled Subscribers:** At the time of the subscriber’s termination of employment or reduction in work hours (or within 60 days of the qualifying event under federal law), if a subscriber or his or her eligible dependent is determined to be disabled under Title II or Title XVI of the Social Security Act, continued group coverage will be available for up to 29 months from the date of the qualifying event. The premium cost for the additional 11 months may be up to 150% of the premium rate.

- **Enrollment:** In order to enroll, you must complete an election form and return it to your group. The form must be returned within 60 days from your date of termination of group coverage or your notification (by your group) of eligibility, whichever is later. If you do not return the completed form, it will be considered a waiver. This means you will not be allowed to continue coverage in this plan under a group contract.

- **For more information about COBRA:** contact your group or the Health Connector.

Continuation of Group Coverage Under Massachusetts (MA) Law: Under MA continuation coverage law, group members may be eligible to continue coverage under the group contract if: you were enrolled in a group which has 2 – 19 eligible employees; you experience a qualifying event which would cause you to lose coverage under your group; and you elect coverage as provided by MA law. Below is a brief summary of MA continuation coverage.

- **Qualifying Events:** Qualifying events that may entitle you to continued coverage under MA law are as follows:
  - Termination of the subscriber’s employment (for reasons other than gross misconduct).
  - Reduction in the subscriber’s work hours.
  - The subscriber’s divorce or legal separation.
  - Death of the subscriber.
  - The subscriber’s entitlement to Medicare.
  - Loss of status as an eligible dependent.

- **Period of Continued Coverage:** In most cases, continuation coverage is effective on the date following the day group coverage ends. In most cases, it ends 18 or 36 months from the date of the qualifying event, depending on the type of qualifying event.

- **Cost of Coverage:** In most cases, you are responsible for payment of 102% of the group premium.

- **Enrollment:** In order to enroll, you must complete an election form and return it to your group. The form must be returned within 60 days from your date of termination of group coverage or your notification (by
your group) of eligibility, whichever is later. If you do not return the completed form, it will be considered a waiver. This means you will not be allowed to continue coverage in this plan under a group contract.

- **For more information about MA Continuation Coverage:** contact your group or the Health Connector.

**Plant Closing:** Under MA law, group members who lose eligibility for coverage under a group contract due to a plant closing or a partial plant closing (as defined by law) may be eligible to continue coverage under the group contract for up to 90 days after the plant closing. If this happens to you, the subscriber and his/her group will each pay your shares of the premium cost for up to 90 days after the plant closing. The group is responsible to notify subscribers of their eligibility. Call your group or the Health Connector for further information.

**Divorce or Separation:**

- In the event of a divorce or legal separation, the person who was the spouse of the subscriber prior to the divorce or legal separation will remain eligible for coverage in this plan under the subscriber’s group contract, whether or not the judgment was entered prior to the effective date of the group contract.
- This coverage requires no additional premium other than the normal cost of covering a current spouse.
- The former spouse remains eligible for this coverage only until the first to occur of the following: the subscriber is no longer required by the judgment to provide health insurance for the former spouse; or the subscriber or former spouse remarries. If the subscriber remarries, and the judgment so provides, the former spouse may continue coverage under the plan in accordance with MA law.

**Coverage Under an Individual Contract:** If your group coverage ends, you may be eligible to enroll in coverage under an individual contract offered through the Health Connector or directly by BMCHP. Please be aware that coverage under an individual contract may differ from coverage under a group contract. For more information, call the Health Connector (1-877-MA-ENROLL), go to the Health Connector website (www.mahealthconnector.org) or call BMCHP Member Services.
CHAPTER 6. MEMBER SATISFACTION PROCESS

Introduction: The plan is committed to solving any concerns you may have about: how the plan is operated; your benefits; or the quality of health care you received from network providers. To do so, we have the following processes (each one described in greater detail below) depending on the type of concern you have:

- Internal Inquiry Process.
- Internal Grievance Process.
- Internal Appeals Process (including Expedited Appeals).
- External Review by the Massachusetts Health Policy Commission/Office of Patient Protection.

Internal Inquiry Process:
What is an Inquiry? An Inquiry is any communication you make to the plan asking us to address a plan action, policy or procedure.

Internal Inquiry Process: This is an informal process used to resolve most Inquiries. Just call Member Services at 1-855-833-8120 to discuss your concern.

Note: The Internal Inquiry Process is not used to resolve concerns about the quality of care received by you or an Adverse Determination (coverage denial based on medical necessity). If your concern involves:
- the quality of care you received from a network provider-Member Services will refer your concern directly to our Internal Grievance Process (see below).
- an Adverse Determination-Member Services will refer your concern directly to our Internal Appeals Process (see below).

Member Services staff will review and investigate your Inquiry and in most cases respond by phone to you within 3 working days. During our call we will: tell you our decision; or tell you that we were unable to resolve your Inquiry within 3 working days. If you tell us that you are not satisfied with our decision, or we were unable to resolve your Inquiry within 3 working days, we will offer to start a review of your concern through our formal Internal Grievance or Appeal Process (see below). The process we use depends on the type of Inquiry that you made.

Internal Grievance Process:
What is a Grievance? A Grievance is a formal complaint by you about:
- Plan Administration (how the plan is operated): any action taken by a plan employee, any aspect of the plan’s services, policies or procedures, or a billing issue. We refer to this type of Grievance as a “plan administrative Grievance.”
- Quality of Care: The quality of care you received from a plan network provider. We refer to this type of Grievance as a “quality of care Grievance.” (If you are comfortable doing so, we encourage you to talk first with the network provider about quality of care concerns before filing a quality of care Grievance. However, you are not required to do so before filing this type of Grievance with us.)

Note: The Internal Grievance Process is not used to resolve complaints that are or could be Appeals. These types of complaints are addressed through the Internal Appeals Process. (See below).

How and Where You Can File a Grievance:
- The preferred way for you to file a Grievance is for you to put it in writing and send it to us by regular mail or by fax.
- You can also deliver it in person to one of our offices. (See Address and Telephone Directory in the beginning of this EOC.)
- You may also submit your Grievance orally in person or by calling Member Services at 1-855-833-8120.
- For oral Grievances related to mental health and/or substance use disorder services, you must call 1-877-957-5600.
- If you file your Grievance orally, we will write a summary of your Grievance and send you a copy within 48 hours of receipt (unless the time limit is extended by mutual written agreement).

Written Grievances should include:
- your name;
You must send your written Grievance to:

BMC HealthNet Plan Qualified Health Plan
529 Main Street, Suite 500
Charlestown, MA 02129
Attention: Member Grievances
Telephone: 1-855-833-8120
Fax: 617-897-0805

If you want to submit a Grievance in person, you can go to any of our office locations. These are listed in our Address & Telephone Directory in the beginning of this EOC.

Written Grievances pertaining to mental health and/or substance use disorder services should include the information referenced above and must be sent to:

Quality Department-Ombudsmen
Beacon Health Strategies, LLC
500 Unicorn Park Drive
Woburn, MA 01801
Telephone: 877-957-5600
Fax: 781-994-7636

When to File a Grievance: You can file your Grievance any time within 180 days of the date of the applicable event, situation or treatment. We encourage you to file your Grievance as soon as possible.

Plan Acknowledgment of Your Grievance: If you filed a written Grievance, we will send you a letter ("acknowledgement") telling you that we received your Grievance. We will send this letter within 15 working days of our receipt of your Grievance. If you filed your Grievance orally, our summary of your Grievance will be sent to you within 48 hours of receipt of your Grievance. This summary will serve as both a written record of your Grievance as well as an acknowledgment of our receipt. These time limits may be extended by mutual written agreement between you and us.

Release of Medical Records:

- We may request a signed Authorization to Release Medical Records form. This form authorizes providers to release medical information to us. It must be signed and dated by you or your Authorized Representative. (When signed by an Authorized Representative, appropriate proof of authorization to release medical information must be provided.)

- If an Authorization to Release Medical Records form is not included with your Grievance, Member Services will promptly send you a blank form. It is very important that you fill out and send us this form. This allows us to obtain medical information we will need to address your Grievance. If we do not receive this form within 30 calendar days of the date we received your Grievance, we may respond to your Grievance without having reviewed relevant medical information.

- In addition, if we receive the form from you but your provider does not give us your medical records in a timely fashion, we will ask you to agree to extend the time limit for us to respond to your Grievance (see “Timelines for Review and Response to Your Grievance,” below). If we cannot reach agreement with you on a timeline extension, we may respond to your Grievance without having reviewed relevant medical information.

Who Will Review Your Grievance: Plan administrative Grievances will be investigated and reviewed by an Appeals & Grievances Specialist. He or she will also talk with other appropriate departments. Quality of care
Grievances will be investigated and reviewed by a clinical staff within the Office of Clinical Affairs. All reviews will be done by appropriate individuals who know about the issues involved in your Grievance. Resolutions will be based on: the terms of this EOC; the opinions of your treating providers; the opinions of our professional reviewers; applicable records provided by you or providers; and any other relevant information available to us.

**Timelines for Review and Response to Your Grievance:** We will send you a written response within 30 calendar days of our receipt of your Grievance. The 30 calendar day period begins as follows:
- If your Grievance requires us to review your medical records, the 30 calendar day period does not begin until we receive from you a signed Authorization to Release Medical Information form.
- If your Grievance does not require us to review your medical records, the 30 calendar day period begins: on the next working day following the end of the 3 working day period for processing Inquiries through the Internal Inquiry Process, if the Inquiry was not addressed within that time period; or on the day you notified us that you were not satisfied with the response to the Inquiry.

These time limits may be extended by mutual written agreement between you and us. Any extension will not exceed 30 calendar days from the date of the agreement. If we don’t respond to a Grievance that involves benefits within the time frames described in this section, including any mutually agreed upon written extension, your Grievance will be deemed resolved in your favor.

Our written response to your Grievance will describe your other options, if any, for further plan review of your Grievance.

No Grievance shall be considered received by us until actual receipt of the Grievance by the plan at the appropriate address or telephone number listed above under “How and Where You Can File a Grievance.”

**Internal Appeals Process:**

**What is an Appeal?** An Appeal is a formal complaint by you about a Benefit Denial, an Adverse Determination, or a Retroactive Termination of Coverage – all as specifically defined as follows:
- **Benefit Denial:**
  - A plan decision, made before or after you have obtained services, to deny coverage for a service, supply or drug that is specifically limited or excluded from coverage in this EOC; or
  - A plan decision to deny coverage for a service, supply or drug because you are no longer eligible for coverage under the plan. (This means you no longer meet the plan’s eligibility criteria.)
- **Adverse Determination:** A plan decision, based on a review of information provided, to deny, reduce, modify or terminate an admission, continued inpatient stay or the availability of any other health care services, for failure to meet the requirements for coverage based on: medical necessity; appropriateness of health care setting and level of care; or effectiveness. These are often known as medical necessity denials because in these cases the plan has determined that the service is not medically necessary for you.
- **Retroactive Termination of Coverage:** A retroactive cancellation or discontinuance of enrollment as a result of the plan’s determination that: you have performed an act, practice or omission that constitutes fraud; or you have intentionally misrepresented a material fact with regard to the terms of the plan.

**How and Where You Can File an Appeal:**
- The preferred way for you to file an Appeal is for you to put it in writing and send it to us by regular mail or by fax.
- You can also deliver it in person to one of our offices. (See Address and Telephone Directory in the beginning of this EOC.)
- You may also submit your Appeal orally in person or by calling Member Services at 1-855-833-8120.
- For oral Appeals related to mental health and/or substance use disorder services, you must call 1-877-957-5600.
- If you file your Appeal orally, we will write a summary of your Appeal and send you a copy within 48 hours of receipt (unless the time limit is extended by mutual written agreement).

Written Appeals should include:
- your name;
• address;
• plan ID number;
• daytime phone number;
• detailed description of the Appeal (including relevant dates and provider names);
• any applicable documents that relate to your Appeal, such as billing statements; and
• the specific result you are requesting.

You must send your written Appeal to:

BMC HealthNet Plan Qualified Health Plan
529 Main Street, Suite 500
Charlestown, MA 02129
Attention: Member Appeals
Telephone: 1-855-833-8120
Fax: 617-897-0805

If you want to submit an Appeal in person, you can go to any of our office locations. These are listed in our Address & Telephone Directory at the beginning of this EOC.

Written Appeals pertaining to mental health and/or substance use disorder services should include the information referenced above and must be sent to:

Appeals Coordinator
Beacon Health Strategies, LLC
500 Unicorn Park Drive
Suite 401
Woburn, MA 01801
Telephone: 1-877-957-5600
Fax: 791-994-7636

When to File an Appeal: You can file your Appeal any time within 180 days of the date of the original coverage denial. Appeals received after 180 days of the date of the original coverage denial will not be reviewed. We encourage you to file your Appeal as soon as possible.

Plan Acknowledgment of Your Appeal: If you filed a written Appeal, we will send you a letter (“acknowledgment”) telling you that we have received your Appeal. We will send you this letter within 15 working days of receipt of your Appeal. If you filed your Appeal orally, the Appeals & Grievances Specialist’s written summary of your Appeal will be sent to you within 48 hours of receipt of your Appeal. This summary will serve as both a written record of your Appeal as well as an acknowledgment of our receipt. These time limits may be extended by mutual written agreement between you and the plan.

Release of Medical Records:
• If your Appeal requires us to review your medical records, you must include a signed Authorization to Release Medical Records form. This form authorizes providers to release medical information to us. It must be signed and dated by you or your Authorized Representative. (When signed by an Authorized Representative, appropriate proof of authorization to release medical information must be provided.)
• If an Authorization to Release Medical Records form is not included with your Appeal, the Appeals Specialist will promptly send you a blank form. It is very important that you fill out and send us this form so that we can obtain medical information we will need to address your Appeal. If we do not receive this form within 30 calendar days of the date we received your Appeal, we may respond to your Appeal without having reviewed relevant medical information.
• In addition, if we receive the form from you but your provider does not give us your medical records in a timely fashion, we will ask you to agree to extend the time limit for us to respond to your Appeal (see “Timelines for Review and Response to Your Appeal,” below). If we cannot reach agreement with you on a timeline extension, we may respond to your Appeal without having reviewed relevant medical information.
Who Will Review Your Appeal: Appeals will be investigated by an Appeals & Grievances Specialist within the plan’s Quality Department. He or she will also talk with other appropriate departments. All decisions will be made by appropriate individuals who know about the issues involved in your Appeal. Appeals regarding Adverse Determinations will also be reviewed by at least one reviewer who is an actively practicing healthcare professional in the same or similar specialty that typically treats the medical condition, performs the procedure or provides the treatment that is the subject of your Appeal. Decisions will be based on: the terms of this EOC; the opinions of your treating providers; the opinions of our professional reviewers; applicable records provided by you or providers; and any other relevant information available to the plan.

Timelines for Review and Response to Your Appeal: We will send you a written response within 30 calendar days of our receipt of your Appeal. The 30 calendar day period begins as follows:

- If your Appeal requires us to review your medical records, the 30 calendar day period does not begin until we receive from you a signed Authorization to Release Medical Information form.
- If your Appeal does not require us to review your medical records, the 30 calendar day period begins: on the next working day following the end of the 3 working day period for processing Inquiries through the Internal Inquiry Process, if the Inquiry was not addressed within that time period; or on the day you notified us that you were not satisfied with the response to the Inquiry.

These time limits may be extended by mutual written agreement between you and us. Any extension will not exceed 30 calendar days from the date of the agreement.

No Appeal shall be considered received by us until actual receipt of the Appeal by the plan at the appropriate address or telephone number listed above under “How and Where You Can File an Appeal.”

Written responses to Adverse Determinations that deny all or part of your request for coverage will explain your right to request an External Review from an independent External Review Agency. This Agency contracts with the Massachusetts Health Policy Commission/Office of Patient Protection.

If we don’t respond to your Appeal within the time frames described in this section, including any mutually agreed upon written extension, your Appeal will be deemed to be decided in your favor.

Expedited (Fast) Internal Appeals Process:

What Is An Expedited Appeal? An Expedited Appeal is a faster process for resolving an Appeal. This faster process can be used when there has been a denial of coverage involving immediate or urgently-needed services. The types of Appeals that are eligible for the Expedited Appeals Process are Appeals involving: substantial risk of serious and immediate harm; inpatient care; durable medical equipment; and terminal illness. (See below for further information.) Expedited Appeals will not be used to review a Benefit Denial or Rescission of Coverage.

How and Where You Can File an Expedited Appeal: You file an Expedited Appeal in the same manner as you file a standard Appeal. See above section: “How and Where You Can File an Appeal.”

Review and Response to Your Expedited Appeal:

Substantial Risk of Serious and Immediate Harm: Your Appeal will be an Expedited Appeal if it includes a signed certification by a physician that, in the physician’s opinion: the service is medically necessary; a denial of such service would create a substantial risk of serious harm to you; and the risk of serious harm is so immediate that the provision of such service should not await the outcome of the standard Internal Appeals Process. This means we will review and resolve your Expedited Appeal and send you a written decision within 48 hours of receipt of this certification (unless a different time limit, described below, applies to you).

Inpatient Care: Your Appeal will be an Expedited Appeal if you are an inpatient in a hospital and your Appeal concerns an Adverse Determination by us that inpatient care is no longer medically necessary. This means we will review and resolve your Expedited Appeal before you are discharged. If our decision continues to deny coverage of continued inpatient care, we will send you a written decision before you are discharged.

Durable Medical Equipment (“DME”) Needed to Prevent Serious Harm: Your Appeal will be an Expedited Appeal if it includes a signed certification by a physician that, in the physician’s opinion: the DME is medically necessary; a denial of the DME would create a substantial risk of serious harm to you (and
describes the harm that will result to you absent action within a 48 hour period); and the risk of serious harm is so immediate that the provision of the DME should not await the outcome of the standard Internal Appeals Process. The certification must also state a reasonable time period, not less than 24 hours, in which we must provide a response. This means we will review and decide your Expedited Appeal and send you a written decision within less than 48 hours of receipt of this certification.

Terminal Illness: Your Appeal will be an Expedited Appeal if you have a terminal illness and submit an Appeal for coverage of services. (A terminal illness is one that is likely to cause death within 6 months.) This means we will provide you a written resolution within 5 working days of receipt of your Appeal. If our decision continues to deny of coverage, you may request a conference with us to reconsider the denial. We will schedule the conference within 10 days of receiving your request. If your physician, after consulting with the plan’s Medical Director, decides that the effectiveness of the proposed service would be materially reduced if not furnished at the earliest possible date, we will schedule the hearing within 5 working days. You and/or your Authorized Representative may attend the conference. Following the conference, we will provide you a written decision.

If we don’t respond to your Expedited Appeal within these time frames, including any mutually agreed upon written extension, your Expedited Appeal will be deemed to be decided in your favor. Also, you may be entitled to pursue remedies under: applicable state law; or section 502(a) of ERISA (for members enrolled through a group contract subject to ERISA).

Other Important Information:

Who Can File a Grievance or Appeal: You may file your own Grievance or Appeal. Or, you may choose to have another person – known as an Authorized Representative—act on your behalf and file for you. You must appoint an Authorized Representative in writing to us on our form entitled: “Appointment of Authorized Representative.” (If you are an inpatient, a health care professional or a hospital representative may be your Authorized Representative without your having to fill out this form.)

• An Authorized Representative may be: a family member; agent under a power of attorney; health care agent under a health care proxy; a health care provider; attorney; or any other person appointed in writing by you to represent you in a specific Grievance or Appeal. We may require documentation that an Authorized Representative meets one of the above criteria.

Reconsideration of a Final Adverse Determination: The plan may offer you the opportunity for reconsideration of its final Appeal decision on an Adverse Determination. We may offer this when, for example, relevant medical information: was received too late for us to review it within the 30 calendar day time limit for standard Appeals; or was not received but is expected to become available within a reasonable time following our written decision on your Appeal. If you request reconsideration, you must agree in writing to a new review time period not to be more than 30 calendar days from the agreement to reconsider the Appeal.

External Review Process for Your Appeal: The External Review process allows you to have a formal independent review of a final Adverse Determination made by us through our standard Internal Appeals Process or Expedited Internal Appeals Process. Only final Adverse Determinations are eligible for External Review—two exceptions: no final Adverse Determination is necessary if (1) the plan has failed to comply with timelines for the Internal Appeals Process; or (2) you (or your Authorized Representative) file a request for an Expedited External Review at the same time that you file a request for an Expedited Internal Appeal. For more information, see below: Independent External Review Process.

Coverage Pending Resolution of Your Appeal: If your Appeal concerns the termination of ongoing coverage or treatment, the disputed coverage remains in effect at our expense through the completion of the standard Internal Appeals Process or Expedited Internal Appeals Process (regardless of the outcome of the process) if: the Appeal was filed on a timely basis; the services were originally authorized by us prior to your filing your Appeal (except for services sought due to a claim of substantial risk of serious and immediate harm); the services were not terminated due to a specific time or episode related exclusion in this EOC; and you continue to be an enrolled member.
Access to Medical Information: You are entitled to have free access to and copies of any of your medical information related to your Grievance or Appeal that is: in our possession; and under our control. To obtain this information, please contact the plan employee who is coordinating the review of your Grievance or Appeal, or Member Services. If we receive or rely on any new or additional information in connection with your Grievance or Appeal, we will provide you with a copy of such information in accordance with law.

Independent External Review Process: You may contest a final Appeal decision regarding an Adverse Determination. To do this, you must request an External Review of the decision. External Reviews are done by an independent organization under contract with the Health Policy Commission's Office of Patient Protection ("OPP"). Benefit Denials and Rescissions of Coverage are not eligible for External Review.

You may also file a request for an External Review before receiving a final Appeal decision regarding an Adverse Determination if the plan fails to comply with the timelines for the Internal Appeals Process.

You can request the External Review yourself. Or, you can have an Authorized Representative, including a health care provider or attorney, act for you during the external review process.

How To Request an External Review: To request External Review, you must file a written request with the OPP within 4 months of your receipt of the plan’s written notice of the final Appeal decision. A copy of the OPP’s External Review forms and other information will be enclosed with the plan’s notice denying your Appeal.

Expedited External Review: You can request an Expedited External Review. To do so, you must include a written certification from a physician that a delay in providing or continuing the health services that are the subject of the final Appeal decision would pose a serious and immediate threat to your health. If the OPP finds that such a serious and immediate threat to your health exists, it will qualify your request as eligible for an Expedited External Review.

You may file a request for an Expedited External Review at the same time as you file a request for an Expedited Internal Appeal.

Requirements for an External Review:
- The request must be submitted on the OPP’s application form called: “Request for Independent External Review of a Health Insurance Grievance.” We will send you this form when we send you the final Adverse Determination letter. Copies of this form may also be obtained by calling Member Services, by calling the OPP at 1-800-436-7757, or from the OPP’s website at: www.mass.gov/hpc/opp.
- The form must include your signature, or the signature of your Authorized Representative, consenting to the release of medical information. If applicable, you must enclose a copy of the plan’s final Appeal decision.
- You must include payment of OPP’s filing fee.

Coverage During the External Review Period: If the subject of the External Review involves termination of ongoing services (outpatient or inpatient), you may apply to the External Review agency to seek the continuation of coverage for the service during the period the review is pending. Any request for continuation of coverage must be made to the review panel before the end of the 2nd working day following your receipt of the plan’s final decision about your Appeal. The review panel may order the continuation of coverage: if it finds that substantial harm to your health may result from termination of the coverage; or for such other good cause as the review panel shall determine. The continuation of coverage shall be at our expense regardless of the final External Review decision.

Access to Information: You may have access to any medical information and records related to your External Review that are in our possession or under our control.

Review Process:
- The OPP will screen requests for External Review to determine whether your case is eligible. If the OPP determines that your case is eligible, it will be assigned to an External Review Agency.
- OPP will notify you and the plan of the assignment.
- The External Review Agency will make a final decision. It will send the written decision to you and the plan.
• For non-expedited External Reviews, the decision will be sent within 60 calendar days of receipt of the case from the OPP. (This is the case unless extended by the External Review Agency).
• For Expedited External Reviews, the decision will be sent within 4 business days from receipt of the case from the OPP. The decision of the External Review Agency is binding on the plan.

If the OPP decides that a request is not eligible for External Review, you will be notified: within 10 working days of receipt of the request; or, for requests for Expedited External Review, within 72 hours of the receipt of the request.


Compliance with Law: The plan administers its Member Satisfaction Process in accordance with applicable state and federal law. Any inconsistency between state and federal requirements will be resolved in the member’s favor.
CHAPTER 7. WHEN YOU HAVE OTHER COVERAGE

Coordination of Benefits (COB):

**COB Program:** In the event you are entitled to benefits under other health plans covering hospital, medical, dental or other health care expenses, we will coordinate our payment of covered services with the benefits under these other plans. This is known as Coordination of Benefits (COB). The purpose of COB is to prevent duplicate payment of the same health care expenses. We conduct COB in accordance with applicable MA law. (Note: with regard to coordinating benefits with Medicare, we conduct COB in accordance with applicable federal law.) Nothing in COB requires us to pay benefits for non-covered services under this EOC.

**Other Plans:** Benefits under this plan will be coordinated with any other plans that provide you with health benefits, including:

- individual or group health benefit plans offered by: medical or hospital service corporation plans; commercial insurance companies; HMOs; PPOs; other prepaid plans; or self-insured plans.
- insured or self-insured dental plans;
- automobile or homeowners insurance;
- personal injury insurance, including medical payment policies; and
- government plans such as Medicare.

**Primary and Secondary Plans:** We coordinate benefits by determining, in accordance with MA or federal law, (depending on which law applies): which plan has to pay first (the “primary” plan); and which plan pays second (the “secondary” plan). The primary plan pays its benefits without regard to the benefits of the secondary plan. The secondary plan determines its benefits after the primary plan, and may reduce its benefits because of the primary plan’s benefits. When coverage under this plan is secondary, no benefits will be paid until after the primary plan determines what it is required to pay.

**Medicare Program:** If you are eligible for Medicare, and Medicare is allowed by federal law to be the primary plan, coverage under this plan will be reduced by the amount of benefits allowed under Medicare for the same covered services. This reduction will be made whether or not you actually receive the benefits from Medicare. For example, if you are eligible for Medicare but have not enrolled in Medicare, this reduction will still apply.

**Member Cooperation:** By enrolling in this plan, you agree to cooperate with our COB program. This includes providing us or the Health Connector with information about any other health coverage you have at the time you enroll, or later if you become eligible for other health benefits after you enroll. The Health Connector or we may ask you for information, and may disclose information, for purposes of: our COB program; enrollment; and eligibility.

**Right to Recover Overpayment:** If we paid more than we should have under COB, we have a right to receive back, from you or another person, organization or insurance company, the amount we overpaid.

For more information about COB, call Member Services.

The Plan’s Rights to Recover Benefit Payments—Subrogation and Reimbursement:

**Right of Subrogation:**

- Subrogation is a means by which we can recover the costs of health care services we paid on your behalf when a third party (another person or entity) is, or is alleged to be, legally responsible for your illness or injury.
- You may have a legal right to recover some or all of the costs of your health care from a person or entity who is, or is alleged to be, responsible for your illness or injury. For example, you may have a right to recover against the person or entity that caused your injury or illness (such as a person who caused your injury in a car accident); his or her liability insurance company (such as an automobile, homeowners, or worker’s compensation insurance company); or your own insurance company (such as your car insurance company – including, but not limited to, uninsured and underinsured motorist coverage, Medpay coverage, Personal Injury Protection; or your rental or homeowner’s insurance company). In such a case, if we paid (or will pay) for health care services to treat your illness or injury, we have a right to recover (get back) what we paid, in your name, directly from the recovery received from that person or
entity (the “recovery”) regardless of whether this recovery is classified as payment for medical expenses, lost wages, pain and suffering, loss of consortium or any other type of recovery.

- Our right to recover from the recovery is up to the full amount that we paid or will pay for your health care services (regardless of what your provider billed us for the services). This is known as the plan’s right of subrogation which applies to the recovery.

To enforce our right of subrogation from the recovery, we can take legal action, with or without your consent, against any party to enforce that right. The plan’s right of subrogation from the recovery has first priority. We are entitled to recover against the total amount of the recovery, regardless of:

- whether the total recovery is less than the amount needed to reimburse you completely for your illness or injury;
- where or by whom the recovered money is held;
- how the recovered money is described or designated; or
- whether all or part of the recovery is for medical expenses.

The amount we are entitled to from the recovery will not be reduced by any attorney’s fees or expenses you may incur in enforcing your right to recover money from another person or entity.

Right of Reimbursement:

- We are also entitled to recover directly from the recovery the costs of health care services we paid (or will pay) if you have been, or could be, reimbursed (due to a lawsuit, settlement or otherwise) for the cost of care by another person or entity.
- In this case, you will be required to reimburse us (pay us back) from the recovery for the cost of health care services we paid (or will pay) for your illness or injury.
- We have the right to be reimbursed from the recovery up to the amount of any payment received by you, regardless of whether (a) all or a part of the recovery was designated, allocated, or characterized as payment for medical expenses; or (b) the payment is for an amount less than that necessary to reimburse you fully for the illness or injury.

Lien Rights. We may also have lien rights under MA law on any recovery you obtain. If so, you agree to fully cooperate with us in our exercising our lien rights.

Assignment of Benefits: By enrolling in this plan, you assign to us any benefits you may be entitled to receive (up to the costs of health care services paid or to be paid by us) from another person or entity that caused, or is legally responsible to reimburse you for, your illness or injury. Your assignment is up to the cost of health care services and supplies, and expenses that we paid or will pay for your illness or injury. Nothing in this EOC shall be interpreted to limit our right to use any remedy provided by law to enforce our rights under this section.

Member Cooperation: You agree to cooperate with the plan in exercising our rights under this section. This cooperation includes:

- notifying us of any events that may give rise to or affect our right to recover, such as an injury caused by someone else (for example, in a car accident) or job-related injuries;
- giving us timely notice of significant events during the negotiation, litigation or settlement with any third party (such as if you start a claim, sue someone, or start settlement discussions) and before you settle any claim;
- giving us information and documents we ask for, and signing documents;
- promptly paying us any monies you received for services for which we paid; and
- other things that we decide are necessary and appropriate to protect our rights.

You also agree not to do anything to limit, interfere with or prejudice our exercise of our rights under this section. If you do not cooperate as described in this Chapter, and as a result, we have additional expenses (such as attorney’s fees) to enforce our rights, you will be liable to us for the reasonable additional expenses we have to enforce our rights.

Note: We may arrange with a third party to carry out our rights under this Chapter. In such case, that third party is our agent for purposes of carrying out our rights.
Workers Compensation or Other Government Programs: The plan does not cover health care services that are or could be covered under: a Workers’ Compensation plan; other similar employer program; or under another federal, state or local government program. If the plan has information that services being provided to you are covered by any of these plans or programs, we may suspend payment of further covered services until a decision is made whether the other plan or program will cover the services. If we paid for services that were covered (or legally should have been covered) by these other plans or programs, we have a right to recover our payments from these other plans or programs.
CHAPTER 8. OTHER PLAN ADMINISTRATION PROVISIONS

Office of Patient Protection: The MA Office of Patient Protection (OPP) makes available to consumers certain information about health care plans. This information includes:

- Evidences of Coverage, including required consumer disclosures.
- Provider Directories.
- A list of sources of independently published information: assessing member satisfaction; and evaluating the quality of health care services offered by health plans.
- The percentage of physicians who voluntarily and involuntarily terminated contracts with the plan; and the three most common reasons for physician disenrollment.
- The percentage of premium revenue expended by the plan for health care services provided to members for the most recent year for which information is available.
- A report detailing, for the previous calendar year, the total number of:
  - filed grievances; grievances that were approved internally; grievances that were denied internally; and grievances that were withdrawn before resolution; and
  - external appeals and their resolution.

The OPP can be reached at:
Health Policy Commission-Office of Patient Protection

Utilization Management: The plan has a Utilization Management Program ("UM Program"). The UM Program’s purpose is to manage health care costs by reviewing whether certain medical services, supplies and drugs are: medically necessary; and are being given in the most clinically appropriate and cost-effective manner. The UM Program involves some or all of the following:

Prospective (or prior) review: Used to evaluate whether proposed treatment is medically necessary. This review occurs before the treatment begins. Examples are prior authorization of: elective inpatient admissions; certain specialists; and certain outpatient treatments and outpatient surgery.

Concurrent utilization review: Used to monitor a course of treatment as it is occurring and to determine when treatment may no longer be medically necessary. Examples include ongoing review of an inpatient admission. (Part of concurrent review involves active case management and discharge planning.)

Retrospective utilization review: used to evaluate treatment after it has been provided.

Timeframes for determinations:
- Prospective review: within 2 working days of receiving all necessary information but no later than 15 calendar days from receipt of the request.
- Concurrent review: within 1 working day of receiving all necessary information.
- Retrospective review: 30 calendar days.

You and your provider will be notified of applicable approvals and denials within legally required timeframes.

In the case of concurrent reviews, the service shall be continued without liability to you until you have been notified.

If your request for coverage is denied, you have the right to file an appeal. See Chapter 6. (The plan makes coverage decisions. Your provider makes all treatment decisions.)

Any inconsistency between state and federal legal requirements regarding UM reviews and decisions shall be resolved in favor of the member.

The UM Program is structured to encourage appropriate care. The Plan bases all utilization management decisions only on the medical necessity and appropriateness of care and services, as well as on the existence of coverage. The plan does not: compensate utilization management staff based on denials; or provide incentives to network providers to provide inappropriate types or levels of care.
You can call us to find out the status or outcome of utilization review decisions:

- 1-855-833-8120 (toll-free) or using our TTY Machine at 711
- Regarding mental health or substance use disorder services: 1-877-957-5600 (toll free).
- Translation services are available (see page 2)

Case Management: The plan may provide some members who have serious or complicated health conditions with case management services. Case management programs include disease management (for chronic conditions such as asthma and diabetes) and complex care management. Complex care management is for members with more serious or multiple health issues and conditions (including more serious cases of those conditions managed in the disease management programs). Examples of serious conditions are bariatric surgery or cancer. These case management services are a coordinated set of activities to: help monitor the member’s treatment progress; and facilitate the use of clinically appropriate and cost-effective care. Plan professionals may contact you and your provider about case management services. This may include: talking about treatment plans; establishing goals; facilitating appropriate use of resources; and when appropriate, suggesting alternative treatments and settings. Entry into the program may happen through completing your Health Needs Assessment, our claims or utilization management information, a Referral from a hospital Care Manager or one of your Providers, or self-Referral. If you feel you would benefit from case management, to learn more, or to opt out call 1-866-853-5241 for medical Care Management.

Individual Benefit Management (“IBM”): Individual Benefit Management is an approach to managing care for members with severe medical conditions. In certain circumstances, the plan may approve an IBM plan as an alternative treatment plan to the treatment currently being provided or proposed. This alternative treatment plan will provide coverage of services that would otherwise not be covered services. The purpose of the IBM plan is to permit a member to be covered for medically necessary services in the most appropriate, least intensive and most cost-effective setting that meets the member’s needs. An IBM plan may be developed if the member’s network physician and a plan authorized reviewer agree that all the following criteria are met:

- The member has a severe medical condition and is expected to require prolonged medical treatment.
- The alternative services are in place of more costly covered services that are currently being provided or are proposed. (For example, outpatient services to take the place of a more expensive inpatient admission.)
- The additional services are medically necessary.
- The member agrees to receive the alternative services as a substitute for the current or proposed covered services.
- The member continues to show improvement in her or his condition. This is determined from time to time by a plan authorized reviewer.

The plan will monitor the appropriateness and effectiveness of the IBM plan. We may change or terminate the IBM plan at any time when the plan authorized reviewer determines: that the IBM plan is no longer contributing to improvement of the member’s condition; or no longer meets the criteria described in this section.

Process to Develop Clinical Review Criteria and Guidelines:

- The plan has: a Medical Policy, Criteria, Technology Assessment Committee (MPCTAC); and Pharmacy and Therapeutics Committee (P&T).
- These committees develop, or review and adopt, clinical review criteria and guidelines to: determine the medical necessity of health care services and drug coverage guidelines; and ensure consistent plan decision-making.
- In doing so, the plan receives input from: internal network providers with professional knowledge and/or clinical expertise in the areas being reviewed; and/or external specialists when appropriate.
- In the process of developing or adopting clinical review criteria and guidelines, the MPCTAC assesses treatments to determine that they are: consistent with generally accepted principles of professional medical practice; known to be effective; based on objective, scientifically-derived and evidence based information in improving health outcomes; and consistent with applicable legal and national accreditation organization standards.
- The MPCTAC and P&T, with input and recommendations from other plan committees, network providers and/or external specialists (as appropriate), review and update clinical review criteria and guidelines periodically, or as needed. This review and update incorporates up-to-date standards of practice as new treatment, applications, drug coverage guidelines and technologies are developed.
Beacon’s Research and Development Committee (R&D) is responsible for the development and review of behavioral health (mental health and substance use disorder) clinical review criteria and guidelines. These clinically informed, proprietary level of care (LOC) criteria are developed with reference to:

- published guidelines (examples are: the American Psychiatric Association; American Medical Association; American Academy of Child and Adolescent Psychiatry; American Society of Addiction Medicine; and the Substance Abuse and Mental Health Services Administration);
- research evidence (when available);
- local consensus; and
- subject matter experts.

In the case of clinical controversies, Beacon also consults experts in the field for up to date best practices. Beacon’s criteria allow accommodation for: changes in needs; levels of care; new technologies; and modified recommendations in evidence-based guidelines. These criteria are reviewed and updated at least annually, and more frequently, as necessary. Any modifications or new criteria are reviewed by: Beacon’s medical leadership; physician advisors; clinical leadership; the Provider Advisory Council; and clinically-appropriate network providers. Final recommendations are forwarded to Beacon’s Clinical Management Committee for approval. Plan-specific modifications are also reviewed and accepted by Beacon’s partners in the specific plan.

Quality Management and Improvement Programs: The plan develops and uses quality management and improvement programs. These programs are designed to assess and help improve the quality of health care and service. These programs may vary over time in order to: address different aspects of care; and service and respond to changing priorities. The plan’s clinical programs may include:

- adoption and distribution of clinical guidelines to assist providers to deliver high quality evidence-based care;
- health promotion initiatives to encourage members to obtain preventive care services;
- disease management and education programs offering provider and member support services for chronic illnesses;
- credentialing of network providers; and
- complaint processes to address member complaints about quality of care.

Process to Evaluate Experimental or Investigational Treatments: The plan evaluates whether a service, treatment, procedure, supply, device, biological product or drug is an experimental or investigational treatment. It does this by: reviewing relevant documents related to the proposal, such as informed consent documents; and reviewing “authoritative evidence” as defined in the definition of experimental or investigational treatments (see Appendix A of this EOC). It considers all of the following:

- The treatment must have final approval from the appropriate governmental regulatory bodies (e.g. the U.S. Food and Drug Administration, FDA), or any other federal governmental body with authority to regulate the technology. This applies to drugs, biological products, devices or other products that must have final approval to be marketed.
- The “authoritative evidence” as defined in the definition of experimental or investigational must permit conclusions concerning the effect of the treatment on health outcomes.
- The treatment must improve the net health outcome and should outweigh any harmful effect.
- The treatment must be as beneficial as any established alternative.
- The outcomes must be attainable outside the investigational settings.

Process to Evaluate and Assess New Technology: As new medical technologies are developed, or when new uses of existing technologies arise, the plan evaluates whether to include these as a covered service. Examples are: medical and behavioral health therapies; devices; surgical procedures; diagnostics; and drugs. Assessment of medical technology is done to determine if the technology improves the quality of life and health outcomes. The plan does not cover experimental or investigational treatment. The technology assessment process is applied to both the development of new medical policies and the updating of existing policies. Plan medical staff conduct an evidence-based assessment process. The purpose is to evaluate the safety and effectiveness of the new technology. This process includes:

- consultation with medical experts with expertise in the new technology; and
- research and review of: published peer-reviewed medical literature; reports from appropriate governmental agencies; and polices and standards of nationally recognized medical associations and specialty societies.

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Staff present proposals to the appropriate internal clinical policy committees for review. These committees in turn present recommendations to the internal clinical management committee responsible for making final coverage decisions.

**Disagreement with Recommended Treatment by Network Providers:**
- When you enroll in the plan, you agree that network providers are responsible to decide the appropriate treatment for you.
- Some members may, for religious or personal reasons: disagree with the recommended treatment; refuse to follow the recommended treatment; or seek treatment (or conditions of treatment) that network providers judge do not meet generally accepted professional standards of medical care. In such instances, you have the right to refuse the treatment advice of a network provider; however, the plan has no further duty to provide coverage for the care in question. If you seek care from non-network providers because of such a disagreement, you will be responsible for the cost and outcome of such care. (For coverage of second opinions, see Chapter 3.) Members have the right to submit an appeal regarding coverage decisions. (See Chapter 6-Member Satisfaction Process.)

**Quality Incentives:** The plan may, from time to time, offer some or all members certain incentives to encourage improvements in health status and the quality of health care. Examples include: additional benefits; waiver of copayments; and rewards cards. If we offer such incentives, we will notify you about them: we may send you a letter; and/or we may put the notice on our website.

**Confidentiality of Personal Health Information:** The plan has a strong commitment to: protecting the confidentiality of your personal health information (“PHI”); and using and disclosing it only in accordance with applicable law. The plan provides members with a separate Notice of Privacy Practices. This Notice describes how the plan uses and discloses your PHI. It also describes rights you have regarding your PHI. Call Member Services for additional copies of our Notice of Privacy Practices.

**Bills from Providers:**
- **Bills from Network Providers:** When you receive covered services from network providers, you should not receive any bill from them (other than for applicable cost-sharing). Network providers will bill the plan for covered services provided to you. The plan will pay network providers for covered services. If you do receive a bill for any amount other than the applicable cost-sharing, call Member Services.

- **Bills from Non-Network Providers:** If you receive covered services from a non-network provider due to any of the reasons described under “Care from Non-Network Providers” in Chapter 2, you may receive a bill from that provider. If you are being billed by the non-network provider:
  - Ask the provider to send the plan a bill on a standard health care claim form to: BMC HealthNet Plan Qualified Health Plan, P.O. Box 55282, Boston, MA 02205-5282
  - If you paid the non-network provider for these services, we will reimburse you, consistent with your Schedule of Benefits and this EOC, if we determine they are covered services. (Please see Chapter 2 regarding payment up to the allowed amount.)
    - To process your reimbursement, we must receive from you: your name; address; phone number; date of birth; your plan ID number (see your member ID card); the date the care was provided to you; a brief description of the illness or injury; a copy of the provider’s bill to you; and a receipt from the provider as proof of payment. Send reimbursement requests to:

      **BMC HealthNet Plan Qualified Health Plan**
      529 Main Street Suite 500
      Charlestown, MA 02129
      Attention: Member Services
      Telephone: 1-855-833-8120; Fax: 617-748-6132

      **Note:** in some cases we may need more information from you or the provider before we pay the claim. If so, we will contact you or the provider. Call Member Services if you have further questions.

      **Time Limits on Claims:** In order for us to reimburse you for covered services, we must receive your claim within 6 months from the date you received care.
Premium Payments: You or your group pay applicable premium payments to the Health Connector. (Some individuals, at their option, may be eligible to pay premiums directly to the plan.) When the Health Connector receives your premium, it forwards applicable premium to the plan. The plan is not responsible if the Connector fails to pay premium to the plan for your coverage. If the Connector fails to pay us premium on time, your enrollment in the plan may be cancelled in accordance with applicable state and federal law. The plan may change the premium that individuals or groups are required to pay. This will be done in accordance with Health Connector policies and applicable laws.

Limitation on Actions: You must complete the internal Member Satisfaction Process before you can file a lawsuit against the plan for failing to pay for covered services. Any lawsuit must be filed within 2 years of the time the cause of action arose.

Relationship between BMCHP and Providers:
- BMCHP arranges for health care services. It does not provide health care services.
- BMCHP contracts with: organizations that contract with network providers; and network providers, including network providers who practice in their private offices throughout the service area.
- Network providers are independent. They are not employees, agents or representatives of BMCHP.
- Network providers are not authorized by BMCHP to change anything in this EOC or create any obligation for BMCHP.
- BMCHP is not liable for statements about this EOC made by network providers or their employees or agents.
- BMCHP is also not liable for any acts, omissions, representations or any other conduct of any network provider.
- BMCHP may change its arrangements with network providers, including adding or removing providers from its network, without prior notice to members (except as specifically set forth in this EOC).

Notice: The plan will send all notices it is required to send to members at the last address of the member that is on file with the plan. If you move, please let the Health Connector and the plan know your new address. Members should send notice to the plan as follows:

Boston Medical Center Health Plan, Inc.
529 Main Street Suite 500
Charlestown, MA 02129
Attention: Member Services

Circumstances Beyond the Plan's Reasonable Control: The plan is not responsible for a failure or delay in carrying out its obligations under this EOC in cases of circumstances beyond its reasonable control. These circumstances could include: riot; war; epidemic; strike; civil insurrection; natural disasters; destruction of plan offices; or other major disasters. In such cases, we will make a good faith effort to arrange for health care services and carry out our administrative responsibilities. However, we are not responsible for the costs or other outcomes of our inability to perform.

Enforcement of Terms: The plan may choose to waive certain terms of this EOC. If we do so, it does not mean that we give up our rights to enforce those terms in the future.

Subcontracting: From time to time the plan may subcontract with other entities to perform some of its obligations under this EOC.

This EOC; Changes to this EOC: This EOC is issued and effective as of the date on the front cover. The EOC consists of this document and the applicable Schedule of Benefits. This EOC supersedes (takes the place of) all previous EOCs issued by the plan. This EOC is a contract between you and the plan. This contract consists of: this document; the applicable Schedule of Benefits, your enrollment form; and any amendments, riders, or additional attachments issued to this document. By signing and returning your enrollment application form to the Health Connector, you: apply for coverage under the plan; and you agree to all the terms and conditions of the Qualified Health Care Program as set forth by the Health Connector, and to the terms and conditions of this EOC.
The plan may change this EOC without sending you advance notice, if we need to comply with changes in
state or federal law. If we make other material changes, we will send written notice as follows: if you are
enrolled under an individual contract, to the subscriber; and if you are enrolled under a group contract, to the
group. Changes do not require your consent. Changes will apply to all plan members in the applicable benefit
package, not just to you. Changes will apply to all covered services received on or after the effective date of
the change.

Please go to our website at www.bmchp.org for the most current version of the EOC.

Notice of Privacy Practices: This Notice describes how health information about you may be used and
disclosed, and how you may access this information. Please review this Notice of Privacy Practices carefully.

This Notice of Privacy Practices is effective September 23, 2013 and supersedes the revision dated June 30,
2012. This Notice describes how we may use and disclose your health information to carry out treatment,
payment or healthcare operations, and for other purposes that are permitted or required by law. It also
describes your rights to access and control your health information.

“Protected health information” or “PHI” is health information, including individually identifiable information,
related to your physical or behavioral health condition used in providing healthcare to you or for payment for
healthcare services.

By law, we are required to:
- Maintain the privacy and confidentiality of your protected health information
- Give you this Notice of Privacy Practices
- Follow the practices in this Notice

We use physical, electronic and procedural safeguards to protect your privacy. Even when disclosure of PHI
is allowed, we only use and disclose PHI to the minimum amount necessary for the permitted purpose.

Other than the situations mentioned in this Notice, we cannot use or share your protected health information
without your written permission, and you may cancel your permission any time by sending us a written
notice.

We reserve the right to change this Notice and to make the revised notice effective for any of your current or
future protected health information. You are entitled to a copy of the Notice currently in effect.

How We May Use and Disclose Your Protected Health Information (PHI)

For Treatment: We may communicate PHI about you to doctors, nurses, technicians, office staff or other
personnel who are involved in taking care of you and need the information to provide you with medical care.
For example, if you are being treated for a back injury, we may share information with your primary care
physician, the back specialist and the physical therapist so they can determine the proper care for you. We
will also record the actions they took and the medical claims they made. Other examples of when we may
disclose your PHI include:
- Quality improvement and cost containment wellness programs, preventive health initiatives, early
detection programs, safety initiatives and disease management programs.
- To administer quality-based cost effective care models, such as sharing information with medical
providers about the services you receive elsewhere to assure effective and high quality care is
coordinated.

For Payment: We may use and disclose your PHI to administer your health benefits, which may include
claims payment, utilization review activities, determination of eligibility, medical necessity review,
coordination of benefits and appeals. For example, we may pay claims submitted to us by a provider or
hospital.

For Healthcare Operations: We may use and disclose your PHI to support our normal business activities. For
example, we may use your information for care management, customer service, coordination of care or
quality management.
Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services: We may contact you to provide appointment or refill reminders, or information about possible treatment options or alternatives and other health-related benefits, or services that may be of interest to you.

As Required By Law: We will disclose PHI about you when we are required to do so by international, federal, state or local law.

Business Associates: We may disclose PHI to our business associates who perform functions on our behalf or provide services if the PHI is necessary for those functions or services. All of our business associates are obligated, under contract with us, to protect the privacy of your PHI.

Coroners, Medical Examiners and Funeral Directors: We may communicate PHI to coroners, medical examiners and funeral directors for identification purposes and as needed to help them carry out their duties consistent with applicable law.

Correctional Facilities: If you are or become an inmate in a correctional facility, we may communicate your PHI to the correctional facility or its agents, as necessary, for your health and the health and safety of other individuals.

Disaster Relief: We may communicate PHI to an authorized public or private entity for disaster relief purposes. For example, we might communicate your PHI to help notify family members of your location or general condition.

Family and Friends: We may communicate PHI to a member of your family, a relative, a close friend, or any other person you identify who is directly involved in your healthcare or payment related to your care.

Food and Drug Administration (FDA): We may communicate to the FDA, or persons under the jurisdiction of the FDA, your PHI as it relates to adverse events with drugs, foods, supplements and other products and marketing information to support product recalls, repairs or replacement.

Health Oversight Activities: We may communicate your PHI to state or federal health oversight agencies authorized to oversee the healthcare system or governmental programs, or to their contractors, for activities authorized by law, audits, investigations, inspections, and licensing purposes.

Law Enforcement: We may release your PHI upon request by a law enforcement official in response to a valid court order, subpoena or similar process.

Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may communicate PHI about you in response to a court or administrative order. We may also communicate PHI about you because of a subpoena or other lawful process, subject to all applicable legal requirements.

Military, Veterans, National Security and Intelligence: If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may be required by other government authorities to release your PHI for national security activities.

Minors: We may disclose PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Organ and Tissue Donation: If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation – such as an organ bank – as necessary to facilitate organ or tissue donation and transplantation.

Personal Representative: If you have a personal representative, such as a legal guardian (or an executor or administrator of your estate after your death), we will treat that person as if that person is you with respect to disclosures of your PHI.
Public Health and Safety: We may communicate your PHI for public health activities. This includes disclosures to: (1) prevent or control disease, injury or disability; (2) report birth and deaths; (3) report child abuse or neglect; (4) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (5) the appropriate government authority if we believe a person has been the victim of abuse, neglect, or domestic violence and the person agrees or we are required to by law to make that disclosure or (6) when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Research: We may use and disclose your PHI for research purposes, but we will only do that if the research has been specially approved by an institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify persons who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. But we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the security of the data, and (3) not identify the information or use it to contact any individual.

Worker’s Compensation: We may use or disclose PHI for worker’s compensation or similar programs that provide benefits for work-related injuries or illness.

Uses and Disclosures that Require Us to Give You an Opportunity to Object and Opt Out

Fundraising: We may use PHI about you in an effort to raise money. If you do not want us to contact you for fundraising efforts, you may opt out by notifying us, in writing, with a letter addressed to the BMC HealthNet Plan Privacy Officer.

Special Protections for HIV, Alcohol and Substance Abuse, Mental Health, and Genetic Information

Special privacy protections apply to HIV-related information, alcohol and substance abuse, mental health, and genetic information that require your written permission, and therefore some parts of this general Notice of Privacy Practices may not apply to these more restricted kinds of PHI.

Your Rights Regarding Protected Health Information about You

Right to Access and Copy: You have the right to inspect and obtain a copy of your PHI. To do so, you must submit a written request to the BMC HealthNet Plan Privacy Officer. We will provide you with a copy or a summary of your records, usually within 30 days and we may ask you to pay a fee to cover our costs of providing you with that PHI, and certain information may not be easily available prior to July 1, 2002. We may deny your request to inspect and copy, in certain limited circumstances.

Right to an Electronic Copy of PHI: You have the right to require that an electronic copy of your health information be given to you or transmitted to another individual or entity if it is readily producible. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic record.

Right to Get Notice of a Security Breach: We are required to notify you by first class mail of any breach of your Unsecured PHI as soon as possible, but no later than 60 days after we discover the breach. “Unsecured PHI” is PHI that has not been made unusable or unreadable. The notice will give you the following information:
- A short description of what happened, the date of the breach and the date it was discovered
- The steps you should take to protect yourself from potential harm from the breach;
- The steps we are taking to investigate the breach, mitigate loses, and protect against further breaches;
- Contact information where you can ask questions and get additional information

Right to Amend: If you believe the PHI we have about you is incorrect or incomplete, you may ask us to amend the PHI. You must request an amendment, in writing, to the BMC HealthNet Plan Privacy Officer and include a reason that supports your request. In certain cases, we may deny your request for amendment, but
we will advise you of the reason within 60 days. For example, we may deny a request if we did not create the information, or if we believe the current information is correct.

Right to an Accounting of Disclosures: You have the right to request an “accounting of disclosures”. This is a list of the disclosures we made of PHI about you for most purposes other than treatment, payment and healthcare operations. The right to receive an accounting is subject to certain exceptions, restrictions and limitations. To obtain an accounting, you must submit your request, in writing, to the BMC HealthNet Plan Privacy Officer. We will provide one accounting a year for free but may charge a reasonable, cost-based fee if you submit a request for another one within 12 months. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003.

Right to Request Restrictions: You have the right to request, in writing, to the BMC HealthNet Plan Privacy Officer, a restriction or limitation on our use or disclosure of your PHI. We are not, however, required by law to agree to your request. If we do agree, we will comply with your request unless the PHI is needed to provide emergency treatment to you.

Right to Request Confidential Communication: You have the right to request that we communicate with you about medical matters only in writing or at a different residence or post office box. To request confidential communications, you must complete and submit a Request for Confidential Communication Form to the BMC HealthNet Plan Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Notice of Privacy Practice: You have the right to receive a paper copy of the Notice of Privacy Practices upon request at any time.

How to Exercise Your Rights

To exercise your rights as described in this Notice, send your request, in writing, to our Privacy Officer at the address listed in this Notice.

Assistance in Preparing Written Documents: BMC HealthNet Plan will provide you with assistance in preparing any of the requests explained in this Notice that must be submitted in writing. There will be no cost to you for this.

Your Written Authorization is Required for Other Uses and Disclosures

Other Uses and Disclosures of PHI: We will obtain your written authorization before using or disclosing your PHI for purposes other than those provided for above (or as otherwise permitted or required by law). You may revoke such an authorization at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

We will never sell your health information or use your health information for marketing purposes or to offer you services or products unrelated to your healthcare coverage or your health status, without your written authorization.

Compliance with State and Federal Laws: If more than one law applies to this Notice, we will follow the more stringent law. You may be entitled to additional rights under state law, and we protect your health information as required by these state laws.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Department of Health and Human Services. To file a complaint with our office, contact:

Privacy Officer
BMC HealthNet Plan
529 Main Street Suite 500
Charlestown, MA 02129

Or, you may call this office at 1-617-748-6325.
You may also notify the Secretary of the Department of Health and Human Services (HHS). Send any complaints to:

**Medical Privacy, Complaint Division**  
**Office for Civil Rights (OCR)**  
**United States Department of Health and Human Services**  
**200 Independence Avenue, SW, Room 509F, HHH Building**  
**Washington D.C., 20201**

You may also contact OCR’s Voice Hotline Number at (800) 368-1019 or send the information to their Internet address: [www.hhs.gov/ocr](http://www.hhs.gov/ocr).

*BMC HealthNet Plan will not take retaliatory action against you if you file a complaint about our privacy practices with either OCR or BMC HealthNet Plan.*

**Notice About Nondiscrimination and Accessibility Requirements and Nondiscrimination Statement**

*Boston Medical Center HealthNet Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Boston Medical Center HealthNet Plan does not exclude people or treat them differently because of race, color national origin, age, disability, or sex.*

*Boston Medical Center HealthNet Plan:*
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

*If you need these services, contact Boston Medical Center HealthNet Plan.*

*If you believe that Boston Medical Center HealthNet Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:*

  **Civil Rights Coordinator**  
  **529 Main Street Suite 500**  
  **Charlestown, MA 02129**  
  **Phone: 1-888-566-0010 (TTY/TDD 711)**  
  **Fax: 1-617-897-0805**

*You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Boston Medical Center HealthNet Plan is available to help you.*

*You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at [https://ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf), or by mail or phone at:*

  **U.S. Department of Health and Human Services**  
  **200 Independence Avenue, SW**  
  **Room 509F, HHH Building**  
  **Washington, D.C. 20201**  
  **1-800-368-1019, 800-537-7697 (TDD)**

*Complaint forms are also available at [http://www.hhs.gov/ocr/office/file/index.html](http://www.hhs.gov/ocr/office/file/index.html).*

**Notice: Massachusetts Mental Health Parity Laws and the Federal Mental Health Parity and Addiction Equity Act (MHPAEA):** This Notice gives you information about your plan benefits for mental health and substance use disorder services. Under both Massachusetts and federal laws, the plan’s benefits for mental health and substance use disorder services must be comparable to benefits for medical/surgical services.
This means that your cost-sharing (copayments, coinsurance and deductibles) for mental health and substance use disorder services must be at the same level as for medical/surgical services. Also, the plan’s review and authorization of mental health or substance use disorder services must be handled in a way that is comparable to the review and authorization of medical/surgical services.

The plan arranges with Beacon to manage mental health and substance use disorder services for its members, including the review and authorization of these services and member appeals. If Beacon makes a decision to deny or reduce authorization of a service, Beacon will send you a letter explaining the reason for the denial or reduction. Beacon will also send you or your provider a copy of the criteria used to make this decision, at your request.

If you think that the plan or Beacon is not handling your benefits for mental health and substance use disorder services in the same way as for medical/surgical services, you may file a complaint with the Division of Insurance (DOI) Consumer Services Section.

You may file a written complaint using the DOI’s Insurance Complaint Form. You may request the form by phone or by mail or find it on the DOI’s webpage at:
http://www.mass.gov/ocabr/consumer/insurance/file-a-complaint/filing-a-complaint.html

You may also submit a complaint to the DOI by phone by calling 877-563-4467 or 617-521-7794. If you submit a complaint by phone, you must follow up in writing and include your name and address, the nature of your complaint and your signature authorizing the release of any information.

Filing a written complaint with the DOI is not the same as filing an appeal with Beacon under your plan benefits. In order to have a denial or reduction in coverage of a mental health or substance use disorder service reviewed, you must file an appeal with Beacon. (See Chapter 6 of this EOC for more information on filing an appeal.) This may be necessary to protect your right to continued coverage of treatment while you wait for an appeal decision. Follow the appeal procedures outlined in Chapter 6 of this EOC. Or, call Beacon toll-free at 1-877-957-5600 for more information about filing an appeal.
APPENDIX A: DEFINITIONS

The words below, when italicized in this EOC, have the following meanings:

Activities of Daily Living: Activities engaged in as part of normal daily life. Examples are: bathing; eating; drinking; walking; dressing; speaking; and maintaining personal hygiene and safety. These do not include special functions needed for occupational purposes or sports.

Allowed Amount: The plan calculates payment of your benefits and cost-sharing amounts based on its allowed amount. The allowed amount depends on the type of health care provider that provides the covered services to you:

For providers with a payment agreement with plan: For providers who have a payment agreement with the plan, the allowed amount is the negotiated amount set forth in the agreement.

For providers with no payment agreement with the plan:
- For covered services provided by providers who do not have a payment agreement with the plan, the allowed amount is either: the amount required by applicable law; or the amount the plan determines, in its sole discretion, is usual, customary and reasonable ("UCR").
- UCR determinations are based on nationally accepted means and amounts of claims payment. These include, without limitation: Medicare fee schedules and allowed amounts; American Medical Association CPT coding guidelines; CMS medical coding policies; and nationally recognized academy and society coding and clinical guidelines. (When the plan has delegated claims processing to a third party, that third party shall have the same discretion as the plan with respect to UCR determinations.)
- The allowed amount is the maximum amount the plan will pay for covered services (minus any applicable member cost-sharing) rendered by providers who do not have a payment agreement with the plan.

In general, your cost-sharing for covered services is calculated based on the initial full allowed amount for the provider. The amount you pay for your cost-sharing is generally not subject to future adjustments (up or down) even when the provider’s payment may be subject to future adjustments (due to, for example, contractual or risk sharing settlements, or rebates). However, cost-sharing may be adjusted due to claims processing or billing modifications or corrections. The claim payment made to the provider will be the full allowed amount less your cost-sharing amount.

Appeal: A formal complaint by you about a Benefit Denial, an Adverse Determination, or a Retroactive Termination of Coverage – all as specifically defined as follows:
- Benefit Denial:
  - A plan decision, made before or after you have obtained services, to deny coverage for a service, supply or drug that is specifically limited or excluded from coverage in this EOC; or
  - A plan decision to deny coverage for a service, supply or drug because you are no longer eligible for coverage under the plan. (This means you no longer meet the plan’s eligibility criteria.)
- Adverse Determination: A plan decision, based on a review of information provided, to deny, reduce, modify or terminate an admission, continued inpatient stay or the availability of any other health care services, for failure to meet the requirements for coverage based on: medical necessity; appropriateness of health care setting and level of care; or effectiveness. These are often known as medical necessity denials because in these cases the plan has determined that the service is not medically necessary for you.
- Retroactive Termination of Coverage: A retroactive cancellation or discontinuance of enrollment as a result of the plan’s determination that: you have performed an act, practice or omission that constitutes fraud; or you have intentionally misrepresented a material fact with regard to the terms of the plan.

Authorized Reviewer: BMCHP’s Chief Medical Officer, or someone named by him or her, to review and determine coverage of certain health care services and supplies to members.

Beacon: Beacon Health Strategies, LLC. Beacon is an organization contracted by BMCHP to administer the plan’s mental health and substance use disorder benefits.
**Benefit Limit:** The visit, day or dollar limit maximum that applies to certain covered services during a benefit year (or other time period, if specified in the EOC). Once the benefit limit is reached, the plan does not provide any further coverage for such service or supply for that benefit year (or other time period.) If you get more of the service or supply beyond the benefit limit, you are responsible for all charges. Benefit limits are in your Schedule of Benefits.

**Benefit Year:** The benefit year is the annual period during which:
- benefits are purchased and administered;
- deductibles, coinsurance, copayments and the out-of-pocket maximum are calculated; and
- applicable benefit limits apply.

See Chapter 1 for more information about benefit years.

**BMCHP:** Boston Medical Center Health Plan, Inc. BMCHP is a not-for-profit MA-licensed health maintenance organization. BMCHP is also known as: Boston Medical Center HealthNet Plan or BMC HealthNet Plan. We arrange for the provision of health care services to members through contracts with network providers in our service area. BMCHP contracts with the Health Connector to offer the plan to members. BMCHP is sometimes referred to as “we,” “our,” or “us.”

**BMC HealthNet Plan Qualified Health Plan (or the “Plan”):** The program of health benefits described in this EOC, along with the corresponding Schedules of Benefits. It is also referred to as the plan. Through an arrangement with the Health Connector, BMCHP offers the plan to persons meeting applicable eligibility requirements.

**Child (or Children):**
- The following individuals, until their 26th birthday:
  - The subscriber or spouse’s natural child, stepchild or adoptive child.
    *A child is an adoptive child as of the date he or she is:
    - legally adopted by the subscriber; or
    - placed for adoption with the subscriber. Placed for adoption means that the subscriber has assumed a legal obligation for the partial or total support of a child in anticipation of adoption. If the legal obligation ends, the child is no longer considered to be placed for adoption. (As required by state law, a foster child is considered an adoptive child as of the date that a petition to adopt was filed.)
  - The dependent child of an enrolled child.
  - A child for whom the subscriber or spouse is the court appointed legal guardian.
  - A subscriber or spouse’s disabled dependent

**Coinsurance:** The percentage of costs you must pay for certain covered services. See Chapter 1 for more information. Coinsurance amounts are in your Schedule of Benefits.

**Copayment:** A fixed amount you pay for certain covered services. Copayments are paid directly to the provider at the time you receive care (unless the provider arranges otherwise). Copayment amounts are in your Schedule of Benefits.

**Cosmetic, or Cosmetic Services:** Services, including surgery, to change or improve appearance.

**Cost-Sharing:** The costs you pay for certain covered services. Cost-sharing consists of deductibles, copayments, and/or coinsurance. Cost sharing amounts are in your Schedule of Benefits.

**Coverage Effective Date:** The date, according to our records, when you become a member and are first eligible for covered services under the plan.

**Covered Services:** The services, supplies and drugs for which the plan will pay according to this EOC. Covered services must be: described as such in the EOC; medically necessary; received while you are an active member of the plan; provided by a network provider (except in an emergency, for urgent care needed while you are outside the service area, or in rare cases when approved in advance by the plan); in some cases, approved in advance by a plan authorized reviewer; not listed as excluded in this EOC; provided to treat an injury, illness or pregnancy, or for preventive care; and consistent with applicable state or federal law.
Covering Provider: A provider who has an arrangement with your PCP to provide or coordinate your care when your PCP is not available. Covering providers often provide coverage for your PCP during evenings, nights, weekends, holidays and vacations.

Custodial Care: Care that is provided: mainly to assist in the activities of daily living; by individuals who do not require specialized medical training or professional skills; or mainly to help maintain your or someone else’s safety when there is no other reason for you to receive medically necessary hospital level of care. Also, routine maintenance of colostomies, urinary catheters or ileostomies is considered custodial care.

Deductible: The specific dollar amount you pay for certain covered services in a benefit year before the plan is obligated to pay for those covered services. Once you meet your deductible, you pay either: nothing, or the applicable copayment or coinsurance for those covered services for the remainder of the benefit year. See Chapter 1 for more information. Deductible amounts are in your Schedule of Benefits.

Dependent: A subscriber’s spouse, child or other dependent – as defined by the Health Connector. Not all dependents are allowed to enroll in all Qualified Health Plan Program benefit packages. Call the Health Connector for eligibility information.

Diagnostic and Statistical Manual: Mental Disorders (DSM): the latest edition of the American Psychiatric Association’s Diagnostic and Statistical Manual: Mental Disorders. This lists illnesses or diseases that qualify as mental disorders.

Disabled Dependent: A subscriber’s or spouse’s child who:
- became permanently physically or mentally disabled before age 26;
- lives with the subscriber or spouse;
- is incapable of supporting him/herself due to the disability; and
- was covered under the subscriber’s family coverage immediately before age 26, or has been covered by other group health coverage since the disability started.

Emergency: An emergency means a medical condition, whether physical, behavioral, related to substance use disorder, or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that, in the absence of prompt medical attention, could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of a member or another person, or, in the case of a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any body organ or part; or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

Experimental or Investigational, or Experimental or Investigational Treatment: A treatment, service, procedure, supply, device, biological product or drug (collectively “treatment”) is considered to be experimental or investigational for use in the diagnosis or treatment of a medical condition if any of the following is true:
- In the case of a drug, device, or biological product, it cannot be marketed lawfully without the approval of the U.S. Food and Drug Administration (“FDA”) and final approval has not been given by the FDA.
- The treatment is described as experimental (or investigational, unproven, or under study) in the written informed consent document provided, or to be provided, to the member by the health care professional or facility providing the treatment.
- Authoritative evidence does not permit conclusions concerning the effect of the treatment on health outcomes.
- There is insufficient authoritative evidence that the treatment improves the net health outcome. (Net health outcome means that the treatment’s beneficial effects on health outcomes outweigh any harmful effects of the treatment on health outcomes.)There is insufficient authoritative evidence that the treatment is as beneficial as any established alternative. This means that the treatment does not improve net outcome as much as or more than established alternatives.
- There is insufficient authoritative evidence that the treatment’s improvement in health outcomes is attainable outside the investigational setting.

“Authoritative evidence,” as used in this definition, shall mean only the following:
• Reports and articles, of well-designed and well-conducted studies, published in authoritative English-language medical and scientific publications. The publications must be subject to peer review by qualified medical or scientific experts prior to publication. In evaluating this evidence, the plan takes into consideration both the quality of the published studies and the consistency of results.

• Opinions and evaluations by: national medical associations; other reputable technology assessment bodies; and health care professionals with recognized clinical expertise in treating the medical condition or providing the treatment. In evaluating this evidence, the plan takes into consideration the scientific quality of the evidence upon which the opinions and evaluations are based.

The fact that a treatment is offered as a last resort does not mean that it is not an experimental or investigational treatment.

Grievance: A formal complaint by you about:
• Plan Administration (how the plan is operated): any action taken by a plan employee; any aspect of the plan’s services, policies or procedures; or a billing issue.
• Quality of Care: The quality of care you received from a network provider.

Group: An employer or other legal entity, as defined by the Health Connector, with which the Health Connector has a group contract to arrange for the provision of group coverage. An employer group subject to the Employee Retirement Income Security Act of 1974 (ERISA) is the ERISA plan sponsor. BMCHP is not the plan sponsor. If you are a member through a group, the group is your agent and is not BMCHP’s agent.

Group Contract: The agreement between a group and the Health Connector under which:
• the Health Connector agrees to arrange for the group to obtain coverage under the plan; and
• the group agrees to pay the premium to the Health Connector for coverage under the plan.
The group contract includes this EOC and the applicable Schedules of Benefits.

Group Member: A category of subscriber (and his/her enrolled dependents) who receives coverage under the plan through a group contract.

Health Connector: The Commonwealth Health Insurance Connector Authority. This is an organization established under MA law to oversee and operate the Qualified Health Plan Program. The Health Connector is the Affordable Care Act-compliant exchange for Massachusetts. When the term Health Connector is used, it also includes its subcontractors.

Individual: A category of subscriber for which there is no employer financial contribution to the premiums under this plan. The individual is responsible to pay the full applicable premium. The individual subscriber (or someone on his/her behalf) enters into an individual contract with the Health Connector.

Individual Contract: The agreement between an individual and the Health Connector under which:
• the Health Connector agrees to arrange for the individual to obtain coverage under the plan; and
• the individual agrees to pay the full applicable premium to the Health Connector for coverage under the plan.
The individual contract includes this EOC and the applicable Schedules of Benefits.

Inpatient: A patient who is admitted to a hospital or other facility; and registered by that facility as a bed patient.

Inquiry: Any communication by you to the plan asking us to address a plan action, policy or procedure. It does not include questions about adverse determinations, which are plan decisions to deny coverage based on medical necessity.

Medically Necessary (or Medical Necessity): Health care services that are consistent with generally accepted principles of professional medical practice as determined by whether: (a) the service is the most appropriate available supply or level of service for the member in question considering the potential benefits and harms to the member; (b) the service is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or (c) for services and interventions not in widespread use, the service is based on scientific evidence.
**Mental Disorders:** Psychiatric illnesses or diseases. (These include drug addiction and alcoholism.) The illnesses or diseases that qualify as mental disorders are listed in the latest edition, at the time of your treatment, of the DSM.

**Member:** A person enrolled in the plan under a group contract or individual contract. Members include subscribers and their enrolled dependents. A member is also referred to as “you” in this EOC.

**Network Pharmacy:** A retail, specialty or mail order pharmacy that is a network provider.

**Network Provider:** A provider with whom the plan has a direct or indirect agreement to provide covered services to members. Network providers are not the plan’s employees, agents or representatives. Network providers are listed in the plan’s Provider Directory.

**Open Enrollment Period:** The period of time each year when eligible persons (including eligible dependents) are able to apply for individual coverage (under an individual contract) or group coverage (under a group contract).

**Out-of-Pocket Maximum:** This is the maximum amount of cost-sharing you are required to pay in a benefit year for most covered services. See Chapter 1 for more information. Out-of-pocket maximum amounts, if any, are in your Schedule of Benefits.

**Outpatient, or Outpatient Services:** Services provided to an individual who is not a registered bed patient in a facility. For example, you receive outpatient services in a provider’s office, an emergency room, health center, or outpatient clinic.

**Outpatient Surgery:** Surgery that is done under anesthesia in an operating room of a facility licensed to perform surgery; and where you are expected to be discharged the same day. Examples are outpatient surgery in a hospital or free-standing ambulatory surgery center.

**Plan:** The benefits described in this EOC (including your Schedule of Benefits). The plan is also known as BMC HealthNet Plan Qualified Health Plan. BMCHP has contracted with the Health Connector to offer the plan to individuals and groups.

**Premium:** The total monthly dollar amount an individual subscriber or group is required to pay for coverage under the applicable benefit package described in this EOC. The Health Connector will tell you the amount of your total monthly premium payment(s).

**Primary Care Provider (PCP):** A network healthcare professional qualified to provide general medical care for common health care problems, who (1) supervises, coordinates, prescribes or otherwise provides or proposes health care services; (2) coordinates and arranges for specialist care; and (3) maintains continuity of care within the scope of practice. PCPs are physicians who are doctors of: internal medicine; family practice; general practice; or pediatric medicine. A PCP may also be a physician assistant or a nurse practitioner (appropriately credentialed) who provides primary care services. Female members may also select an obstetrician/gynecologist as their PCP.

**Provider:** Health care professionals or facilities licensed under state law. Providers include but are not limited to: physicians; physician assistants, nurse practitioners, hospitals; skilled nursing facilities; psychologists; licensed mental health counselors; licensed independent clinical social workers; licensed marriage and family therapists; licensed psychiatric nurses certified as clinical specialists in psychiatric and mental health nursing; psychiatrists; licensed alcohol and drug counselors, certified nurse midwives; lab and imaging centers; and pharmacies. Some providers may be referred to as practitioners. To find out if a provider is in your provider network, call Member Services or look in the Provider Directory.

**Provider Directory:** A listing of our network providers.

**Provider Network (or Network):** The providers with whom the plan has an agreement to provide covered services to members. The plan has different provider networks. The provider network applicable to you is listed in your Schedule of Benefits.
Qualified Health Plan Program: The Qualified Health Plan Program overseen by the Health Connector.

Resident: a natural person living in Massachusetts. Confinement in a nursing home, hospital or other institution is not by itself sufficient to qualify a person as a resident.

Serious Harm: Circumstances which could: seriously jeopardize the member’s life, health or ability to regain maximum function; or result in severe pain.

Service Area: The geographical area in which network providers are located. Please visit the plan’s website at www.bmchp.org for more information about our service area. (We may add or delete cities and towns to our service area from time to time.)

Spouse: As defined by the Health Connector. It includes a subscriber’s divorced or separated spouse as required by MA law.

Subscriber: The person who:
- signs the membership application form on behalf of himself/herself* and (if allowed) any dependents;
- in whose name the premium is paid in accordance with either a group contract or an individual contract (as applicable);
- for an individual contract, is a MA resident; and
- for a group contract, is an employee of a group.
*Note: in the case of some eligible individuals under age 21 who enroll in an individual contract, the membership application form is signed by that individual’s parent or legal guardian on behalf of that individual.

Urgent Care: Medically necessary care that is required to prevent serious deterioration of your health when you have an unforeseen illness or injury. Urgent care does not include, among other things: routine care (including routine maternity or prenatal or postpartum care); preventive care; care for chronic medical conditions that require ongoing medical treatment; elective inpatient admissions; or elective outpatient surgery.

You: See “Member.”
APPENDIX B: MEMBER RIGHTS AND RESPONSIBILITIES

1. Members have a right to receive information about: BMCHP; its services; its network providers; and member rights and responsibilities.
2. Members have a right to be treated with respect and recognition of their dignity and right to privacy.
3. Members have a right to participate with network providers in making decisions about their health care.
4. Members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regards of cost or benefit coverage.
5. Members have a right to voice complaints or appeals about BMCHP or the care arranged for by the plan.
6. Members have a right to make recommendations regarding BMCHP’s member rights and responsibilities policies.
7. Members have a responsibility to supply information (to the extent possible) that BMCHP and network providers need to arrange for and provide care.
8. Members have a responsibility to follow plans and instructions for care that they have agreed on with their network provider.
9. Members have a responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
APPENDIX C: ERISA INFORMATION FOR GROUP MEMBERS

Introduction to ERISA: If you are a group member and your plan is an ERISA plan, you have certain rights and protections under ERISA. ERISA stands for the Employee Retirement Income Security Act of 1974. Most plans are ERISA plans, but there are exceptions. Please contact your plan administrator to learn if your plan is an ERISA plan.

Information about Your Plan and Benefits: ERISA entitles all plan participants to:

- Examine, without charge, at the plan administrator’s office and at other specified locations all documents governing the plan. These include, when applicable: insurance contracts; collective bargaining agreements; and a copy of the most current annual report (Form 5500 Series) filed by your plan with the US Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Upon written request to the plan administrator, you are entitled to obtain copies of documents governing the operation of the plan. These include the documents listed above as well an updated summary plan description. The plan administrator may charge you a reasonable charge for the copies.
- Receive a summary of the plan’s annual financial report. The plan administrator is required by law to provide each participant with a copy of this summary annual report.

Continuation of Group Health Plan Coverage: ERISA states that all plan participants are entitled to:

- Continue health care coverage for the subscriber, spouse or other dependents if there is a loss of coverage under the plan as a result of a qualifying event. The subscriber or dependents may have to pay for such continued coverage.
- Review the plan’s summary plan description and the other documents governing the plan on the rules governing your continuation coverage rights under COBRA (the Consolidated Omnibus Budget Reconciliation Act).
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under a group health plan, if you have creditable coverage from another plan.
  - You should be provided a free certificate of creditable coverage from your group health plan or health insurance issuer when: you lose coverage under the plan; when you become entitled to elect COBRA continuation coverage; when your COBRA continuation coverage ceases; if you request it before losing coverage; or if you request it up to 24 months after losing coverage.
  - Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. (The coverage described in this EOC does not contain a preexisting condition exclusion.)

Prudent Actions by Plan Fiduciaries: ERISA imposes duties upon people who are responsible for the operation of the plan. The people who operate your plan are called “fiduciaries” of the plan. They have a duty to operate your plan prudently and in the interests of plan participants and beneficiaries. No one, including your employer, union, or any other person, may fire a subscriber or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your ERISA rights.

Enforcing Your Rights:

- If your claim for a plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
- ERISA provides for steps you can take to enforce the above rights.
  - For example, if you request a copy of a plan document and do not receive it within 30 days, you may file suit in a federal court. In such case, the court may require the plan administrator to provide the documents and pay you up to $110 a day until you receive the documents, unless the documents were not sent because of reasons beyond the control of the plan administrator.
  - If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.
  - Also, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.
  - If a plan fiduciary misuses the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor. You may also file suit in a federal court.
court. The court will decide who has to pay court costs and legal fees. If you are successful, the
court may order the person you sued to pay these costs and fees. If you lose, the court may order
you to pay these costs and fees. For example, if a court finds your claims is frivolous, you may have
to pay court costs and legal fees.

Help With Your Questions: You should contact your plan administrator if you have any questions about your plan. If you have questions about this statement or about your ERISA rights, or if you need help obtaining documents from the plan administrator, you should contact:
- the nearest office of the Employee Benefits Security Administration, US Department of Labor, listed in your telephone directory; or

You may also obtain certain publications about your rights and responsibilities under ERISA. Call the publications hotline of the Employee Benefits Security Administration.

PROCESSING OF CLAIMS FOR PLAN BENEFITS: The Department of Labor’s (DOL) Employee Benefits Security Administration has published benefit determination procedure regulations for employee benefit plans governed by ERISA. The regulations set forth requirements regarding the processing of claims for plan benefits, including urgent care claims, pre-service claims, post-service claims and review of claims denials.

Who can submit a claim? The DOL regulations apply to claims submitted by ERISA participants or their beneficiaries. In accordance with the regulations, the plan permits an authorized representative (referred to here as the “authorized claimant”) to act on your behalf in submitting a claim or obtaining a review of a claim decision. An authorized claimant can be any individual (including, for example, a family member, an attorney, etc.) whom you designate to act on your behalf with respect to a claim for benefits.

How do I designate an Authorized Claimant? An authorized claimant can be designated at any point in the claims process—at the pre-service, post service or appeal level. Please contact Member Services at 1-855-833-8120 for information on appointing an authorized claimant.

Types of claims: There are several different types of claims that you may submit for review. The plan’s procedures for reviewing claims depends upon the type of claim submitted (urgent care claims, pre-service claims, post-service claims, and concurrent care decisions).

Urgent care claim:
- An “urgent care claim” is a claim for medical care or treatment where the application of the claims review procedure for non-urgent claims: (1) could seriously jeopardize your life, health or ability to regain maximum function, or (2) based upon your provider’s determination, would subject you to severe pain that cannot adequately be managed without the care or treatment being requested.
- For urgent care claims, we will respond to you within 72 hours after receipt of the claim.
- If we determine that additional information is needed to review your claim, we will notify you within 24 hours after receipt of the claim and provide you with a description of the additional information we need to evaluate your claim. You have 48 hours after that time to provide the requested information. We will evaluate your claim within 48 hours after the earlier of: our receipt of the requested information, or the end of the extension period given to you to provide the requested information.

Concurrent care decisions:
- A “concurrent care decision” is a determination relating to the continuation/reduction of an ongoing course of treatment.
- If the plan has already approved an ongoing course of treatment for you and considers reducing or terminating the treatment, we will notify you sufficiently in advance of the reduction or termination of treatment to allow you to appeal the decision and obtain a determination before the treatment is reduced or terminated.
- If you request to extend an ongoing course of treatment that involves urgent care, we will respond to you within 24 hours after receipt of the request (provided that you make the request at least 24 hours prior to the expiration of the ongoing course of treatment).
• If you reach the end of a pre-approved course of treatment before requesting additional services, the “pre-service” or “post-service” time limits will apply.

Pre-service claim:
• A “pre-service claim” is a claim that requires approval of the benefit in advance of obtaining the care.
• For pre-service claims, the plan will respond to you within 15 days after receipt of the claim*.
• If we determine that an extension is necessary due to matters beyond our control, we will notify you within 15 days informing you of the circumstances requiring the extension and the date by which we expect to render a decision (up to an additional 15 days).
• If you make a pre-service claim, but do not submit enough information for us to make a determination, we will notify you within 15 days and describe the information that you need to provide to us. You will have no less than 45 days from the date you receive the notice to provide the requested information.

Post-service claim:
• A “post-service claim” is a claim for payment for a particular service after the service has been provided.
• For post-service claims, the plan will respond to you within 30 days after receipt of the claim.
• If we determine that an extension is necessary due to matters beyond our control, we will notify you within 30 days informing you of the circumstances requiring the extension and the date by which we expect to render a decision (up to an additional 15 days).
• If you make a post-service claim, but do not submit enough information for us to make a determination, we will notify you within 30 days and describe the information that you need to provide to us. You will have no less than 45 days from the date you receive the notice to provide the requested information.
• If your request for coverage is denied, you have the right to file an appeal. See Chapter 6 for information on how to file an appeal.

*In accordance with MA law, the plan will make an initial determination regarding a proposed admission, procedure, or service that requires such a determination within two working days of obtaining all necessary information.

Statement of Rights Under the Newborns and Mothers’ Health Protection Act: Under federal law, group health plans and health insurance issuers offering group health insurance coverage:
• Generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the group health plan or issuer may pay for a shorter stay if the attending provider (e.g., the mother’s physician or nurse midwife), after consultation with the mother, discharges the mother or newborn earlier.
• May not set the level of benefits or out of pocket costs so that any later portion of the 48 hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.
• May not require that a physician or other health care provider obtain authorization for prescribing a length of stay up to 48 hours, or 96 hours as applicable. However, to use certain providers or facilities, you may be required to obtain prior authorization. For information on prior authorization, contact Member Services.
APPENDIX D: MEMBER EXTRAS

In addition to the covered services described above, we offer our members additional savings.

Get Fit! Fitness Reimbursements: You are eligible for reimbursement of 25% of your annual membership fees at a Qualifying Health Club. Reimbursement is limited to one member per family per calendar year if you meet all the following requirements:

- Be a member of a Qualifying Health Club, which is a club that offers both cardiovascular and strength-training exercise equipment such as traditional health and fitness clubs or YMCA/YWCAs. It does not include martial arts centers, gymnastics facilities, social clubs, tennis-or pool-only facilities, country clubs or sports teams or leagues.
- Be a member of the plan and of your Qualifying Health Club for at least the same 3 months in a calendar year.
- Submit a completed reimbursement request form to the plan no later than March 31 of the following calendar year. Visit our website at www.bmchp.org or call us at 1-855-833-8120 to get the reimbursement request form.

Weight Watchers®
You are eligible for reimbursement of 25% of the fees paid for a Weight Watchers program. Reimbursement is limited to one member per family per calendar year if you meet all the following requirements:

- Purchase any online, local meeting, or coaching subscription from Weight Watchers
- Submit a completed reimbursement form to the plan no later than March 31 of the following calendar year. Visit www.bmchp.org or call us at 1-855-833-8120 to get the reimbursement request form.

Eyewear Discounts: When you go to a Vision Services Provider (“VSP”) participating eye care provider, you can receive:

- 20% off the retail price of complete sets of prescription glasses frames and lenses. Simply present a valid prescription (no older than 12 months) from any qualified optometrist or ophthalmologist.
- 15% off the professional fee for prescription contact lens fitting and evaluation.

Find participating VSP eye care providers at www.vsp.com. Show your plan ID card when purchasing from a VSP-participating provider to receive the discount.

These savings programs may change over time without advance notice to members. To check on current Member Extras savings programs, you can:

- Call Member Services at 1-855-833-8120; or
- Visit our website at www.bmchp.org