Welcome!

Important information to know
This member handbook was created to help describe how your new plan works: which healthcare services will be provided to you at no or low cost, what extra benefits qualifying members can receive* (such as free car seats, dental kits, and money back for joining Weight Watchers®), and who to call if you have any questions.

Feeling overwhelmed? No problem. The meanings of certain words are included in a glossary within this handbook to help you better understand your new plan. Or look back to your colorful Quick Start Guide which shares some of the most important information to know.

We speak your language
Would you prefer a copy of the information in this package in Spanish? Simply call our Member Services team at the number at the bottom of this page or visit us at www.bmchp.org. If you would like us to read this information to you in any other language, call the same number. All translation services are free.

You can also request a Braille translation, American Sign Language video clips or a large font version. Just ask.

We’re here to help
Around the clock, our Nurse Advice Line can answer questions and possibly save you a trip to the hospital or emergency room. Learning more about free transportation to scheduled healthcare appointments is just a phone call away. And our Member Services team is happy to answer your questions and help make sure your needs are addressed.

We’re very happy that you chose our plan. Thank you for trusting us with your healthcare.

Important phone numbers

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone: 800-973-6273</th>
<th>Phone: 800-841-2900</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMC HealthNet Plan Member Services</td>
<td>888-566-0010 (English/other languages)</td>
<td>800-841-2900</td>
</tr>
<tr>
<td></td>
<td>888-566-0012 (Spanish)</td>
<td></td>
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<tr>
<td></td>
<td>711 (TTY/TDD)</td>
<td>800-497-4648</td>
</tr>
<tr>
<td></td>
<td>711 (Relay operator)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hours: 8:00 a.m. – 6:00 p.m., Monday – Friday</td>
<td>Hours: 8:00 a.m. – 5:00 p.m., Monday – Friday</td>
</tr>
<tr>
<td>Behavioral Health (Beacon Health Strategies)</td>
<td>888-217-3501</td>
<td></td>
</tr>
<tr>
<td></td>
<td>866-727-9441 For hearing impaired:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>24 hours a day/7 days a week</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>866-909-5170 For mail order drugs:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>711 For hearing impaired:</td>
<td></td>
</tr>
<tr>
<td>Nurse Advice Line</td>
<td>800-973-6273</td>
<td></td>
</tr>
<tr>
<td>MassHealth Member Services Center</td>
<td>800-841-2900</td>
<td></td>
</tr>
<tr>
<td></td>
<td>800-497-4648 For hearing impaired:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5:00 p.m., Monday – Friday</td>
<td></td>
</tr>
</tbody>
</table>

*Some eligibility and frequency restrictions may apply. Some benefits are only available to specific programs.
Multi-language Interpreter Services

Important! This information is about your BMC HealthNet Plan benefits. It needs to be translated right away. BMC HealthNet Plan can translate it for you. If you speak English, language assistance services, free of charge, are available to you. Call 1-888-566-0010.

日本語表示！この情報はあなたのBMC HealthNet Planの利益についてです。これを直ちに翻訳する必要があります。BMC HealthNet Planはこれを翻訳します。あなたが英語を話している場合、無料で言語支援サービスが利用可能です。電話番号は1-888-566-0010です。

重要！この情報はあなたのBMC HealthNet Planの利点についてです。これを直ちに翻訳する必要があります。BMC HealthNet Planはこれを翻訳します。あなたが英語を話している場合、無料で言語支援サービスが利用可能です。電話番号は1-888-566-0010です。

हामारी यह सूचना आपके BMC HealthNet Plan के लाभों के बारे में है। इसका अनुवाद तुरंत करने की आवश्यकता है। BMC HealthNet Plan ये अनुवाद करता है। आप इंग्लिश में बोलते हैं, तो आपके लिए समर्थन सेवाएं अनुमुदित होंगी। आपके लिए फ्री की सेवा। कॉल करें 1-888-566-0010।


Introduction

Importante! Esta información es sobre los beneficios de su Plan BMC HealthNet. Necesita traducirse inmediatamente. BMC HealthNet Plan también traducirá por usted. Si habla Español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-566-0012. (SP)

Важно! Эта информация касается ваших льгот по плану BMC HealthNet Plan. Ее необходимо перевести незамедлительно. Такую услугу вам может предоставить план BMC HealthNet Plan. Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-566-0010. (RUS)


Important! This information is about the benefits of your BMC HealthNet Plan. It needs to be translated immediately. BMC HealthNet Plan will translate it for you. If you speak Spanish, you have free language assistance services available. Call 1-888-566-0012. (PTB)
# Table of Contents

1. How Your New Plan Works ................................................................. 5
2. Which Services Your Plan Covers .................................................. 6
3. Which Services Your Plan Does Not Cover ................................. 14
4. Your Plan ID Card ........................................................................ 15
5. Important Phone Numbers ............................................................ 15
6. Your Benefits ............................................................................... 16
7. Your Primary Care Provider (PCP) ............................................... 20
8. Your Healthcare, Emergency Care and Behavioral Health Services ........................................................................ 21
9. Pregnancy, Family Planning, Preventive Care, Well Child Care and EPSDT ................................................................. 26
10. Care Management ...................................................................... 29
11. Rights and Responsibilities .......................................................... 30
12. Inquiries, Grievances and Appeals .............................................. 32
14. Notice About Nondiscrimination and Accessibility Requirements ........................................................................ 39
15. Advance Directives ..................................................................... 40
16. Disenrollment ............................................................................ 41
17. Coordination of Benefits/Subrogation ........................................ 42
18. Glossary .................................................................................... 44
What is BMC HealthNet Plan?
BMC HealthNet Plan is a Managed Care plan. Being part of a Managed Care plan means that you will choose a Primary Care Provider (PCP) who will manage your healthcare and coordinate your care with Specialists, if necessary. You can choose your PCP from BMC HealthNet Plan’s Provider Network. See section 7 of this Member handbook for more information about PCPs.

New Member orientation
We will contact you to welcome you to the Plan and go over all your benefits so you understand how to use them. This is also a good time for you to ask any questions you may have about your coverage. If we can’t reach you, please call the Member Services department and a representative will be happy to speak with you. To make sure we can reach you, always call our Member Services department and MassHealth Member Services if you change your address or phone number. If you don’t keep MassHealth up to date on your contact information, you could lose your MassHealth and BMC HealthNet Plan eligibility.

Doctors and other healthcare Providers near you
We contract with doctors, hospitals, pharmacies, Behavioral Health and other healthcare Providers throughout all of Massachusetts. Our Service Area includes the following regions of Massachusetts: Western, Central, Southeastern, Northern and Greater Boston. We work with doctors, hospitals, and other Providers to offer healthcare services within our Service Area. This means that you don’t need to travel a long way to get your healthcare.
You can find out more information about our Service Area, including any geographic areas not in our Service Area, and how BMC HealthNet Plan contracts with healthcare Providers by calling our Member Services department.

Provider Directory
Our Provider Directory shows BMC HealthNet Plan’s Network Providers, including:
- Primary Care Sites
- Hospitals
- Behavioral Health Providers
You are free to choose among our Network of Primary Care Providers in our Service Area. The Provider Directory also has a complete list of our Network pharmacies, facility and ancillary Providers, hospital Emergency services, Emergency Services Program (ESP) Providers for Behavioral Health, and durable medical equipment suppliers. In the Provider Directory, you can also find information about Providers, including contact information and addresses, applicable specialty, board certification status, languages spoken, handicap accessibility, hours of operation and, when applicable, hospital affiliation. To access our Provider Directory, go to bmchp.org.
For a copy of a printed Provider Directory, you may call our Member Services department to request one.

Provider information
If you want more Provider information – such as any malpractice, medical school or residency information – contact the Massachusetts Board of Registration in Medicine. The number is 1-800-377-0550; or go to www.massmedboard.org and click on “Physician Profiles.”

Your MassHealth coverage
As a Member of BMC HealthNet Plan, you keep all your MassHealth coverage and benefits; therefore, you must be MassHealth eligible in order to be covered by BMC HealthNet Plan. Most people have to have their MassHealth eligibility re-determined every year. So make sure you immediately fill out and return your Eligibility Review Verification (ERV) form to MassHealth when you get it in the mail. If you need another form or help filling out the form, call BMC HealthNet Plan’s Member Services department, or call the MassHealth Member Services center.

About your Enrollment options
If you have questions about your health plan enrollment options with MassHealth – including BMC HealthNet Plan – please call the MassHealth Member Services center. You may change your Managed Care plan at any time.

Special help if you have certain health conditions
Our plan offers special health programs to Members with certain health conditions. For example, we have programs for Members with:
- asthma
- depression
- HIV/AIDS
- cancer
- diabetes
- obesity
- congestive heart failure
- high blood pressure
- or who are pregnant
See Section 10 for more information on our Care Management programs. If you have a chronic or long-term condition that is not listed here, BMC HealthNet Plan will work with you and your healthcare Provider to manage your care.
Section 1. How Your New Plan Works

Get more!
Members of BMC HealthNet Plan get all the benefits that MassHealth provides. See your Covered and Excluded Services list in this handbook for a list of your BMC HealthNet Plan benefits. Plus, our Members get free healthcare information from highly trained registered nurses through our 24-hour Nurse Advice Line. And, qualified BMC HealthNet Plan Members get:
- Free infant/toddler car seats
- Free bicycle helmets for kids
- Free dental kits - annually for members 4 years and up
- Reimbursement for qualified gym membership fees and Weight Watchers® Programs: up to the amount described on our website: bmchp.org.

Section 2. Which Services Your Plan Covers

This is a list of all Covered Services and benefits for MassHealth Standard Members enrolled in BMC HealthNet Plan.1 The list also indicates if a Prior Authorization is required by BMC HealthNet Plan and/or if a Referral by your Primary Care Provider (PCP) is necessary. Please note that it is BMC HealthNet Plan’s responsibility to coordinate all Covered Services listed below. It is your responsibility to always carry your BMC HealthNet Plan and your MassHealth identification cards and show them to your provider at all appointments.
You can call BMC HealthNet Plan Member Services Department for more information about services and benefits.
- For questions about medical health services, please call BMC HealthNet Plan’s Member Services Department at 1-888-566-0010 or TTY: 711 with partial or total hearing loss.
- For questions about Behavioral Health services, please call 1-888-217-3501 or TTY: 1-866-727-9441 for people with partial or total hearing loss.
- For more information about pharmacy services go to BMC HealthNet Plan’s pharmacy page at www.bmchp.org or call BMC HealthNet Plan Member Services Department at 1-888-566-0010 or TTY: 711 for people with partial or total hearing loss.
- For questions about dental services, please call DentaQuest Customer Service at 1-800-207-5019 or TTY 1-800-466-7566 or Translation Services at 1-800-207-5019. Hours: 8:00 a.m. – 6:00 p.m.

“Yes” in either the “Prior Authorization Required for Some or All of the Services?” or the “Primary Care Physician (PCP) Referral Required for Some or All of the Services?” column means that Prior Authorization, or a PCP Referral (or both) is required for some or all of the services in the category. In addition, your PCP or Specialist must get a Prior Authorization before you see a Specialist who is affiliated with any of the following hospitals in BMC HealthNet Plan’s provider network, unless your PCP and the Specialist are both affiliated with the hospital: Beth Israel Deaconess Medical Center (all locations), Carney Hospital, St. Elizabeth’s Medical Center, Tufts Medical Center. If an authorization is required, it will be granted when care is not available at Boston Medical Center. There is more information about authorizations and PCP Referrals in this Member handbook.

Please keep in mind that services and benefits change from time to time. These Covered and Excluded Services Lists are for your general information only. Please call BMC HealthNet Plan for the most up to date information. MassHealth regulations control the services and benefits available to you. To access MassHealth regulations:
- Go to MassHealth’s website www.mass.gov/masshealth; or
- Call MassHealth Member Services at 1-800-841-2900 (TTY: 1-800-497-4648 for people with partial or total hearing loss) Monday through Friday from 8:00 a.m. – 5:00 p.m.

1Members enrolled in MassHealth through either the Breast and Cervical Cancer Waiver or the HIV Waiver are eligible for the covered services under the Standard/CommonHealth benefit plan.
### Section 2. Which Services Your Plan Covers

<table>
<thead>
<tr>
<th>MassHealth Standard &amp; CommonHealth Covered Services for BMC HealthNet Plan Members</th>
<th>Prior Authorization Required for Some or All of the Services? Yes/No?</th>
<th>Primary Care Provider (PCP) Referral Required for Some or All of the Services? Yes/No?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Services - Medical and Behavioral Health</strong></td>
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<td></td>
</tr>
<tr>
<td>Emergency Transportation Services – ambulance (air and land) transport that generally is not scheduled, but is needed on an Emergency basis, including Specialty Care Transport that is an ambulance transport of a critically injured or ill Enrollee from one facility to another, requiring care beyond the scope of a paramedic.</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Emergency Inpatient and Outpatient Services</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Medical Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abortion Services</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Acupuncture Treatment For relief of pain or anesthesia.</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Acute Inpatient Hospital Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes all inpatient services such as daily physician intervention, surgery, obstetrics, radiology, laboratory and other diagnostic and treatment procedures and shall include Administratively Necessary Days.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Adult Day Health Services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Center based services offered by adult day health providers may include:  
  - Nursing services and health oversight  
  - Therapy  
  - Assistance with activities of daily living  
  - Nutritional and dietary services  
  - Counseling activities  
  - Care management  
  - Transportation | * | * |
| Adult Dentures  
Full and partial dentures, and repairs to said dentures, for adults ages 21 and over | * | * |
| Adult Foster Care Services  
Residential based services offered by adult foster care providers may include:  
  - Assistance with activities of daily living, instrumental activities of daily living and personal care  
  - Care management  
  - Nursing services and oversight | * | * |
| Ambulatory Surgery Services  
Outpatient, surgical, related diagnostic and medical and dental services | Yes | No |
| Audiologist (Hearing) Services | Yes | No |
| Breast Pumps  
Including double electric pumps, are provided to expectant and new mothers once per birth or as medically necessary or as determined by the member’s requesting physicians and consistent with the provisions of the Affordable Care Act of 2010 and Section 274 of Chapter 165 of the Acts of 2014. | Yes | No |

Note: List is effective 10/1/16.  
*These services are covered directly by MassHealth and may require authorization, however BMC HealthNet Plan will assist in the coordination of these services.
### Section 2. Which Services Your Plan Covers

<table>
<thead>
<tr>
<th>MassHealth Standard &amp; CommonHealth Covered Services for BMC HealthNet Plan Members</th>
<th>Prior Authorization Required for Some or All of the Services? Yes/No?</th>
<th>Primary Care Provider (PCP) Referral Required for Some or All of the Services? Yes/No?</th>
</tr>
</thead>
</table>
| Chiropractic Services  
Limit of 20 office visits or chiropractic manipulative treatment or any combination thereof | No | No |
| Community Health Center Services  
For example:  
- Office visits for primary care and specialists  
- OB/GYN and prenatal care**  
- Pediatric services, including EPSDT  
- Health education  
- Medical social services  
- Tobacco cessation services  
- Fluoride varnish to prevent tooth decay in children and teens  
- Vaccines/immunizations (HEP A & B)  
- Diabetes self-management training  
- Nutrition services, including diabetes self-management training and medical nutrition therapy | No | No |
| Day Habilitation Services  
Center based services for members with mental retardation or developmental disabilities offered by day habilitation providers may include:  
- Nursing services and healthcare supervision  
- Developmental skills training  
- Therapy services  
- Assistance with activities of daily living | * | * |
| Dental Services  
- Emergency related dental care  
- Oral surgery performed in an outpatient hospital or ambulatory surgery setting which is medically necessary to treat an underlying medical condition  
- Preventive and basic services for the prevention and control of dental diseases and the maintenance of oral health for adults | No | No |
| Dialysis Services | No | No |
| Durable Medical Equipment  
Including but not limited to the purchase or rental of medical equipment, replacement parts, and repair for such items | Yes | Yes |
| Early Intervention Services | No | No |
| Family Planning Services² | No | No |

² A BMC HealthNet Plan member may obtain family planning services at any MassHealth family planning services provider, even if it is outside of BMC HealthNet Plan’s provider network.

*These services are covered directly by MassHealth and may require authorization, however BMC HealthNet Plan will assist in the coordination of these services.

**If you are pregnant, you should contact MassHealth or BMC HealthNet Plan because you may qualify for additional benefits due to your pregnancy.
### Section 2. Which Services Your Plan Covers

<table>
<thead>
<tr>
<th>MassHealth Standard &amp; CommonHealth Covered Services for BMC HealthNet Plan Members</th>
<th>Prior Authorization Required for Some or All of the Services? Yes/No?</th>
<th>Primary Care Provider (PCP) Referral Required for Some or All of the Services? Yes/No?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Adult Foster Care Services</td>
<td></td>
<td>*</td>
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<tr>
<td>Services provided by group adult foster care providers are offered in a group supported housing environment and may include:</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>• Assistance with activities of daily living, instrumental activities of daily living and personal care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Care management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Nursing services and oversight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Aid Services</td>
<td>No, except for surgically implanted aids</td>
<td>No</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hospice Services</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Infertility</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Diagnosis of infertility and treatment of underlying medical condition in certain cases. Please contact your MCO for additional information about coverage.</td>
<td></td>
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<tr>
<td>Intensive Early Intervention Services</td>
<td>*</td>
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</tr>
<tr>
<td>Provided to eligible children under three years of age who have a diagnosis of autism spectrum disorder.</td>
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<td></td>
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<tr>
<td>Laboratory Services</td>
<td>Yes, for select labs</td>
<td>No</td>
</tr>
<tr>
<td>All services necessary for the diagnosis, treatment and prevention of disease, and for the maintenance of health.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthotic Services</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Braces (non-dental) and other mechanical or molded devices to support or correct any defect of form or function of the human body. For individuals over age 21, certain limitations apply.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital Services</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Services provided at an outpatient hospital, for example:</td>
<td>(See Section 6 of this handbook for specific information on prior authorization requirements)</td>
<td></td>
</tr>
<tr>
<td>• Outpatient surgical and related diagnostic, medical and dental services</td>
<td></td>
<td></td>
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<tr>
<td>• Office visits for specialists</td>
<td></td>
<td></td>
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<tr>
<td>• Therapy services (physical, occupational and speech)</td>
<td></td>
<td></td>
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<tr>
<td>• Diabetes self-management training</td>
<td></td>
<td></td>
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<tr>
<td>• Medical nutritional therapy</td>
<td></td>
<td></td>
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<tr>
<td>• Office visits for primary care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• OB/GYN and prenatal care**</td>
<td></td>
<td></td>
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<tr>
<td>• Tobacco cessation services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fluoride varnish to prevent tooth decay in children and teens</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxygen &amp; Respiratory Therapy Equipment</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

3 A BMC HealthNet Plan member can get hospice care from BMC HealthNet Plan or MassHealth. If you choose to receive hospice care from MassHealth, you will be disenrolled from BMC HealthNet Plan and receive all of your healthcare services from MassHealth.

*These services are covered directly by MassHealth and may require authorization, however BMC HealthNet Plan will assist in the coordination of these services.

**If you are pregnant, you should contact MassHealth or BMC HealthNet Plan because you may qualify for additional benefits due to your pregnancy.
<table>
<thead>
<tr>
<th>MassHealth Standard &amp; CommonHealth Covered Services for BMC HealthNet Plan Members</th>
<th>Prior Authorization Required for Some or All of the Services?</th>
<th>Primary Care Provider (PCP) Referral Required for Some or All of the Services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Care Attendant</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>Services to assist members with activities of daily living and instrumental activities of daily living, for example:</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>• Bathing</td>
<td>• Feeding</td>
<td></td>
</tr>
<tr>
<td>• Dressing</td>
<td>• Medication management</td>
<td></td>
</tr>
<tr>
<td>Physician (primary and specialty), Nurse Practitioners acting as Primary Care Providers, and Nurse Midwife Services</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>For example:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Office visits for primary care</td>
<td>• OB/GYN and prenatal care**</td>
<td>No</td>
</tr>
<tr>
<td>• Diabetes self-management training</td>
<td>• Tobacco cessation services</td>
<td></td>
</tr>
<tr>
<td>• Fluoride varnish to prevent tooth decay in children and teens</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Office visit or specialty care</td>
<td>• Medical nutritional therapy</td>
<td>Yes</td>
</tr>
<tr>
<td>Podiatrist Services (Foot Care)</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Private Duty Nursing/Continuous Skilled Nursing</td>
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<td>*</td>
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<tr>
<td>A nursing visit of more than two continuous hours of nursing services. This service can be provided by either a home health agency or Independent Nurse.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthetic Services</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Radiology and Diagnostic Services For example:</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>• X-Rays</td>
<td></td>
<td></td>
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<tr>
<td>• Magnetic resonance imagery (MRI) and other imaging studies</td>
<td></td>
<td></td>
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<tr>
<td>• Radiation oncology services performed at radiation oncology centers (ROCs) which are independent of an acute outpatient hospital or physician service.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Skilled Nursing Facility, Chronic Disease and Rehabilitation Hospital</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Therapy Services</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>For example:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Occupational therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physical therapy</td>
<td></td>
<td></td>
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<tr>
<td>• Speech/language therapy</td>
<td></td>
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<tr>
<td>Transportation Services (Non-Emergency)</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>• Non-emergency transportation by land ambulance, chair car, taxi, and common carriers that generally are pre-arranged to transport an Enrollee to and from covered medical care in Massachusetts or within 50 miles or less of the Massachusetts border.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Non-emergent to out-of-state location – ambulance and other common carriers that generally are pre-arranged to transport an Enrollee to a service that is located outside a 50-mile radius of the Massachusetts border.</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

* BMC HealthNet Plan covers up to 100 days of a combination of Skilled Nursing, Chronic Disease and Rehabilitation Hospital Services in a Plan Year. If you need Skilled Nursing, Chronic Disease and Rehabilitation Hospital Services beyond the 100 days provided by your health plan, you will be disenrolled from BMC HealthNet Plan and receive such services from MassHealth on a fee-for-service basis. Call BMC HealthNet Plan or MassHealth Member Services for more information.

*These services are covered directly by MassHealth and may require authorization, however BMC HealthNet Plan will assist in the coordination of these services.

**If you are pregnant, you should contact MassHealth or BMC HealthNet Plan because you may qualify for additional benefits due to your pregnancy.
### Section 2. Which Services Your Plan Covers

#### MassHealth Standard & CommonHealth Covered Services for BMC HealthNet Plan Members

<table>
<thead>
<tr>
<th>Service</th>
<th>Prior Authorization Required for Some or All of the Services?</th>
<th>Primary Care Provider (PCP) Referral Required for Some or All of the Services?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vision Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For example:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Comprehensive eye exams once every year for enrollees under 21 and once every 24 months for enrollees 21 and over, and whenever medically necessary</td>
<td><strong>No</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td>• Vision training</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td>• Ocular prosthesis</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td>• Contacts, when medically necessary, as a medical treatment for a medical condition such as keratoconus</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td>• Bandage lenses</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td>• Prescription and dispensing of ophthalmic materials, including eye glasses and other visual aids, excluding contacts</td>
<td><strong>Yes</strong></td>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td><strong>Wigs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As prescribed by a physician related to a medical condition</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

#### Pharmacy Services (Medications) See co-payment information at the end of Section 2.

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes/No?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Medicines</td>
<td>Yes</td>
</tr>
<tr>
<td>Over-the-Counter Medicines</td>
<td>Yes</td>
</tr>
</tbody>
</table>

#### Behavioral Health (Mental Health and Substance Use Disorder) Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes/No?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-24 Hour Diversionary Services:</td>
<td>Yes, except for PHP, IOP, and SOAP</td>
</tr>
<tr>
<td>• Community support programs</td>
<td></td>
</tr>
<tr>
<td>• Partial hospitalization (PHP)**</td>
<td></td>
</tr>
<tr>
<td>• Structured outpatient addiction program (SOAP)**</td>
<td></td>
</tr>
<tr>
<td>• Intensive outpatient program (IOP)**</td>
<td></td>
</tr>
<tr>
<td>• Psychiatric day treatment</td>
<td></td>
</tr>
<tr>
<td>24 Hour Diversionary Services:</td>
<td>Yes, except for ATS, EAT, and CSUS</td>
</tr>
<tr>
<td>• Community crisis stabilization (CCS)</td>
<td></td>
</tr>
<tr>
<td>• Community-based acute treatment for children and adolescents (CBAT)</td>
<td></td>
</tr>
<tr>
<td>• Acute treatment services for substance use disorder (Level III.7) (ATS)**</td>
<td></td>
</tr>
<tr>
<td>• Enhanced acute treatment services for substance use disorder (EAT)**</td>
<td></td>
</tr>
<tr>
<td>• Clinical support services – substance abuse (Level III.5) (CSUS)**</td>
<td></td>
</tr>
<tr>
<td>• Transitional care unit (TCU)</td>
<td></td>
</tr>
<tr>
<td>Emergency Services Program (ESP) Services:</td>
<td>No</td>
</tr>
<tr>
<td>• Crisis assessment, intervention, and stabilization</td>
<td></td>
</tr>
<tr>
<td>• Mobile crisis intervention for children under 21 – when your child is having a crisis and needs help right away. You can call 24/7. A trained team will come to your home, a school, or other place in the community to help with the crisis. The team may also be able to help you get other services for your child and family. If your child gets outpatient therapy, in-home therapy, or intensive care coordination and needs more help, he or she may be able to get in-home behavioral health services, therapeutic mentoring or family support and training.</td>
<td></td>
</tr>
<tr>
<td>• Medication evaluation</td>
<td>Yes, specialing only</td>
</tr>
<tr>
<td>• Specialing – a one-to-one monitoring service</td>
<td></td>
</tr>
<tr>
<td>Inpatient Services:</td>
<td>Yes, except Level IV services</td>
</tr>
<tr>
<td>• Inpatient mental health services</td>
<td></td>
</tr>
<tr>
<td>• Inpatient substance use disorder services (Level IV)**</td>
<td></td>
</tr>
</tbody>
</table>
### MassHealth Standard & CommonHealth Covered Services for BMC HealthNet Plan Members

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Prior Authorization Required for Some or All of the Services?</th>
<th>Yes/No?</th>
<th>Primary Care Provider (PCP) Referral Required for Some or All of the Services? Yes/No?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Services, such as:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Individual, couples, group, and family counseling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Diagnostic evaluations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Dialectical Behavioral Therapy (DBT)</td>
<td>12 visits per year without authorization. Pre-Authorization required for additional visits.</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>- Medication visits</td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>- Family and case consultations</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>- Collateral contacts for youth under age 21</td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>- Narcotic-treatment services (including acupuncture)***</td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>- Psychiatric Consultation on an Inpatient Medical Unit</td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>- Inpatient-Outpatient Bridge Visit</td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>- Acupuncture</td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>- Treatment Opioid Replacement Therapy***</td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>- Ambulatory Detoxification (Level II.d)***</td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>- Psychological testing or special education psychological testing</td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>- Electro-convulsive therapy</td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>- Assessment for Safe and Appropriate Placement (ASAP)</td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>- Applied Behavioral Analysis for members under 21 years of age (ABA Services)</td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td><strong>Intensive Home or Community-Based Outpatient Services for Youth:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Intensive care coordination (ICC) – for youth under 21 with serious emotional disturbances. In ICC, a Care Coordinator assists in coordinating the adults in the child’s life so that everyone is working together to help the child. Parents choose who is on the team, including professionals (counselors, social workers, teachers) and personal supports (friends or relatives). The parents may also ask for a “Family Partner”, a parent trained to make sure your voice is heard. Together, the team will help the parent and child reach the family’s goals. Children and youths get ICC services through Community Service Agencies (CSAs). There are 32 CSAs located throughout Massachusetts. Three (3) of the 32 CSAs are specially trained to serve Black, Latino, and deaf and hard-of-hearing children and youths.</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

*These services are covered directly by MassHealth and may require authorization, however BMC HealthNet Plan will assist in the coordination of these services.

***Pursuant to the requirements of Section 19 of Chapter 258 of the Acts of 2014 and MassHealth policy, there are no Prior Authorization requirements for the following Substance Use Disorder Recovery Services:
- inpatient substance use disorder services (Level IV)
- enhanced acute treatment services for substance use disorder (EAT)
- acute treatment services for substance use disorder (Level III.7) (ATS)
- clinical support services – substance use disorder (Level III.5) (CSUS)
- Partial hospitalization (PHP)
- Structured Outpatient Addition Program (SOAP)
- Intensive Outpatient Program (IOP)
- outpatient counseling or ambulatory detoxification
Section 2. Which Services Your Plan Covers

### MassHealth Standard & CommonHealth Covered Services for BMC HealthNet Plan Members

<table>
<thead>
<tr>
<th>Intensive Home or Community-Based Outpatient Services for Youth (cont’d):</th>
</tr>
</thead>
<tbody>
<tr>
<td>• In-home therapy services – aimed at working with the whole family, helping the parent to help the child. In-home therapy can help the child and family resolve conflicts, learn new ways to do things, make new routines, set limits, and find resources.</td>
</tr>
<tr>
<td>• In-home behavioral services – aimed at assisting the family with a child who is repeating bothersome or harmful behavior. These services include a therapeutic mentor who will go with the child to the places where the child has the most trouble and teach him/her new skills, or better methods of interacting with other children and adults.</td>
</tr>
<tr>
<td>• Therapeutic mentoring services – this service includes a therapeutic mentor who will go with the child to the places where the child has the most trouble and teach him/her new skills, or better methods of interacting with other children and adults.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prior Authorization Required for Some or All of the Services? Yes/No?</th>
<th>Primary Care Provider (PCP) Referral Required for Some or All of the Services? Yes/No?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

### Enrollees under age 21: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services.

#### Screening Services

Children who are under age 21 should go to their PCP for checkups even when they are well. As part of a well-child checkup, the PCP will perform screenings that are needed to find out if there are any health problems. These screenings include health, vision, dental, hearing, behavioral-health, developmental, and immunization status screenings. MassHealth pays PCPs for these checkups. At well-child checkups, PCPs can find and treat small problems before they become big ones. More information about the schedule for checkups is in this Member Handbook under “Additional services for children.” In addition to regular checkups, children should also visit their PCP any time there is a concern about their medical or behavioral health, even if it is not time for a regular checkup. Children under age 21 are also entitled to get regular visits with a dental provider.

| Yes | No |

#### Diagnosis and Treatment Services

BMC HealthNet Plan pays for all Medically Necessary services that are covered by federal Medicaid law, even if the services are not provided by BMC HealthNet Plan. This coverage includes healthcare, diagnostic services, treatment, and other measures needed to correct or improve defects and physical and mental illnesses and conditions. When a PCP (or any other clinician) discovers a health condition, BMC HealthNet Plan will pay for any medically necessary treatment covered under Medicaid law if it is delivered by a Provider who is qualified and willing to provide the service and a BMC HealthNet Plan-enrolled physician, nurse practitioner, or nurse midwife supports, in writing, the Medical Necessity of the service. You and your PCP can seek assistance from BMC HealthNet Plan to determine what Providers may be available in the Network to provide these services, and how to use out-of-Network Providers, if necessary. Most of the time, these services are covered by your child’s MassHealth coverage type and are included as a Covered Service elsewhere in this list. If the service is not already covered or is not listed elsewhere on this list, the clinician or Provider who will deliver the service can ask BMC HealthNet Plan for Prior Authorization for the service. BMC HealthNet Plan uses this process to determine if the service is Medically Necessary. BMC HealthNet Plan will pay for the service if Prior Authorization is given. If Prior Authorization is denied, you have the right to appeal. More information about appeals is in this Member Handbook under “Appeals and Grievances.” Talk to your child’s PCP, behavioral-health provider, or other specialist for help in getting these services.

| Yes | No |

| No | No |
Most members who are age 21 and older must pay the following pharmacy co-payments:

- $1 for certain covered generic medicines mainly used for diabetes, high blood pressure, and high cholesterol. These medicines are called antihyperglycemics (such as metformin), antihypertensives (such as lisinopril), and antilipidemics (such as simvastatin);
- $3.65 for certain over-the-counter (OTC) medicines for which you have a prescription from the doctor.
- $3.65 for both first-time prescriptions and refills for certain covered generic and OTC medicines; and
- $3.65 for both first time prescriptions and refills of covered brand-name medicines.

Members who do NOT have pharmacy co-payments

These members do not have any co-payments:

- Members under age 21;
- Members enrolled in MassHealth because they were in the care and custody of the Department of Children and Families (DCF) when they turned 18, and their MassHealth coverage was continued;
- Pregnant women, or women whose pregnancy ended less than 60 days ago (your provider must notify the Plan, your pharmacist and MassHealth about your pregnancy) and;
- Members who are in hospice care;
- American Indian or Alaska Native who is currently receiving or has ever received an item or service furnished by the Indian Health Service, an Indian tribe, a tribal organization, or an urban Indian organization, or through referral, in accordance with federal law; and
- Members who are receiving inpatient care in an acute hospital, nursing facility, chronic disease hospital, rehabilitation hospitals, or intermediate-care facility for the developmentally delayed.

In addition, members do not have to pay co-payments for family planning supplies (birth control).

Co-payment Cap

Unless you don’t need to pay a co-payment as described above, Standard/CommonHealth members ages 21 and older have a co-payment cap (limit) of $250 on the co-payments pharmacies can charge each calendar year. The cap is the total amount of co-payments pharmacies have charged you, not what you paid. Call BMC HealthNet Plan for more information.

Section 3. Which Services Your Plan Does Not Cover

Excluded Services

Except as otherwise noted or determined Medically Necessary, the following services are not covered under MassHealth and as such are not covered by BMC HealthNet Plan:

1. Cosmetic surgery, except as determined by BMC HealthNet Plan to be necessary for:
   a. Correction or repair of damage following an injury or illness;
   b. Mammaplasty following a mastectomy; or
   c. Any other medical necessity as determined by BMC HealthNet Plan. All such services determined by BMC HealthNet Plan to be Medically Necessary shall constitute a BMC HealthNet Plan Covered Service.
2. Treatment for infertility, including but not limited to in-vitro fertilization and gamete intrafallopian tube (GIFT) procedures.
4. Personal comfort items including air conditioners, radios, telephones, and televisions.
5. A service or supply which is not provided by or at the direction of a Network Provider, except for:
   a. Emergency Services;
   b. Family Planning Services; and
   c. Services provided to newborns during the period prior to notification of the newborn’s enrollment by the Executive Office of Health and Human Services
6. Non-covered laboratory services.
7. Services provided outside the United States and its territories.
A BMC HealthNet Plan Member ID Card will be mailed to you
Every BMC HealthNet Plan Member receives an identification Card (ID Card). Please check your ID Card to make sure the information is correct. If it’s not correct, or if you did not get an ID Card, please call the Member Services department promptly.
(Remember: If you change your address and phone number, you need to call the Member Services department and you need to call the MassHealth Member Services center to update your information.) Your ID Card has important phone numbers for contacting us. And it says what to do when you need Emergency or Urgent Care. (See Section 8 for more information about Emergency or Urgent Care.) Always carry your BMC HealthNet Plan ID Card to receive healthcare or pharmacy services. You should also always carry your MassHealth ID Card.

Lost your BMC HealthNet Plan Member ID Card?
To replace your BMC HealthNet Plan ID Card, call the Member Services department. You can also order a new ID Card from our website at bmchp.org. Call MassHealth to order a new MassHealth card. Even if you don’t have your ID Card, a healthcare Provider should never deny care to you or your BMC HealthNet Plan covered family members. If a Provider refuses to treat you or a covered family member, call our Member Services department. We will verify your Eligibility for the Provider.

Section 5. Important Phone Numbers

Your healthcare Providers
- You should write down your PCP’s phone number and put it somewhere where you can find it quickly. Call your PCP first for health-related questions or problems, except in an Emergency. In case of an Emergency, you should call 911 or go to the nearest hospital Emergency room. See our online Provider Directory at bmchp.org for a list of statewide hospital Emergency rooms. You may also call our Member Services department to request a printed copy.
- If you have a Behavioral Health Emergency, call 911 or go to the nearest hospital Emergency room. You can also contact the Emergency Services Program (ESP) Provider in your area. See our online Provider Directory at bmchp.org for a list of statewide ESPs.

BMC HealthNet Plan
- Call our Member Services department if you have benefit questions.
- Our website, bmchp.org, contains a lot of important information, such as:
  - Find out about your coverage
  - Search for a healthcare Provider
  - Find a Provider’s hospital affiliation
  - Find health information
- Read our Member newsletter
- Find a pharmacy near you
You may also send an e-mail to us from our website, bmchp.org.
If you don’t have a computer at home, you can go to your local library for free internet access.

Benefits, Eligibility and healthcare questions
We want to make sure it’s easy for you to get the information you want. Here is some helpful information.
  - MassHealth Eligibility questions
If you have questions about your MassHealth Eligibility, you may call us or call MassHealth at one of the following numbers: BMC HealthNet Plan at 1-888-566-0010 (TTY/TDD: 711) or MassHealth at 1-888-841-2900 (TTY/TDD 1-800-497-4648).
  - Benefits questions
  - Refer to your Covered and Excluded Services list included in this handbook or on the plan website for more information about your benefits. Your Covered and Excluded Services list will also show you which benefits are covered by BMC HealthNet Plan and which are covered by MassHealth. When you want to speak with someone about the benefits and Covered Services you get as a BMC HealthNet Plan Member, please call our Member Services department.
  - If you have questions about your MassHealth benefits, you may call us or call MassHealth at one of the following numbers: BMC HealthNet Plan at 1-888-566-0010 (TTY/TDD: 711) or MassHealth at 1-888-841-2900 (TTY/TDD 1-800-497-4648).
  - Health-related questions
  - If you think you’re having a health (medical or Behavioral Health) Emergency, call 911 or go to the nearest hospital Emergency room. (See Section 8 for more information on Emergency care.) Remember to call your PCP about your Emergency as soon as possible.
Section 5. Important Phone Numbers

- If you are having a Behavioral Health Emergency, you can also call your local Emergency Services Program (ESP) Provider. Often ESPs can be a better choice than a hospital Emergency room. Remember to call your PCP, and your Behavioral Health Provider, if you have one, about your Emergency as soon as possible.

- If you are not having a medical or Behavioral Health Emergency, always call your healthcare Provider first if you have questions about your health or if you need Urgent Care or Routine Care.

You can also call the Nurse Advice Line from BMC HealthNet Plan. The number is 1-800-973-6273. You can get healthcare information from a highly trained registered nurse, 24 hours a day, seven days a week. Some examples of health problems or questions include:

- feeling sick
- dizziness
- back pain
- coughing
- baby is crying and feels hot
- colds

Remember: The Nurse Advice Line can help you, but it should not take the place of your healthcare Provider.

Care When You Travel Outside our Service Area

When Members are away from home, BMC HealthNet Plan will cover only Emergency, Post-stabilization and Urgent Care services. To ensure coverage, be sure to take care of your routine healthcare needs before traveling outside of BMC HealthNet Plan’s Service Area. Only Emergency, Post-stabilization and Urgent Care health services provided in the United States or its territories are covered. You should still seek care in an Emergency when you are outside the United States, but be advised that BMC HealthNet Plan will not cover these services.

If you need Emergency or Urgent Care while you are temporarily outside the BMC HealthNet Plan Service Area, go to the nearest doctor or hospital Emergency room. You do not have to call your Primary Care Provider before seeking Emergency or Urgent Care while outside the BMC HealthNet Plan Service Area. You or a family member should call your Primary Care Site (or your Behavioral Health Provider in a Behavioral Health Emergency) within 48 hours of receiving out-of-area care. BMC HealthNet Plan will cover all Medically Necessary Emergency, Post-stabilization and Urgent Care services delivered outside the Service Area. BMC HealthNet Plan will not cover:

- Emergency services provided outside the United States or its territories.
- Tests or treatment that your Primary Care Provider asked for before you left the Service Area.
- Routine Care or follow-up care that can wait until your return to the Service Area, such as physical exams, flu shots, stitch removal, mental health counseling.
- Care that you knew you were going to need before you left the Service Area, such as elective surgery.

A Provider may ask you to pay for care received outside of BMC HealthNet Plan’s Service Area at the time of service. If you pay for Emergency Care, Post-stabilization Care or Urgent Care that you receive while outside of BMC HealthNet Plan’s Service Area but within the United States or its territories, you may submit a Claim to BMC HealthNet Plan to be reimbursed. See the section on “If You Receive a Bill” to find out how to submit a Claim. You may also call the Plan’s Member Services department for help with any bills that you may receive from a Provider.

Section 6. Your Benefits

How to obtain your benefits

The Covered and Excluded Services list included in this Member handbook shows that we cover most of your benefits. But MassHealth also directly covers some benefits even though we may coordinate them. That’s why you should always carry both your BMC HealthNet Plan and MassHealth ID Cards. Always check your Covered and Excluded Services list to see what services are covered and are not covered. And, always show both your BMC HealthNet Plan ID Card and MassHealth ID card to receive your Plan Covered Services and benefits. If you need help getting any benefits or Covered Services, please call our Member Services department. Your Primary Care Provider is the best person to tell you if you need any of these services. If you need a ride to a healthcare appointment, and if you’re eligible for non-emergency transportation services, we can help arrange for it. Just call our Member Services department and a representative can assist you. (See Section 8 for more information on transportation assistance.)

Specialty care

There may be times when you may need to see a Specialist. A Specialist is a healthcare Provider who is trained to provide specific, often more detailed, treatments than your PCP. For example, a cardiologist is a doctor who specializes in treating heart problems. Orthopedists specialize in treating certain disorders with bones and joints. Pulmonologists treat asthma and other breathing problems. Psychiatrists specialize in treating mental health conditions. If you think you need to see a Specialist, you should first call your PCP. Your PCP can help you identify your specialty care needs and refer you to an appropriate Specialist. Your PCP may also help you with any follow-up care that is important for your health and recovery, both while being treated by a Specialist and afterward. Therefore, it is important that you talk with your PCP about your specialty care needs and treatment even after you are feeling better and no longer need those services.
Receiving care from Providers within the BMC HealthNet Plan Network

Healthcare Providers who have contracts with BMC HealthNet Plan are considered Network Providers. These include both Primary Care Providers and Specialists. You must always receive your care from Network Providers, except as described in “Receiving care from Providers outside of the BMC HealthNet Plan Network” later in this section.

When Prior Authorization is needed for visits to Network Specialists

Your PCP coordinates all your care, including specialty care. Your PCP or Specialist does not need to get a Prior Authorization from us before you visit most Specialists in our Provider Network. For example, your PCP or Specialist does not need a Prior Authorization for you to visit a Specialist within the Network if your PCP and the Specialist are both affiliated with the same hospital or if the Specialist is affiliated with Boston Medical Center. However, there are some situations, where your PCP or Specialist does need to get Prior Authorization from us before you see a Specialist within our Provider Network. Your PCP or Specialist must get Prior Authorization before you see a Specialist who is affiliated with any of the following hospitals, unless your PCP and the Specialist are both affiliated with the same hospital:

- Beth Israel Deaconess Medical Center (all locations)
- Carney Hospital
- St. Elizabeth’s Medical Center
- Tufts Medical Center

When Prior Authorization is required, it will be granted for specialty care with Specialists affiliated with these hospitals when the specialty care is not available from:

- a Specialist affiliated with Boston Medical Center; or
- a BMC HealthNet Plan Network Specialist affiliated with the same hospital as the Member’s PCP

Here is a chart to further explain how this works:

<table>
<thead>
<tr>
<th>If you would like to go to a Network Specialist affiliated with:</th>
<th>Does my PCP or Network Specialist have to get Prior Authorization from BMC HealthNet Plan before I visit this network Specialist?</th>
<th>Will BMC HealthNet Plan approve a Prior Authorization for my visit?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston Medical Center</td>
<td>NO</td>
<td>NOT APPLICABLE</td>
</tr>
<tr>
<td>the same hospital as my PCP</td>
<td>NO</td>
<td>NOT APPLICABLE</td>
</tr>
<tr>
<td>any network hospital - except those hospitals listed in the box below</td>
<td>NO</td>
<td>NOT APPLICABLE</td>
</tr>
<tr>
<td>- Beth Israel Deaconess Medical Center (all locations)</td>
<td>YES (Unless the network specialist is affiliated with the same hospital as your PCP)</td>
<td>BMC HealthNet Plan will approve your visit only if the specialty care you need is not available from a network Specialist affiliated with Boston Medical Center or a BMC HealthNet Plan Network Specialist affiliated with the same hospital as your PCP.</td>
</tr>
</tbody>
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Prior authorization is NOT required in the following cases:

- In an Emergency
- To see a BMC HealthNet Plan Network Specialist affiliated with Boston Medical Center
- To see a BMC HealthNet Plan Network Specialist affiliated with the same hospital as your PCP
- To see a BMC HealthNet Plan Network Specialist affiliated with any BMC HealthNet Plan contracted hospital not listed above
Your Benefits

- To go to any BMC HealthNet Plan 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, including any follow-up obstetric or gynecological services determined to be Medically Necessary as a result of such exam
  - Medically Necessary evaluations and related healthcare services for acute or Emergency gynecological conditions
  - To get a mammogram
  - To get Family Planning Services from any BMC HealthNet Plan Network Family Planning Services Provider or MassHealth-contracted Family Planning Services Provider
  - For the first 12 visits to a Behavioral Health Provider

Before you visit a Specialist, you should always check with your PCP or the Specialist to find out if he or she has gotten Prior Authorization from us, if necessary. You can look up hospital affiliations for PCPs and specialists on our website. You can also call our Member Services department for help with this.

When Prior Authorization is needed for other services

In addition to Prior Authorization needed to see certain Network Specialists, there are other services that must be authorized in advance by BMC HealthNet Plan, MassHealth or Beacon Health Strategies in order for these services to be covered. (Beacon Health Strategies is responsible for authorizing Behavioral Health – mental health and substance abuse – services for Members). The Covered and Excluded Services list in this Member handbook shows the services that require Prior Authorization. When a service requires Prior Authorization, your Provider must submit a request for those services to BMC HealthNet Plan, Beacon Health Strategies (for Behavioral Health services) or MassHealth.

Timeframes for Prior Authorization decisions

Prior Authorization decisions are made by a healthcare professional that has appropriate clinical expertise within the following timeframes:

- Standard Authorization decisions: Within 14 calendar days after the request is received.
- Expedited (fast) Authorization decisions: Within 72 hours after the request is received. Only a Provider can recommend, or the Plan can decide, when an Authorization request may be expedited (processed fast) by determining that following the standard timeframe could seriously jeopardize your life or health, or your ability to get, maintain or regain maximum function.

These Authorization decision timeframes may be extended to up to an additional 14 calendar days if you or your Provider requests an extension, or the Plan has a good reason to believe that:

- The extension is in your best interest.
- The Plan needs additional information that we think, if we receive it, will lead to approval of your request.
- Such outstanding information is reasonably expected to be received by the Plan within 14 calendar days.

If BMC HealthNet Plan asks for an extension of the Authorization timeframes, we will send you, and your Authorized Representative, a written notice. If you or your Authorized Representative disagrees with this decision, you or your Authorized Representative may file a Grievance in writing, over the phone or in person. Our Member Services department representatives can help you with this. (For more information on how to file a Grievance or an Internal Appeal, please see Section 12 “Inquiries, Grievances and Appeals.”)

We will send a written notice to you, and your Authorized Representative, if we did not meet these timeframes. You, or your Authorized Representative, have the right to file an Internal Appeal if the Plan does not make the Authorization decisions within the above timeframes. (For more information on how to file a Grievance or an Internal Appeal, please see Section 12 “Inquiries, Grievances and Appeals.”)

We will send a written notice to you, and your Authorized Representative, and the requesting Provider of any decision to deny an authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. You, or your Authorized Representative, have the right to file an Internal Appeal if the Plan denies an Authorization request or authorizes a service amount, duration or scope that is less than what was requested. (For more information on how to file a Grievance or an Internal Appeal, please see Section 12 “Inquiries, Grievances and Appeals.”)

Receiving care from Providers outside of the BMC HealthNet Plan Network

Providers who do not have contracts with BMC HealthNet Plan are considered “out-of-Network Providers.” You are not covered for services provided by an out-of-Network Provider, except in any of the following cases:

- An Emergency
- Your Network Primary Care Provider (PCP) has gotten Prior Authorization from BMC HealthNet Plan
- Family Planning Services with any MassHealth-contracted provider of Family Planning services
- If we are unable to provide a specific covered service through our Network Provider. Requests must go through the Prior Authorization process described above. If we determine that the specific covered service is Medically Necessary and not available through a BMC HealthNet Plan Network Provider, we will adequately cover the service in a timely manner with an

...
Section 6. Your Benefits

Out-of-Network Provider for as long as the service is Medically Necessary and not available through our Network Provider.

Coverage if you changed plans
To ensure continuity of care, there are some times when BMC HealthNet Plan may be able to provide coverage for health services from a Provider who is not part of our Network. For new Members who were already receiving care from a Provider who is not part of BMC HealthNet Plan’s Network when they join the Plan:

- If you are in your second or third trimester of your pregnancy, you may remain under the care of your current OB/GYN (even if out-of-Network) through delivery and follow-up check-up within the first six weeks of delivery. Your second trimester is the start of your 4th month of pregnancy based on the expected delivery date.
- For a limited period, if you are receiving ongoing covered treatment or management of chronic issues, including previously authorized services for Covered Services.

It is still your responsibility to make sure that you have Authorization before you see a Provider that is not part of the Plan’s Network. You may ask your PCP to arrange this or call the Plan’s Member Services department. When your Provider is no longer in BMC HealthNet Plan’s Network because they have been disenrolled from the Plan’s Network for reasons not related to quality of care or Fraud, BMC HealthNet Plan may be able to provide coverage for:

- Up to 30 calendar days if the Provider is your PCP or up to 90 calendar days if the Provider, including a PCP, is providing you with active treatment for a chronic or acute medical condition or until that active treatment is completed, whichever comes first.
- If you are in your second or third trimester of your pregnancy, you may remain under the care of your current OB/GYN (even if out-of-Network) through delivery and follow-up within the first six weeks of delivery. Your second trimester is the start of your 4th month of pregnancy based on the expected delivery date.
- With respect to a terminal illness, coverage shall apply to services rendered until death.

If you get a bill for Covered Services
If you get a bill for a Covered Service, here’s what you should do:

- Print the name of the Member who received the care, and his or her BMC HealthNet Plan Member ID Card number on the bill.
- Make a copy of the bill for your records.
- Mail any bills for medical services to:
  Member Services Department, BMC HealthNet Plan, Suite 500, Charlestown, MA 02129
- Mail any bills for Behavioral Health services to:
  Beacon Health Strategies, LLC, 500 Unicorn Park Drive, Suite 401, Woburn, MA 01801
  You cannot be charged for:
- Emergency or Post Stabilization Care services provided in the United States and its territories. Post Stabilization Care services are the services you get after your Emergency condition is brought under control so that your condition can then stay stable. For example, if you’re treated for a Behavioral Health Emergency by an Emergency Services Program (ESP) Provider, you may also be covered for the follow-up services such as community crisis stabilization services once your Emergency has been dealt with.
- Services you get from a BMC HealthNet Plan Provider or an out-of-Network Provider if these services were prior authorized by the Plan. It is the responsibility of the Provider to obtain Prior Authorization from us when needed.
- Services provided by a MassHealth Provider when those services are covered directly by MassHealth.
- Family Planning Services received from any MassHealth contracted Family Planning Services Provider.

However, care that is not covered by us or by MassHealth may be your responsibility to pay. We can help you figure this out. If you have questions, please call our Member Services department. We’ll help you resolve the problem.

Extras, “free” for our qualified Members

- Infant/toddler safety car seats – If you’re having a baby, call the Member Services department to find out how to get your free convertible car seat. You can get the seat up to 45 days before your due date.
- Bicycle helmets for kids – Kids who are Members of BMC HealthNet Plan can get a free bike helmet. Call our Member Services department to find out how to get the helmet.

For more information on whether you qualify for these Extras, call our Member Services department.

For all our MassHealth Members:

- The Nurse Advice Line from BMC HealthNet Plan can help you answer your health questions 24-hours a day, seven days a week. The number is 1-800-973-6273. Remember: the Nurse Advice Line can help you, but it should not take the place of your Primary Care Provider.
Process to evaluate new technology
We review new medical technologies and new uses for existing medical technologies for safety and efficacy before we determine coverage. (Efficacy means that the technology works.) Such technologies include medical and Behavioral Health therapies, devices, surgical and diagnostic procedures and medications. The review process by the Plan’s medical staff includes consulting with medical experts who have expertise in the new technology; research and review of published peer-reviewed medical literature and reports from appropriate governmental agencies (such as the federal Food and Drug Administration), and policies and standards of nationally recognized medical associations and specialty societies. The information is then presented to the Plan’s internal committees who are responsible for making final decisions concerning coverage of the medical technology.

Section 7. Your Primary Care Provider (PCP)

Primary Care Provider (PCP)
Every BMC HealthNet Plan Member needs to have a Primary Care Provider (PCP). He or she is your personal doctor or nurse practitioner. Your PCP will do many things for you and your BMC HealthNet Plan enrolled family members:

- Provide or coordinate all your care, except in an Emergency
- Treat you for your basic health needs and problems
- Refer you to other healthcare Providers and Specialists
- Admit you to the hospital and arrange for your hospital care, if necessary
- Keep your medical records
- Write prescriptions
- Request Prior Authorizations from BMC HealthNet Plan, when necessary
- Respond to your phone calls about your medical needs or problems, even after business hours

Picking a PCP
Call us if you need help choosing a PCP. And if you already have a PCP when you call, we want to make sure that we have the correct information for our records. If you haven’t picked a PCP yet, we have a long list of PCPs and we’ll help you choose one for you and for each BMC HealthNet Plan-enrolled family member. Even though you can pick a PCP from anywhere in our Network, it makes sense that you pick one who is near you. You should call us immediately to pick a PCP if you haven’t already done so. Or check out our online Provider Directory at bmchp.org. You can also have a printed Provider Directory sent to you by calling our Member Services department. BMC HealthNet Plan will assign a PCP to any Member who does not pick one within 15 days of Effective Date of enrollment in the Plan. You can change your PCP at any time.

Providers who are PCPs
There are a few different kinds of healthcare Providers who may act as PCPs:

- Family practice Providers treat adults and children. They can also provide women’s health services for pregnant women.
- General practice-Providers treat adults and children.
- Internal medicine Providers treat adults over the age of 17 years. (A medical doctor who practices internal medicine is called an “internist.”)
- Pediatric Providers treat children and young adults up to age 21 years.
- Nurse practitioners – registered nurses with advanced training in the treatment of many health issues.
- Obstetricians/Gynecologists treat women’s health and reproductive issues. (They must also be contracted with BMC HealthNet Plan as a PCP. Check your online Provider Directory at bmchp.org to see if they are listed as a PCP.)

Each family member enrolled in our Plan must have a PCP. If every enrolled Member in your family wants the same PCP, you can choose a family practice or general practice Provider to be the PCP for each BMC HealthNet Plan family member.

Call your PCP for an appointment
When you become a BMC HealthNet Plan Member, you should make an appointment to see your PCP for a checkup. Make sure you write down your PCP’s phone number and put it where you can find it quickly. Call your PCP’s office. Tell the office staff this will be your first visit with this PCP, or that this is your first visit with the PCP using your BMC HealthNet Plan insurance. If you have any problems making an appointment, call our Member Services department. If it’s your first visit with your PCP, most likely you will get a physical exam. Your PCP will ask you questions about your health and your family’s health. The more your PCP knows about you and your family’s health history, the better he or she can manage your care. Adults should visit their PCPs at least once a year for a comprehensive annual exam. Infants, children and pregnant women should see their PCPs more often. Please see Section 9 for information on how often to see your healthcare Provider.
Section 7. Your Primary Care Provider (PCP)

Call your PCP first when you’re sick – unless you think it’s an Emergency
Your PCP will provide and coordinate all your care, except in an Emergency. If you think you are having an Emergency, call 911 or go to the nearest hospital Emergency room listed in our online Provider Directory at bmchp.org. If it’s a Behavioral Health Emergency, call 911, go to the nearest hospital Emergency room, or contact the nearest Emergency Services Program (ESP) Provider listed in both our online and print Provider Directories. If you need a printed directory, call Member Services and they will send you one. At all other times, you should call your PCP’s office. There’s always a healthcare Provider on call for you, 24 hours a day, seven days a week to help you.

Changing your PCP
We want you to be happy with your PCP. It is important to have an ongoing relationship with your PCP for continuity of your healthcare and wellness. However, if you feel the need to change your PCP, you can pick a new PCP at any time by calling our Member Services department.

Getting a Second Opinion
You may ask for a Second Opinion from another BMC HealthNet Plan Provider about any healthcare that your Provider thinks you should have. We can also arrange for you to get a second opinion from a provider outside of our network. In both cases, we will pay for your Second Opinion visit.

Section 8. Your Healthcare, Emergency Care and Behavioral Health Services

Emergencies and Urgent Care
Whether you have a medical Emergency or a Behavioral Health Emergency, you should seek immediate care when there’s no time to call your healthcare Provider. You do not need approval from your healthcare Provider to seek Emergency care. And you’re covered for Emergency care 24 hours a day, seven days a week, even if you’re outside BMC HealthNet Plan’s Service Area or need to see an out-of-Network Provider. You’re also covered if a BMC HealthNet Plan representative tells you to seek Emergency care. Note: You cannot be denied Emergency care based on your diagnosis (your illness or condition).
However, you are not covered for Emergency care outside of the United States or its territories. You should still seek Emergency care when you’re outside the country, but be aware that the services you receive will not be covered by our Plan. The Emergency care doctor or Provider treating you is responsible for deciding when you are stable enough to be transferred or discharged. The Provider’s decision is binding on those responsible for coverage and payment. This means that BMC HealthNet Plan and anyone responsible for covering or paying for your care must follow the direction the Provider decides. You are also covered for ambulance transportation and Post Stabilization Care services that are related to an Emergency. Post Stabilization Care services are the services you get after your Emergency condition is stabilized so that your condition can then stay stable. For example, if you’re treated for a Behavioral Health Emergency at an Emergency Services Program (ESP) Provider, you are also covered for the follow-up services you will need once your Emergency has been dealt with. This follow-up care might include outpatient visits or treatment at another facility.
In a medical Emergency: Call 911 or immediately seek care in any hospital Emergency room. A statewide list of Emergency rooms is in your BMC HealthNet Plan Provider Directory in the “Statewide Emergency Care by Hospitals” and in our online Provider Directory at bmchp.org.
In a Behavioral Health Emergency: Call 911, go to the nearest hospital Emergency room or immediately contact the Emergency Services Program (ESP) Provider in your area. A statewide list of ESPs is in your Provider Directory in the “Statewide Behavioral Health Emergency Services Programs” and in our online Provider Directory at bmchp.org. Below are some examples of medical and Behavioral Health Emergencies. Please note that these are only the most common Emergencies. This list does not include all the health Emergencies that you might have. Call 911 if you think you are having an Emergency.
Section 8. Your Healthcare, Emergency Care and Behavioral Health Services

Examples of medical Emergencies
- Broken bones
- Convulsions
- Heart attacks
- Serious accidents
- Severe headaches
- Shortness of breath
- Sudden change of vision
- Throwing up continuously
- Chest pain
- Loss of consciousness
- Severe burns
- Severe wounds
- Stroke (this includes numbness or difficulty with speech)
- Throwing up blood
- Fainting or dizzy
- Poisoning
- Severe pain
- Heavy bleeding
- Chest pain
- Fainting or dizzy
- Poisoning
- Severe pain
- Heart attacks
- Loss of consciousness
- Convulsions
- Sudden change of vision
- Severe headaches
- Shortness of breath
- Sudden, severe pain or pressure in or below the chest

Examples of Behavioral Health Emergencies
- Wanting to harm yourself
- Wanting to harm other people

Urgent Care
An Urgent Care condition is a health problem that's serious - but that you do not think is an Emergency. Your PCP must see you within 48 hours after you request an Urgent Care appointment. Your Behavioral Health Provider must also see you within 48 hours for Urgent Care for Behavioral Health conditions. If your Urgent Care condition gets worse before you are seen by your PCP or Behavioral Health Provider, you can go to an Emergency room. Even if you're out of town or out of the Service Area, you should call your PCP if an Urgent Care condition occurs. You can call your PCP 24 hours a day, seven days a week. If your PCP is not available, a covering doctor or other healthcare Provider will call you back.

Behavioral Healthcare
Choosing Behavioral Health services
BMC HealthNet Plan has partnered with Beacon Health Strategies (Beacon) to manage and coordinate Behavioral Health (mental health and substance abuse) services for Members and manage the Behavioral Health Provider network. Beacon is a Massachusetts based company with an excellent reputation for coordinating quality Behavioral Health services. You can find a list of Behavioral Health Providers in our online Provider Directory at bmchp.org. If you need a printed Provider Directory, call our Member Services department.

Behavioral Health services are available by “self-Referral”. This means that you can go to a BMC HealthNet Plan Behavioral Health Provider when you want to. You can find the listing of these Providers in our online Provider Directory or you can ask family members, guardians, a community agency, or your Provider (including your PCP) to recommend a BMC HealthNet Plan Behavioral Health Provider.

No Prior Authorization is needed for up to the first 12 visits to a Behavioral Health Provider in our Network. Your Behavioral Health Provider will arrange for any needed Prior Authorizations beyond the first 12 visits. Certain Behavioral Health services must be authorized in advance for them to be covered.

The Covered and Excluded Services list in this Member handbook shows the Behavioral Health services that require Prior Authorization. Your Provider should be able to make arrangements for Prior Authorization. You can always call the Behavioral Health Member line if you have any questions about Prior Authorization for Behavioral Health Covered Services.

Remember, in a Behavioral Health Emergency you should call 911, go to the nearest hospital Emergency room, or contact the Emergency Services Program (ESP) Provider in your area. A statewide list of Emergency Services Program (ESP) Providers is in your printed and online Provider Directory at bmchp.org.

Note that you are not covered for Emergency or Urgent Care outside of the United States or its territories. You should still seek Emergency or Urgent Care when you’re outside the country, but be aware that the services you receive will not be covered by BMC HealthNet Plan.

Health Needs Assessment
Your new Member materials include a special form called a Health Needs Assessment (HNA). The HNA will help us to better understand your health needs – so that we can make sure that we address your healthcare needs and that you’re getting any special care you may need.

It is very important that you fill out the HNA and return it to us in the postage-paid envelope that’s provided. You can also complete your HNA online via the Member self-service section at bmchp.org. Filling this out DOES NOT affect your MassHealth Eligibility or your health benefits in any way. Please know that we will keep your Protected Health Information (PHI) confidential.

If you do not fill out your HNA, a representative from BMC HealthNet Plan may call you and ask you to give us your Health Needs Assessment information. (See Section 13 for information about your PHI and your rights to keep it private.) The answers you give in the Health Needs Assessment help us to help you stay healthy, so please complete your HNA.
How long it should take to get care
When you don’t feel well or when you really want to see your healthcare Provider, you don’t want to wait too long for an appointment. That’s why we require all of our Providers to comply with the guidelines that follow. You shouldn’t need to wait any longer than what is listed. If you think that any of these timeframes have not been met, then you, or your Authorized Representative, have the right to file an Internal Appeal. (For Appeals information, see Section 12, “Inquiries, Grievances and Appeals.”)

Getting medical care
Emergency care: An Emergency room or other healthcare Provider of Emergency services must give you care immediately, 24 hours a day, seven days a week. Members have unrestricted (no limit) access at any qualified Emergency care Provider whether or not the Providers are part of BMC HealthNet Plan’s Network.
Urgent Care: A healthcare Provider must give you Urgent Care within 48 hours of your request for an appointment.
Primary care: Non-urgent, symptomatic care (if you are sick or have other symptoms that are not urgent): A healthcare Provider must give you care within 10 calendar days of your request for an appointment.
• Routine, non-symptomatic care: (if you’re not sick and don’t have any other symptoms): A healthcare Provider must give you care within 45 calendar days of your request for an appointment. That is unless you or your child needs an appointment as part of the EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Periodicity Schedule. Your child’s healthcare Provider can give you more information about EPSDT schedules. (For more information on EPSDT, see Section 9.)
• Routine, first prenatal and first family-planning visit: Within 10 working days of requesting an appointment.
Specialty care: Non-urgent, symptomatic care (if you’re sick or have other symptoms that aren’t urgent): A healthcare Provider must give you care within 30 calendar days of your request for an appointment.
• Routine, non-symptomatic care: (if you’re not sick and don’t have symptoms): A healthcare Provider must give you care within 60 calendar days of your request for an appointment.

Getting Behavioral Healthcare
Emergency Behavioral Healthcare: A hospital Emergency room, an Emergency Services Program (ESP) Provider or other healthcare Provider of Emergency services must give you care immediately, 24 hours a day, seven days a week.
Urgent Behavioral Healthcare: A healthcare Provider must give you Urgent Care within 48 hours of your request for an appointment.
Other Behavioral Health services: A healthcare Provider must give you care within 14 calendar days of your request for an appointment.
For services described in an Inpatient or 24-hour diversionary services discharge plan, you must get care within these time frames:
• For non-24-hour diversionary services: within two calendar days of discharge
• For medication management: within 14 calendar days of discharge
• For other outpatient services: within seven calendar days of discharge
• For Intensive Care Coordination services: within twenty-four (24) hours of Referral, including self-Referral, offering a face-to-face interview with the family.

Children in the care or custody of the Department of Children and Families (DCF):
If you have children in the care or custody of DCF, a healthcare Provider must:
• Give your child a healthcare screening within seven calendar days after you or the DCF worker asks for it.
• Give your child a full medical exam within 30 calendar days after you or the DCF worker asks for it, unless a shorter time frame is required by Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services schedule. (See Section 9 for EPSDT information.)

Utilization Management
Utilization Management is a process used by qualified BMC HealthNet Plan staff to make sure you’re getting the right healthcare when you need it. The Utilization Management decision making process at BMC HealthNet Plan follows certain guidelines to encourage the right use of services to help ensure positive outcomes for our Members. For example, 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. BMC HealthNet Plan does not reward decision makers for issuing denials nor does it offer them financial incentives that encourage underutilization of services. BMC HealthNet Plan Members can call 1-888-566-0010 to find out the status or outcome of utilization review decisions involving their care.
Quality Improvement program
BMC HealthNet Plan’s Quality Improvement committee approves a Quality Improvement program (QIP) annually. This program looks to improve the quality of care and services that our Members receive. For example, in the past the Plan focused on improving care for Members with diabetes and asthma as well as on improving overall coordination of care and Member satisfaction with the Plan. At the end of each year we will evaluate our progress, identify opportunities for improvement and establish the following year’s goals and Quality Improvement program.

Clinical Practice Guidelines
We adopt, develop and implement Clinical Practice Guidelines (CPGs) relevant to our membership for providing appropriate, effective care to all our Members and include preventive and non-preventive acute and long-term clinical services for medical and Behavioral Health conditions. CPGs help us establish standards of care throughout our Provider Network. The Plan adopts Clinical Practice Guidelines from national sources or develops guidelines in collaboration with specialty organizations and/or regional collaborative groups. You may request a copy of the Plan’s current CPGs by contacting the Member Services department.

Transportation assistance
As a benefit from MassHealth, some BMC HealthNet Plan members may be eligible for non-Emergency transportation to go to covered healthcare visits. This benefit is administered by MassHealth. However, we assist Members to obtain the transportation. In order to be eligible for this benefit:

1. You do not have a family member or other person who can take you.
2. You do not have access to public transportation, or there is a medical reason that you cannot use it.
3. Your appointment must be for a Medically Necessary Service.
4. You must see a MassHealth Provider.

For more information, contact our Member Services department. You should contact the Plan well in advance of your appointment so we can process your request.

Staying healthy
The best healthcare happens before you get sick. It’s called preventive care. To help you stay healthy, we’ve put together a chart to show you all the tests and shots you and your enrolled children should have, depending on age. If you’d like a copy of the chart to be sent to you, please call the Member Services department. You can also find the chart on our website at bmchp.org.

Preventive care for adults
Routine preventive care is an important part of staying healthy. BMC HealthNet Plan encourages all Members to visit their Primary Care Providers for preventive care. Examples of covered preventive care benefits for Members ages 21 and older include:

- Physical exams every one to three years
- Blood pressure monitoring at least every two years and whenever you have a visit with your PCP
- Cholesterol screening every five years beginning at age 18 or as recommended by your healthcare Provider
- Pelvic exams and Pap smears (women) every one to three years (starting at age 21 or earlier if sexually active)
- Breast cancer screening (mammogram) every year over age 40 (or earlier if there is an immediate family history of breast cancer. Breast exams could then be as often as every six months.)
- Colorectal cancer screening every 10 years starting at age 50 (or earlier if there is an immediate family history of colorectal cancer. In that case, exams could be more frequent.)
- Flu shot annually
- Eye exams once every 24 months (or more often if there are certain medical conditions that exist.)
- Dental. (Both adults and children are eligible for dental benefits. Some of these benefits are covered by BMC HealthNet Plan. Some are covered by MassHealth. Refer to your Covered and Excluded Services list in this Member handbook for details on dental coverage or call the Member Services department.)

Prescription medication coverage
Getting your prescriptions filled
Your BMC HealthNet Plan healthcare Provider needs to write a prescription for both prescription medications and over-the-counter medications if you need them. We have more than 1,000 pharmacies in our Network across Massachusetts – including all the major chain stores – where you can pick up your medications. Our online Provider Directory lets you search for a pharmacy in your area where you can get your medicines. If you have problems finding a pharmacy, call our Member Services department.

We contract with EnvisionRx Options to manage your prescription drug benefit. If you need help, such as information about Covered drugs or pharmacies (retail, specialty and mail-order pharmacies) in our Provider Network, you may contact our Member Services Department or EnvisionRx Options: 2181 East Aurora Road, Twinsburg, Ohio 44087 Telephone: 1-800-361-4542 available 24 hours, 7 days a week.
Paying at the pharmacy

Unless you fall into one of the following categories, you will need to pay a Co-payment at the pharmacy for your prescription drugs. Please refer to your Covered and Excluded Services list for information on Co-pays. Please note that BMC HealthNet Plan Members pay the same Co-payments for prescription medications as Members of other MassHealth Managed Care plans. Some Members don’t have a pharmacy Co-payment. Members do not have a pharmacy Co-payment if:

- You are under age 19.
- You are enrolled in MassHealth because you were in the care and custody of the Department Children and Families (DCF) when you turned 18, and your MassHealth coverage was continued.
- You are pregnant. (You must tell the pharmacist you’re pregnant.)
- It’s within 60 days following the month your pregnancy ended.
- You are receiving family planning supplies.
- You are in hospice care.
- You are a Native American or Alaska Native from a federally recognized tribe.
- You are receiving Inpatient care in an acute hospital, nursing facility, chronic disease hospital, rehabilitation hospital, or intermediate-care facility for the developmentally delayed.
- You have met the Co-payment cap for the calendar year (January through December). We’ll send you a letter to let you know that you’ve reached your cap. If you have reached the cap and are still being asked for Co-payments, you should send your receipts to BMC HealthNet Plan. (The cap is the total amount of the Co-payments you’ve been charged, whether or not you actually paid the Co-payments.) If you don’t have receipts for all the Co-payments you were charged, you can request a prescription Co-payment record from your pharmacist. When you’re ready to send in your receipts, call our Member Services department. Ask them to send you a copy of a form you’ll need to fill out and include with your receipts when you send them to us. You can also get a copy of the form at our website, bmchp.org. (You will need to download the form to a printer.) The instructions for where to send your receipts are on that form.

If you can’t pay the Co-payment

The pharmacy still must fill your prescription even if you can’t pay the Co-payment. However, the pharmacy can bill you later for the Co-payment. Don’t go without your medication if you can’t pay the Co-payment. Please call our Member Services department if a pharmacy refuses to give you your prescription.

Mail-order pharmacy program

Our members can have maintenance medications sent to their homes instead of filling prescriptions at a local retail pharmacy. Maintenance medications are those medications that are refilled regularly for conditions like diabetes, asthma and high blood pressure. The plan contracts with Orchard Pharmaceutical Services (“Orchard”) 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 three months. Only certain maintenance drugs are available through mail-order. To use the mail-order service you must first enroll with Orchard. To enroll in this service and begin getting medications in the mail you must either contact Orchard 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 Orchard website. Your prescribing Provider may also call Orchard 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 orchardrx.com.

Pharmacy programs

While most medications simply require a prescription from your healthcare Provider, we use a number of pharmacy programs to promote the safe and correct use of certain prescription medications. Medications that belong to these programs have Clinical Practice Guidelines that must be met before we cover the medication. You can see which medications belong to a pharmacy program on the drug list or formulary on our website: bmchp.org. The formulary also lists the drugs that may not be covered. 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. If you want a copy of the formulary, please call our Member Services department and ask for the pharmacy department.

If your BMC HealthNet Plan healthcare Provider thinks it is Medically Necessary for you to take a medication that’s only covered in one of our pharmacy programs, he or she can submit a Prior Authorization request to us. This request will be reviewed by a clinician. If the medication is Medically Necessary, BMC HealthNet Plan will cover the medication. If the Prior Authorization request is denied, you or your Authorized Representative can appeal the decision. (See Section 12 for Grievances and Appeals information.) If you want more information about the pharmacy programs, visit our website at bmchp.org. Or you can call our Member Services department and ask for the pharmacy department.
Section 8. Your Healthcare, Emergency Care and Behavioral Health Services

Prior Authorization program – Some medications always require Prior Authorization. If your Provider feels that a medication that falls into this group is Medically Necessary for you, he or she can submit a Prior Authorization request. That request will be reviewed by a clinician. If the medication is Medically Necessary, BMC HealthNet Plan will cover the medication. If the Prior Authorization request is denied, you or your Authorized Representative can appeal the decision. (See Section 12 for Grievances and Appeals information.)

Step therapy program – Some types of medications have many options. Step therapy requires that a Member tries certain first-level medications before we will cover another medication of that type. If you and your Provider feel that a certain first-level medication is not appropriate to treat a medical condition, your Provider can submit a Prior Authorization request. That request will be reviewed by a clinician. If the medication is Medically Necessary, we will cover the medication. If the Prior Authorization request is denied, you or your Authorized Representative can appeal the decision. (See Section 12 for Grievances and Appeals information.)

New-to-market medication program – We review new medications for safety and efficacy before we add them to our list of medications or formulary. (Efficacy means that the medication works.) If your Provider feels that a new-to-market medication is Medically Necessary, he or she can submit a Prior Authorization request. That request will be reviewed by a clinician. If approved, BMC HealthNet Plan will cover the medication. If the Prior Authorization request is denied, you or your Authorized Representative can appeal the decision. (See Section 12 for Grievances and Appeals information.)

Quantity limitation program – This program ensures the safe and appropriate use of some medications by covering a specific amount that can be dispensed (given by the pharmacist) at one time. If your Provider feels that a quantity greater than the specified amount is Medically Necessary, he or she can submit a Prior Authorization request. That request will be reviewed by a clinician. If approved, we will cover the medication. If the Prior Authorization request is denied, you or your Authorized Representative can appeal the decision. (See Section 12 for Grievances and Appeals information.)

Specialty pharmacy program – This program requires that some medications be supplied by a specialty pharmacy. These medications include injectable and intravenous medications that are often used to treat chronic (ongoing) conditions like Hepatitis C or Multiple Sclerosis. These types of health conditions require additional expertise and support. Specialty pharmacies have knowledge in these areas and can provide additional help to Members and Providers.

Mandatory generic substitution program – The federal Food and Drug Administration (FDA) determines that certain generic medications are therapeutically equivalent (“AB rated”) to their brand name alternatives. This means that the “AB rated” generic medication is as effective as the brand name medication. If your Provider determines that the brand name medication is Medically Necessary, he or she may submit a Prior Authorization request. That request will be reviewed by a clinician. If approved, we will cover the medication. If the Prior Authorization request is denied, you or your Authorized Representative can appeal the decision. (See Section 12 for Grievances and Appeals information.)

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.

Medicare Part D

If you are a BMC HealthNet Plan Member with Medicare coverage, your prescription drug benefit may be covered by a Medicare Prescription Drug Coverage (Part D) plan. Most of your prescription drugs will be covered under your Medicare Part D benefit. You should have a separate ID card for your Medicare Prescription Drug Coverage. You will need to show your Medicare Part D ID card when filling a prescription. There are some drugs that we will continue to cover. For example, BMC HealthNet Plan will continue to cover your over-the-counter (OTC) drugs. BMC HealthNet Plan Co-payment exceptions will still apply for BMC HealthNet Plan covered drugs. For more information, contact our Member Services department. To find out more about your Medicare Prescription Drug Coverage, you may:
1. contact Medicare at 1-800-633-4227 (TTY: 1-877-486-2048);
2. go to Medicare’s website at www.medicare.gov;
3. refer to the Medicare and You Handbook;

Remember to carry all your ID Cards with you when you go to the pharmacy. When you fill a prescription, please show your BMC HealthNet Plan Member ID Card and your Medicare Prescription ID card.

Section 9. Pregnancy, Family Planning, Preventive Care, Well Child Care and EPSDT

Pregnancy (prenatal) care

The healthcare you get while you’re pregnant (before your baby is born) is called “prenatal care.” This type of care is very important. It’s the best way to see how your pregnancy is going, if you and your unborn baby are getting adequate nutrition, and to make sure your baby is developing properly. Your healthcare Provider will monitor you throughout your pregnancy to make sure your baby is developing properly. Even if you’ve given birth before, it’s very important for you to get prenatal care throughout your current pregnancy.
Make an appointment with an obstetrician/gynecologist (OB/GYN)
You need to see an obstetrician (OB) as soon as you can after you become pregnant. An obstetrician is a doctor who’s trained to treat pregnant women and deliver babies. This type of doctor is usually also a gynecologist (GYN). That means that he or she is trained to know all about diseases of the female reproductive system. The short name for this combined specialty is OB/GYN. If you think you’re pregnant, you should either:
• Ask your PCP to recommend an OB/GYN doctor (you do not need a Prior Authorization) OR
• Call a BMC HealthNet Plan OB/GYN doctor and make an appointment. You don’t need a Prior Authorization to see a BMC HealthNet Plan OB/GYN doctor. But your PCP can provide important health information about you to the OB/GYN doctor so that you and your unborn baby remain in good health. That’s why you need to tell your PCP that you’re pregnant.

Your OB/GYN doctor
Early and regular prenatal care is very important to help you have a healthy baby and a safe delivery. We recommend that you see your OB/GYN as soon as you think you’re pregnant. You should also see your OB/GYN as often as the OB/GYN wants to see you. Our Plan covers all these visits.

Family Planning Services
We cover Family Planning Services that include family planning medical services, family planning counseling, birth control advice, pregnancy tests, sterilization services, and follow-up healthcare. You can get Family Planning Services from your PCP. Or, you can get these services from any BMC HealthNet Plan or MassHealth contracted Family Planning Services Provider. These services do not require Prior Authorization. You can self-refer by calling the Family Planning Services Provider directly. Or ask your PCP to refer you to a Family Planning Services Provider. For a listing of these Providers, see our online or printed Provider Directory.

Preventive and well-child care for all children
Children who are under age 21 should go to their PCP for checkups even when they are well. As part of a well-child checkup, your child’s PCP will offer screenings to find out if there are any health problems. These screenings include health, vision, dental, hearing, Behavioral Health, developmental, and immunization status screenings.

Behavioral Health screenings can help you and your doctor or nurse to identify Behavioral Health concerns early. MassHealth requires that Primary Care Providers and nurses use standardized screening tools to check a child’s Behavioral Health during their well-child visits. The screening tools are approved by MassHealth. Screening tools are short questionnaires or checklists that the parent or child (depending on the child’s age) fill out and discuss with the doctor or nurse. The screening tool might be the Pediatric Symptom Checklist (PSC) or the Parents’ Evaluation of Developmental Status (PEDS). Or it can be another screening tool chosen by your PCP. You can ask your PCP which tool he or she will use when screening your child for Behavioral Health concerns.

Your Provider will discuss the completed screening with you. The screening will help you and your doctor or nurse decide if your child needs further assessment by a Behavioral Health Provider or another medical professional. Information and assistance will be available if you or your doctor or nurse thinks that your child needs to see a Behavioral Health Provider. For more information on how to access Behavioral Health Covered Services, or to pick a Behavioral Health Provider, talk to your PCP or call our Behavioral Health Member line.

BMC HealthNet Plan pays your child’s PCP for these checkups. At well-child checkups, the PCP can find and treat small problems before they become big ones. Here are the ages to take a child for full physical exams and screenings:
• at 1 to 2 weeks
• at 1 month
• at 2 months
• at 4 months
• at 6 months
• at 9 months
• at 12 months
• at 15 months
• at 18 months
• At ages 2-20 – children should visit their PCP once a year.

Children should also visit their PCP any time there is a concern about their medical, emotional or Behavioral Health needs, even if it is not time for a regular checkup.

Preventive Pediatric Healthcare Screening and Diagnosis (PPHSD) services for children enrolled in MassHealth Family Assistance
If you or your child is under 21 years old and enrolled in MassHealth Family Assistance, BMC HealthNet Plan will pay for all Medically Necessary services covered under your child’s coverage type. This means that, when a PCP (or any other clinician) discovers a health condition, BMC HealthNet Plan will pay for any Medically Necessary services included in your child’s coverage type.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children enrolled in MassHealth Standard or CommonHealth

If you or your child is under age 21 and enrolled in MassHealth Standard or CommonHealth, BMC HealthNet Plan will pay for all Medically Necessary services that are covered by federal Medicaid law (even if the services are not specifically mentioned in your Covered and Excluded Services list). This coverage includes healthcare, diagnostic services, treatment and other measures needed to correct or improve deficits and physical and Behavioral Health illnesses and conditions. When a PCP or any other clinician discovers a health condition, BMC HealthNet Plan will pay for any Medically Necessary services covered under Medicaid law. The treatment must be delivered by a Provider who is qualified and willing to provide the service. In addition, a physician, nurse practitioner, or nurse midwife must support in writing the Medical Necessity of the service. You and your PCP can seek help from BMC HealthNet Plan to determine what Providers may be available in the Plan’s Network to provide these services and how to use out-of-Network Providers, if necessary. Most of the time these services are covered by your child’s coverage type and are included on your Covered and Excluded Services list. If the service is not already covered or is not on the list, the clinician or Provider who will deliver the service can ask BMC HealthNet Plan for Prior Authorization. BMC HealthNet Plan uses this process to determine if the service is Medically Necessary. The Plan will pay for the service if Prior Authorization is given. If Prior Authorization is denied, you, or your Authorized Representative, have a right to appeal. (See Section 12 for more information about the Appeal processes.) Talk to your child’s PCP, Behavioral Health Provider or other Specialist for help in getting these services.

Children’s Behavioral Health Initiative (CBHI)

The Children’s Behavioral Health Initiative is an inter-agency initiative of the Commonwealth’s Executive Office of Health and Human Services whose mission is to strengthen, expand and integrate Massachusetts state services into a comprehensive, community-based system of care, to ensure that families and their children with significant behavioral, emotional and mental health needs obtain the services necessary for success in home, school and community. Our Plan arranges for a full range of Behavioral Health services including individual, group or family therapy, “diversionary” services such as partial hospitalization and Inpatient care. As part of the Children’s Behavioral Health Initiative, Behavioral Health services for certain children and youth under the age of 21 have been expanded to include, when Medically Necessary, home- and community-based services including outpatient therapy, mobile crisis intervention, in-home therapy, in-home behavioral services, family support and training, therapeutic mentoring and intensive care coordination. A statewide list of Community Service Agencies can be found in your printed and online Provider Directory. For more information, call our Behavioral Health Member line.

Dental care for children

MassHealth pays for preventive and basic services for the prevention and control of dental diseases and the maintenance of oral health for enrolled children. Your child’s PCP will give a dental exam at each well-child checkup. When your child is three years old (or earlier if there are problems) his or her PCP will suggest that you take your child to the dentist at least twice a year. When your child goes for routine exams, the dentist will give a full dental exam, teeth cleaning and fluoride treatment. It’s important that your child gets the following dental care:

- A dental checkup every six months starting no later than age three.
- Other dental treatments needed, even before age three, if your child’s PCP or dentist finds problems with your child’s teeth or oral health.

Your child’s dental health may be improved by having fluoride varnish applied to his or her teeth. This can be done by a dentist or other healthcare Provider. Fluoride varnish is mostly for children up to age 3. But it is allowed for Members up to age 21 if they don’t have access to a dentist. It’s best to have the varnish applied when the child is very young. That means as soon as the front teeth begin to show at around age six months.

Children who are under age 21 and enrolled in MassHealth Standard or CommonHealth can get all Medically Necessary services covered under Medicaid law. This includes dental treatment even if the service is not otherwise covered by MassHealth. Children who are under age 21 and enrolled in MassHealth Family Assistance can get all Medically Necessary services covered under their coverage type. This includes dental treatment. Talk to your child’s PCP or dentist for help in getting these services.

Please note:

- Children do not need Prior Authorization to see a MassHealth dentist.
- Children can visit a dentist before age three.
Additional services for children
Children under age 21 years are entitled to certain additional services under federal law.

Early intervention services for children with growth or developmental problems
Some children need extra help for healthy growth and development. Providers who are early intervention Specialists can help them. Some of these Providers are:
- Social workers
- Nurses
- Physical, occupational and speech therapists

All of these Providers work with children under three years old – and their families – to make sure a child gets any extra support necessary. Some of the services are given at home. And some are at early intervention centers. Talk to your child’s PCP as soon as possible if you think your child has growth or development problems. Or contact your local early intervention program directly.

Section 10. Care Management
We are committed to giving you, our Members, the information and tools you need to build and maintain a healthy lifestyle. Our Care Management program is free for Members (adults and children) and is just a phone call away. Our experienced staff includes registered nurses, licensed social workers, and trained Care Management Specialists. Our staff works with you to help you understand and get the right services and information so you can manage your condition and be healthy. Our Care Management program includes you, your healthcare Providers, and us, working together for you to be healthy. BMC HealthNet Plan care managers (or Beacon care managers, if Behavioral Health) will be in touch with you to check on your progress and help coordinate care with all necessary healthcare Providers. We also help you learn what benefits and community resources are available because we want to help you with more than just healthcare. Our experienced staff can link you with services such as transportation to healthcare appointments, food stamps, housing and emergency shelter, assistance with utilities, and support groups. These community resource services are available to all Members, not just those enrolled in Care Management.

Medical Care Management, including disease management, consists of three program levels to make sure you receive the necessary level of Care Management. The three levels are:
- Care Management Education and Wellness
- Care Management Healthcare Coordination
- Medical Complex Care Management

In addition to our medical Care Management program, Beacon Health Strategies (Beacon) offers BMC HealthNet Plan Members Behavioral Healthcare Management and Intensive Clinical Management (ICM) services. For Members with both medical and Behavioral Healthcare needs, BMC HealthNet Plan’s and Beacon’s Care Management teams will work together to ensure full coordination of care.

Care Management Education and Wellness
This level of Care Management offers educational materials, tools, and resources for wellness and prevention. The goal is to help you learn and follow new and easy ways to manage specific illnesses such as diabetes, asthma, and high blood pressure. You can access these resources by logging on to bmchp.org and clicking on Care Management under the Member pages. BMC HealthNet Plan’s online Wellness Center also has helpful information for Members on how to stay healthy.

Care Management Healthcare Coordination (Disease Management)
The Healthcare Coordination level offers Members a more involved approach. Care managers work with you and a team of healthcare Providers to help you be as healthy as possible. This involves an assessment of your condition, coordination of care, and review of available benefits. Your care manager can help you set up services such as family support and community resources. Our care managers help you come up with your individual care plan. By following this care plan, you will learn more about your condition while building skills to lead a healthy lifestyle. Some of the conditions followed in this program are:
- Asthma
- HIV/AIDS
- Hypertension
- Diabetes
- Obesity
- Congestive heart
- Pregnancy

Medical Complex Care Management
Medical Complex Care Management manages Members with complex medical conditions. If you are at high risk for problems because of your health condition (including one of the conditions listed above) or have complex medical needs or special healthcare needs, you may be enrolled in Medical Complex Care Management. This level gives you all the information and tools you need to manage your condition, but includes more frequent check-ins from a care manager, including in-person visits at home or in the community as needed. A Care Management team, including registered nurses, pharmacists, and other healthcare Providers, help with your medical and social needs. They also educate you about what you need to know about managing your condition, arranging for care, and coordinating services and medical equipment. The team works together with you to set health related goals and work towards them.
Our Care Management program is free and voluntary. Your participation in the program does not replace the care and services that you receive from your PCP and other healthcare Providers. Entry into the program may happen through completing your Health Needs Assessment, our claims information, a Referral from a hospital Care Manager or one of your Providers, or self-Referral. If you think you would benefit from one of our programs, please call medical Care Management at 1-866-853-5241 to learn more. You can also opt out of any of our programs by calling the same number.

**Behavioral Healthcare Management**

Beacon offers support to BMC HealthNet Plan Members with certain Behavioral Health conditions. Our care managers are licensed Behavioral Health clinicians that are trained to help you with your Behavioral Healthcare needs. Beacon can help you with finding a Behavioral Health counselor near you or explaining available treatment options. Some of the conditions followed in this program are:

- Depression
- Emotional distress significantly impacting your relationships, school, work, job performance, difficulty with sleep or eating patterns
- Mental health needs such as bipolar disorder, mood disorders, psychotic disorders, schizophrenia
- Substance use or misuse such as alcohol, pain medications, illegal drugs

To learn more, call 1-888-217-3501 for Behavioral Healthcare Management.

**Intensive Clinical Management**

Beacon also offers an Intensive Clinical Management program (ICM) to provide additional support. This is a Care Management program provided by Beacon for BMC HealthNet Plan Members who are experiencing complex Behavioral Health or psychosocial conditions, sometimes in addition to medical concerns. ICM is a voluntary, flexible, short-term program to meet the individual needs and promote your optimal Behavioral Health. Both adults and children can receive ICM services. The program is offered by licensed Behavioral Health clinicians who provide services by phone and during face-to-face meetings with Members and their healthcare Providers.

ICM care managers work with you to advocate for your needs and link you to services. We will work to ensure you receive coordinated care, discharge planning after a Behavioral Healthcare admission, and resources and support in your community. With your permission, we will collaborate with your PCP and/or other healthcare Providers and family members in order to assist you. Our ICM care plans are individually developed with you and your Behavioral Healthcare Providers and establish goals and the resources you need to achieve the goals.

For more information about Behavioral Healthcare Management or ICM:

- Call our Behavioral Health Member line at 1-888-217-3501 (24 hours a day/7 days a week)
- Or visit our website: www.bmchp.org

**Mental Health Parity**

Federal and state laws require that all managed care organizations, including BMC HealthNet Plan, provide Behavioral Health services to MassHealth members in the same way they provide physical health services. This is what is referred to as “parity.” In general, this means that:

1. Our Plan must provide the same level of benefits for any mental health and substance abuse problems you may have as for other physical problems you may have;
2. Our Plan must have similar Prior Authorization requirements and treatment limitations for mental health and substance abuse services as it does for physical health services;
3. Our Plan must provide you or your provider with the medical necessity criteria used by BMC HealthNet Plan for Prior Authorization upon your or your Provider’s request; and
4. Our Plan must also provide you within a reasonable time frame the reason for any denial of authorization for mental or substance abuse services.

If you think that we are not providing parity as just explained, you have the right to file a Grievance with BMC HealthNet Plan. For more information about Grievances and how to file them, please see Section 12 (Inquiries, Grievances and Appeals) in this handbook. You may also file a Grievance with MassHealth. You can do this by calling the MassHealth Member Services Center at 1-800-841-2900 (TTY: 1-800-497-4648) Monday – Friday 8:00 a.m. to 5:00 p.m. For more information, please see 130 CMR 450.117(J).

**Section 11. Rights and Responsibilities**

As a Member of BMC HealthNet Plan, you have certain rights concerning your healthcare. You also have certain responsibilities to the Providers who are taking care of you. Regardless of your health condition, you cannot be refused Medically Necessary treatment. But your PCP may refer you to a Specialist for treatment that your PCP cannot provide.
Section 11. Your Rights and Responsibilities

Your Rights

1. You have the right to be treated with respect and with recognition of your dignity and right to privacy. (See Section 13 “Notice of Privacy Practices”.)
2. You have the right to be told about and understand any illness you have.
3. You have the right to be told in advance – in a manner you understand – of any treatment(s) and alternatives that a Provider feels should be done.
4. You have the right to take part in decisions regarding your healthcare, including the right to refuse treatment as far as the law allows, and to know what the outcome may be.
5. You have the right to have an open and honest discussion of appropriate or Medically Necessary treatment options for your health conditions, regardless of cost or benefit coverage. You may be responsible for payment of services not included in the Covered and Excluded Services list for your coverage type.
6. You have the right to expect your healthcare Providers to keep your records private, as well as anything you discuss with them. No information will be released to anyone without your consent, unless required by law.
7. You have the right to request an interpreter when you receive healthcare. Call the Member Services department if you need help with this service.
8. You have the right to request an interpreter when you call or visit BMC HealthNet Plan or Beacon Health Strategies (for Behavioral Health). Call the Member Services department if you need help with this service.
9. You have the right to choose your own Primary Care Provider (PCP) and you can change your PCP at any time. You must call the Member Services department if you want to change your PCP.
10. You have the right to receive healthcare within the timeframes described in the “How Long It Should Take To Get an Appointment” part of Section 8, and to file an Internal Appeal if you do not receive your care within those timeframes.
11. You have the right to voice a complaint and file a Grievance with our Member Services department, Beacon Health Strategies, and/or MassHealth Member Services center about services you received from the Plan or from a healthcare Provider. You also have the right to Appeal certain decisions made by BMC HealthNet Plan or Beacon Health Strategies (for Behavioral Health). The reasons for Grievances and Internal Appeals are described in Section 12, “Inquiries, Grievances and Appeals.”
12. You have the right to talk about your health records with your Provider and obtain a complete copy of those records. You also have the right to request a change to your health records.
13. You have the right to know and receive all of the benefits, services, rights and responsibilities you have under BMC HealthNet Plan and MassHealth.
14. You have the right to have your Member Handbook and any printed materials from BMC HealthNet Plan translated into your primary language, and/or to have these materials read aloud to you if you have trouble seeing or reading. Oral interpretation services will be made available upon request and free of charge.
15. You have the right to ask for a Second Opinion about any healthcare that your PCP advises you to have. BMC HealthNet Plan will pay for the cost of your Second Opinion visit.
16. You have the right to receive Emergency care, 24 hours a day, seven days a week. Please see the “Emergencies” section for complete information.
17. You have the right to be free from any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience or retaliation.
18. You have the right to freely exercise these rights without adversely affecting the way BMC HealthNet Plan and its Providers treat you.
19. You have the right to receive health treatment from BMC HealthNet Plan Providers without regard to race, age, gender, sexual preference, national origin, religion, health status, economic status, or physical disabilities. And no Provider should engage in any practice, with respect to any BMC HealthNet Plan Member, that constitutes unlawful discrimination under any state or federal law or regulation.
20. You have the right to disenroll from BMC HealthNet Plan and change to another MassHealth health plan by calling the MassHealth Member Services center.
21. You have the right to receive information about BMC HealthNet Plan, our services, and Providers, and your rights and responsibilities.
22. You have the right to make recommendations about our Rights and Responsibilities statement.
Section 11. Your Rights and Responsibilities

Your Responsibilities

1. You should tell your healthcare Provider your health complaints clearly and provide as much information as possible.
2. You should tell your healthcare Provider about yourself and your health history.
3. You should talk to your PCP about seeking the services of a Specialist before you go to a hospital (except in cases of Emergencies or when you refer yourself for certain Covered Services).
4. You should treat your healthcare Provider with dignity and respect.
5. You should keep appointments, be on time, and call in advance if you’re going to be late or have to cancel.
6. You should learn about your health problems and any recommended treatment, and consider the treatment before it’s performed.
7. You should partner with your healthcare Provider and work out treatment plans and goals together.
8. You should follow the instructions and plans for care that you and your healthcare Provider have agreed to, and remember that refusing treatment recommended by your healthcare Provider might harm your health.
9. You should authorize your PCP to get copies of all your health records.
10. You must receive all of your healthcare from BMC HealthNet Plan Providers, except in cases of Emergency or Family Planning Services or unless BMC HealthNet Plan provides a Prior Authorization for out-of-Network care. For services not covered by BMC HealthNet Plan that you get using your MassHealth Card, you may receive care from any MassHealth-contracted Provider.
11. You must not allow anyone else to use your BMC HealthNet Plan or MassHealth ID cards to obtain healthcare services. See the “Reporting Healthcare Fraud” section that follows.
12. You must notify BMC HealthNet Plan’s Member Services department and the MassHealth Member Services center when you believe that someone has purposely misused BMC HealthNet Plan or MassHealth benefits or services.
13. You must notify BMC HealthNet Plan’s Member Services department and the MassHealth Member Services center if you change your address or phone number.
14. You are responsible for payment of services not included in the Covered and Excluded Services list for your coverage type.

Reporting Healthcare Fraud

If you know of anyone trying to commit healthcare Fraud, please call our confidential compliance hotline at 1-888-411-4959. You do not need to identify yourself. Examples of healthcare Fraud include:

- Receiving bills for healthcare services you never received
- People loaning their health insurance ID cards to others for the purpose of receiving healthcare services or prescription medications
- Being asked to provide false or misleading healthcare information

Section 12. Inquiries, Grievances and Appeals

We want you to contact us if you have any concerns with your care or services. Our Member Services department will help you resolve your concerns. You also have the right to voice any concerns to MassHealth at any time. You may call a Member Services representative at the MassHealth Member Services center.

Inquiries

An Inquiry is any question or request that you may have about BMC HealthNet Plan’s or Beacon Health Strategies’ (Behavioral Health manager) operations. An Inquiry does not address your dissatisfaction with the Plan or Beacon Health Strategies (see “What is a Grievance?”). We will resolve your Inquiries immediately or, at the latest, within one business day of the day we receive your Inquiry. We will let you know about the outcome/resolution on the day your Inquiry is resolved. To make an Inquiry, call the Plan’s Member Services department or Beacon Health Strategies (for Behavioral Health).

Authorized Representative for Grievances and Internal Appeals, and Board of Hearings

An Authorized Representative is someone you have authorized, in writing, to act on your behalf with respect to a Grievance, Internal Appeal, or Office of Medicaid’s Board of Hearings (BOH) Appeal. If your Authorized Representative is your family member, you can have him or her represent you in multiple Grievance or Internal Appeal cases. The family member can have a standing Authorization until you send the Plan a letter informing us that the Authorization has been revoked. If you pick an Authorized Representative who is not a family member, you must get a new Authorization each time. We must receive this written Authorization before our deadline for resolving your Grievance or Standard Internal Appeal expires. We can help you write an Authorized Representative letter, or we can mail you an Authorized Representative form for you to complete. For a copy of the form, call the Plan’s Member Services department or Beacon Health Strategies (for Behavioral Health).

What is a Grievance?

You or your Authorized Representative (see description above) have the right to file a Grievance if you are not satisfied with any aspect of BMC HealthNet Plan’s or Beacon Health Strategies’ operations or interactions, or with the quality of care or services you receive from a Provider. A Grievance can also be filed when we:
Section 12. Inquiries, Grievances and Appeals

- Extend the timeframes to process a Prior Authorization request and you, or your Authorized Representative, disagree with those decisions,
- Do not approve your request for an Expedited (fast) Internal Appeal and processes it as a standard Internal Appeal, and/or
- Extend the timeframes to process your Internal Appeal and you, or your Authorized Representative, disagree with those decisions. For an explanation of these timeframes, see the sections “How Long Should It Take to Get an Appointment”, “Services that Require Prior Authorization” and “How Quickly Will You Receive a Decision on Your Internal Appeal?”

When can the Plan or Beacon Health Strategies dismiss your Grievance?
We may dismiss your Grievance if someone else files it on your behalf and we did not receive your written Authorization for that person to serve as your Authorized Representative before our timeframe for resolving your Grievance expires. If this happens, we will send you a Grievance dismissal notification.

How to file a Grievance
You, or your Authorized Appeal Representative, may file a Grievance in writing, over the telephone, or in person. If you want to submit a Grievance over the telephone, you may call:
- Our Member Services department.
- If you, or your Authorized Representative, want to submit a Grievance in writing, please mail it to:
  BMC HealthNet Plan – MassHealth, 529 Main Street, Suite 500, Charlestown, MA 02129, Attention: Member Grievances
  Fax: 617-897-0805

For Grievances related to Behavioral Health services, call the Beacon Health Strategies Behavioral Health Member line at 888-217-3501. Grievances regarding Behavioral Health services can be mailed or filed in person at:
Quality Department – Ombudsman, Beacon Health Strategies, LLC, 500 Unicorn Park Drive, Suite 401, Woburn, MA 01801
Fax: 781-994-7636

If you want to submit a Grievance to BMC HealthNet Plan in person, we are located at:
BMC HealthNet Plan, 529 Main Street, Suite 500, Charlestown, MA 02129
You may also file a Grievance directly with MassHealth by calling MassHealth Member Services at 800-841-2900 (TTY: 800-497-4648), Monday through Friday, from 8 a.m. to 5 p.m., to file a complaint.

How quickly will the Plan or Beacon make a decision on your Grievance?
Once we receive your Grievance, we’ll send you a written acknowledgement of receipt within one business day. We’ll immediately begin to work on resolving your Grievance. We’ll send you and your Authorized Representative a written response within 30 calendar days from the date we received your Grievance.

What do you do if you do not speak English?
If you do not understand English, the Plan or Beacon Health Strategies (for Behavioral Health) will help you with interpreter or translation services during the Grievance process at no cost to you. If you have any questions about the Grievance process, please call the BMC HealthNet Plan Member Services department or Beacon Health Strategies (for Behavioral Health).

What is an Internal Appeal?
You, or your Authorized Appeal Representative, have the right to file an Internal Appeal with BMC HealthNet Plan or Beacon Health Strategies (for Behavioral Health concerns) if you disagree with one of the following Adverse Actions or inactions:
- We denied or decided to provide limited Authorization for a service requested by your healthcare Provider, including the determination that the requested service is not a Covered Service.
- We reduced, suspended or terminated a Covered Service that was previously authorized.
- We denied, in whole or in part, payment for a Covered Service due to service coverage issues.
- We did not make a service Authorization decision within the timeframe described in Section 6.
- We did not notify you of an Internal Appeal decision within the timeframe described in Section 12.
- You’re unable to obtain healthcare services within the timeframes described in Section 8 “Your Healthcare”.

In most instances, you will receive a notice letting you know that one of the actions listed above has occurred. However, you, or your Authorized Representative, may file an Internal Appeal whenever one of these actions occurs, even if you did not receive a notice from BMC HealthNet Plan or Beacon Health Strategies. Parties involved in the Internal Appeal can also include the legal representative of a deceased Member’s estate. Internal Appeal decisions are made by healthcare professionals who have the appropriate clinical expertise and were not involved in the original action that is being appealed or, if the Internal Appeal has multiple levels, were not involved in any of the previous levels of review.
When and how to file a standard Internal Appeal with the Plan or Beacon

We provide Members two levels of Internal Appeal review, a first level and a second level (reviewed by a clinician not involved with your first level Internal Appeal). You, or your Authorized Representative, may file a first level Internal Appeal within 30 calendar days of our notice to you telling you that one of the Adverse Actions described above has occurred. However, if you did not receive a notice from BMC HealthNet Plan or Beacon Health Strategies, you, or your Authorized Representative, may appeal within 30 calendar days of learning on your own that one of the Adverse Actions described above occurred.

You, or your Authorized Representative, may file a first level Internal Appeal in writing, over the telephone, or in person. If you, or your Authorized Representative, want to submit a first level Internal Appeal over the telephone, you may call:

- Our Member Services department.
- Or you may call the Appeals department at (617) 748-6338.

- For Appeals related to Behavioral Health services, call the Beacon Health Strategies Behavioral Health Member line. If you, or your Authorized Representative, want to submit a first level Internal Appeal in writing, please mail it to:

  BMC HealthNet Plan, MassHealth, Suite 500, Charlestown, MA 02129 Attention: Member Appeals, Fax: 617-897-0805

For Appeals related to Behavioral Health services, call the Beacon Health Strategies Behavioral Health Member line. If you want to submit an Internal Appeal pertaining to Behavioral Health services, please mail it to:

  Appeals Coordinator, Beacon Health Strategies, LLC, 500 Unicorn Park Drive, Suite 401, Woburn, MA 01801, Fax: 781-994-7636

If you, or your Authorized Representative, want to submit an Internal Appeal in person, please visit us at the applicable office location.

Oral requests to appeal an action are treated as Appeals (to establish the earliest possible filing date for the Appeal). We will confirm your oral Inquiry in writing, unless you, your Authorized Representative, or your Provider requests an expedited (fast) resolution (decision). Once your first level Internal Appeal is received, an Appeals & Grievances specialist will send you and/or your Authorized Representative a written acknowledgement of receipt within one business day, and will immediately begin to work on resolving your Appeal.

How quickly will you receive a decision on your first level Internal Appeal?

Unless you, or your Authorized Representative, file an Expedited (fast) Internal Appeal, we will resolve your first level Internal Appeal within a total of 20 calendar days from the day we receive it unless you, your Authorized Representative, BMC HealthNet Plan or Beacon Health Strategies requests to extend the timeframe by up to 14 calendar days as described next. We will notify you, or your Authorized Representative, in writing of our decision.

What do you do if you disagree with the decision the Plan or Beacon reached on your first level Internal Appeal?

If you disagree with the decision we reach on your first level Internal Appeal, you, or your Authorized Representative, can either request a second level review of your Internal Appeal through us, or you can skip the second level Internal Appeal review and file an Appeal directly with the Board of Hearings (see “How to File a Board of Hearing Appeal”). If you choose to file with the Board of Hearings, you waive the right to a second level Internal Appeal review.

If you decide to request a second level Internal Appeal review, you, or your Authorized Representative, must file your request with BMC HealthNet Plan or Beacon Health Strategies (for Behavioral Health concerns) within 30 calendar days of receiving the notice of your first level Internal Appeal denial. Once we receive your second level Internal Appeal request, we will send you and your Authorized Representative a written acknowledgement of receipt within one business day. We will immediately begin to work on the second level review of your Internal Appeal and will resolve your second level review within a total of 20 calendar days unless you, your Authorized Representative, or BMC HealthNet Plan or Beacon Health Strategies requests to extend the timeframe by up to 14 calendar days as described below. (BMC HealthNet Plan and Beacon Health Strategies cannot request an extension if we requested an extension during your first level Internal Appeal.)

We will notify you, and your Authorized Representative, in writing of our decision. If you disagree with the decision, you, or your Authorized Representative, can file an Appeal with the Board of Hearings (see “How to File a Board of Hearing Appeal”).

What is an Expedited (fast) Internal Appeal?

BMC HealthNet Plan and Beacon Health Strategies (for Behavioral Health concerns) provide Members with one level of Expedited (fast) Internal Appeal review. You, your Authorized Representative, or your healthcare Provider can request that your Internal Appeal be expedited (processed fast) if you or your healthcare Provider feel that taking the 20 calendar day timeframe for a standard Internal Appeal resolution could seriously jeopardize your life, health or your ability to get, maintain or regain maximum function.

If your Provider is acting as your Authorized Representative, or if your Provider supports the request filed by you or your Authorized Representative, in most cases we will honor the request that your Internal Appeal be treated as an Expedited (fast) Internal Appeal. We may refuse your Provider’s request to expedite (process fast) your Expedited (fast) Internal Appeal request only if it is totally unrelated to your health condition. If your Provider is not involved in your request for an Expedited (fast) Internal Appeal, then we have the right to determine whether or not to process the Appeal as an Expedited (fast) Internal Appeal.
If your request does not qualify for an Expedited (fast) Internal Appeal, we will notify you and your Authorized Representative, in writing, of this decision and process your Internal Appeal within the standard 20 calendar day timeframe. You, or your Authorized Representative, have the right to file a Grievance following the procedures described above if you disagree with this decision not to treat your Internal Appeal as an Expedited (fast) Internal Appeal (see “How to File a Grievance”).

Neither BMC HealthNet Plan nor Beacon Health Strategies will take disciplinary action against a Provider who requests an Expedited (fast) Internal Appeal or supports a Member’s Expedited (fast) Internal Appeal request.

If your Appeal is expedited (fast), it is decided within 72 hours unless the timeframes are extended as described below. We will notify you, and/or your Authorized Representative in writing of the decision. We will also try to contact you by telephone to tell you about the decision. If you, or your Authorized Representative, disagree with the decision that we reach with your Expedited (fast) Internal Appeal, you can file an Appeal with the Board of Hearings (see “How to File a Board of Hearing Appeal”). It is not possible to request a second level Internal Appeal review through BMC HealthNet Plan or Beacon Health Strategies for Expedited (fast) Internal Appeals.

Can Internal Appeal timeframes be extended?
You, or your Authorized Representative, may request to extend the timeframes for resolving standard Internal Appeals by up to 14 calendar days for each level of Internal Appeal. We may request to extend the timeframes for resolving either your first level or second level Internal Appeal by 14 calendar days. You, your Authorized Representative, BMC HealthNet Plan or Beacon Health Strategies may request to extend the timeframes for resolving Expedited (fast) Internal Appeals by up to 14 calendar days. Whenever we choose to extend a timeframe we will send you, and your Authorized Representative, a notice of this decision. If you disagree with the decision, you, or your Authorized Representative, may file a Grievance following the procedures described above (see “How to File a Grievance”). Please note that we can only request an extension if:

- The extension is in your best interest.
- We need additional information that we believe, if received, will lead to approval of your request.
- Such outstanding information is reasonably expected to be received within the five or 14 calendar days extension timeframe.

When can the Plan or Beacon dismiss your Internal Appeal?
We may dismiss your Internal Appeal if:

- Someone else files an Internal Appeal on your behalf and we do not receive your written Authorization for that person to serve as your Authorized Representative before the timeframe for resolving your Internal Appeal expires. A written Authorization is not required for Expedited Appeals; OR
- You, or your Authorized Representative, filed the Standard or Expedited (fast) Internal Appeal more than 30 calendar days after the notice from BMC HealthNet Plan or Beacon Health Strategies telling you that you had a right to Appeal (or, if you did not receive such a notice, more than 30 calendar days after learning on your own about our actions or inactions that give you a right to Appeal); OR
- You, or your Authorized Representative, filed the second level review of your Internal Appeal more than 30 calendar days after the notice from BMC HealthNet Plan or Beacon Health Strategies telling you about our decision to uphold your first level Internal Appeal.

We will send you and/or your Authorized Representative an Internal Appeal dismissal notification.

Can an Internal Appeal dismissal be disputed?
If you, or your Authorized Representative, believe that you indeed requested your Internal Appeal within 30 calendar days and have supporting evidence, you, or your Authorized Representative, have the right to dispute our Appeal dismissal and request that we continue with your Appeal. To do so, you, or your Authorized Representative, must submit a letter to BMC HealthNet Plan or Beacon Health Strategies (for Behavioral Health concerns) requesting reconsideration of the dismissal within 10 calendar days of the Internal Appeal dismissal notice. We will review your request for reconsideration of dismissal and notify you and/or your Authorized Representative of our decision.

Continuing Services during your Internal Appeal
If your Internal Appeal involves a decision by us to modify a previously authorized service, including a decision to reduce, suspend, or terminate a service, you can choose to continue receiving the requested services from BMC HealthNet Plan or Beacon Health Strategies during the Internal Appeal process. But if you lose the Appeal, you may have to pay back the cost of these services. If you want to receive Continuing Services, you and/or your Authorized Representative must:

- Submit your (Standard first level or Expedited (fast)) Internal Appeal request within 10 calendar days from the date of our notice that we have decided to modify a previously authorized service or submit your second level standard Internal Appeal request within 10 calendar days from the date of our notice that we have decided your first level Internal Appeal; and
- Indicate in your request that you want to continue to get these services.
Section 12. Inquiries, Grievances and Appeals

Your rights during the Internal Appeal process
We will provide you, or your Authorized Representative, a reasonable opportunity to present evidence and allegations of fact or law, in person and in writing, as well as allow you, or your Authorized Representative, to access your files before as well as during the Internal Appeal process. If you do not understand English, we will help you with interpreter or translation services during the Internal Appeal process at no cost to you.

What if we do not resolve your Standard/Expedited Internal Appeal within the required timeframes?
If we do not resolve your (first or second level) standard Internal Appeal within 20 calendar days (or within five additional calendar days if we take an extension), you, or your Authorized Representative, can file your Appeal with the Board of Hearings.

How to file a Board of Hearings Appeal
You, or your Authorized Representative, have the right to request a hearing before a hearing officer at the Executive Office of Health and Human Services, Office of Medicaid’s, Board of Hearings. You may file a hearing request within 30 calendar days of the Plan’s or Beacon’s notification of a standard or Expedited (fast) Internal Appeal decision if you, or your Authorized Representative, disagree with the decision that we reach when we resolve your:
- first level standard Internal Appeal and you choose to skip our second level Internal Appeal;
- second level standard Internal Appeal; OR
- Expedited (Fast) Internal Appeal.

We will include the request for fair hearing form and other instructive material that you, or your Authorized Representative, need to request a fair hearing in the written decision resolving your Internal Appeal. We will also assist you, or your Authorized Representative, in completing the application.

How do you get an Expedited (fast) fair hearing at the Board of Hearings?
If you, or your Authorized Representative, are appealing a decision resolving an Expedited (fast) Internal Appeal and you, or your Authorized Representative, must submit the fair hearing request within 20 calendar days from the date of the decision. If you, or your Authorized Representative, file between 21 and 30 calendar days, the Board of Hearings will process your Appeal within the standard Board of Hearings Appeal timeframe.

Continuing Services during your fair hearing at the Board of Hearings
If your Board of Hearings Appeal involves a decision by BMC HealthNet Plan or Beacon Health Strategies to modify a previously authorized service, including a decision to reduce, suspend, or terminate a service, you can choose to continue receiving the requested services during the Board of Hearings Appeal process. But if you lose the Appeal, you may have to pay back the cost of these services. If you want to receive Continuing Services during the Board of Hearings process, you, or your Authorized Representative, must submit your Board of Hearings Appeal request within ten (10) calendar days from the date of the decision resolving your Internal Appeal. If you do not want to keep getting the requested services during your Board of Hearing Appeal, you must check Box A in Section III of the fair hearing form.

What rights do you have during the Board of Hearings Appeal process?
BMC HealthNet Plan and Beacon Health Strategies (for Behavioral Health concerns) will allow you, or your Authorized Representative, to access your files during the Board of Hearings Appeal process. At the hearing, you may represent yourself or be accompanied by an Authorized Representative or an attorney, acting as your Authorized Representative, at your own expense. Parties may also include the legal representative of a deceased Member’s estate. We will implement the Board of Hearings Appeal decision immediately. If you do not understand English and/or are hearing or sight impaired, the Board of Hearings will make sure that an interpreter and/or assisting device is available for you at the hearing. If you have any questions about the Board of Hearings Appeal process, please call the BMC HealthNet Plan or Beacon Health Strategies (for Behavioral Health concerns) Member Services department.

Section 13. Notice of Privacy Practices
This Notice describes how health information about you may be used and communicated, and how you can get this information. Please review this Notice of Privacy Practices carefully. If you have any questions, please call our Member Services department. The Notice of Privacy Practices is effective September 23, 2013 and supersedes all previous Notices of Privacy Practices. 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. It also describes your rights to access and control your Protected Health Information. Protected Health Information or PHI is information about you, including demographic information, that may identify you and that relates to your health condition and/or related 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 of Privacy Practices, 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 of Privacy Practices 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 of Privacy Practices currently in effect.

**We May Use and Communicate Protected Health Information (PHI) about You**

**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 Administration:** 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.
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 if we did not create the information, or if we believe the current information is correct.

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 losses, and protect against further breaches; and
- 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

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; (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 if we did not create the information, or if we believe the current information is correct.

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 losses, and protect against further breaches; and
- 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
Section 13. Notice of Privacy Practices

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

If you have any questions or would like a copy of this Notice of Privacy Practices, please contact our Member Services department.
1-888-566-0010 (English and other languages), or 1-888-566-0012 (Spanish)
BMC HealthNet Plan, 529 Main Street, Suite 500, Charlestown, MA 02129
Website: bmchp.org

Section 14. Notice About Nondiscrimination and Accessibility Requirements

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)
Section 14. Notice About Nondiscrimination and Accessibility Requirements

- 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, 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.

Section 15. Advance Directives

Advance Directives are legal documents that allow you to share your decisions about end-of-life care ahead of time. Advance Directives provide a way for you to communicate your wishes to family, friends and healthcare professionals, and to avoid confusion. An Advance Directive allows you to legally express in writing your healthcare wishes in case you can’t do so if you are seriously sick or injured. There are two kinds of Advance Directives: a Living Will and a Healthcare Proxy.

Living Will
The Living Will lists medical procedures/types of healthcare that you do or do not want under certain circumstances if you become seriously sick or injured. An example would be if you decided that you don’t want to be kept alive using life support if you became very ill.

Healthcare Proxy
A Healthcare Proxy is a document that lets you name someone to make decisions about your medical care — including decisions about life support — if you can no longer speak for yourself. This person would carry out the wishes you described in your “living will.” This person becomes known as your Healthcare "Agent" or “Proxy.” Once you set up your Advance Directives, you can change your mind at any time. To get the Healthcare Proxy and Living Will forms, you can visit BMC HealthNet Plan’s website at bmchp.org. BMC HealthNet Plan can also mail the forms to you. Call the Plan’s Member Services department.
Voluntary Disenrollment

Depending on the circumstances, you may choose to end your coverage with us. To disenroll from BMC HealthNet Plan, call MassHealth Member Services. Voluntary Disenrollments are usually effective one business day after BMC HealthNet Plan gets the request from MassHealth. There are different types of voluntary disenrollments that may affect whether you can leave the Plan. These are outlined below:

Voluntary Disenrollment during a Plan Selection Period

During a MassHealth Plan Selection Period (PSP), you may end your coverage with us at any time. The PSP is the annual 90-day period for individuals enrolled in a MassHealth managed care organization (MCO) health plan. A helpful guide to the PSP is below.

If you’re happy with your current plan you don’t need to do anything.

These changes do not apply to children in the care or custody of the Department of Youth Services or the Department of Children and Families. They can choose another health plan at any time.

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 1, 2016</td>
<td>Start of Plan Selection Period.</td>
</tr>
<tr>
<td>December 31, 2016</td>
<td>Last day to change your health plan for any reason.</td>
</tr>
<tr>
<td>January 1, 2017</td>
<td>Start of Fixed Enrollment Period. Members enrolled in an MCO cannot change their health plan until the next Plan Selection Period on October 1, 2017, except for certain reasons.</td>
</tr>
</tbody>
</table>

If you are enrolled in an MCO health plan on or BEFORE October 1, 2016

Your Plan Selection Period starts on the day you’re enrolled in a MCO Health Plan

MassHealth will send you a letter letting your know your Plan Selection Start Date. For example, if you enroll in an MCO health plan on November 3, that is the start of your Plan Selection Period.

Your Plan Selection Period is for 90 days

For example, if your Plan Selection Period started on Nov. 3, you have until Jan. 30 (90 days) to change your health plan for any reason.

Your Fixed Enrollment Period starts when your Plan Selection Period Ends

MassHealth will send you a letter letting your know your Fixed Enrollment Period has started. For example, if your Plan Selection Period was from Nov. 3 – Jan 30. Your Fixed Enrollment Period starts Feb. 1 (90 days and you can only change your health plan if you meet a special exception.

During this time, you can choose a health plan or switch your health plan for any reason. To disenroll from BMC HealthNet Plan, call MassHealth Member Services. Voluntary Disenrollments are usually effective one business day after BMC HealthNet Plan gets the request from MassHealth. BMC HealthNet Plan will continue to provide coverage for:

- Covered Services through the date of Disenrollment
- Any custom-ordered equipment approved prior to Disenrollment, even if not delivered until after Disenrollment

Voluntary Disenrollment outside of a Plan Selection Period

You may only request disenrollment from BMC HealthNet Plan outside of your PSP if you have cause. At any time, you may request a transfer out of BMC HealthNet Plan for any of the reasons listed below.

(a) The following reasons defined as for cause disenrollment:
  1. you need related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within our network; and your primary care provider or another provider determines that receiving the services separately would subject you to unnecessary risk; or
  2. other reasons, including but not limited to
Section 16. Disenrollment

(a) poor quality of care, lack of access to services covered, or lack of access to providers experienced in dealing with your health-care needs;
(b) BMC HealthNet Plan is longer contracted with the MassHealth agency to cover your service area;
(c) you adequately demonstrate to the MassHealth agency that BMCHP has not provided access to providers that meet your health care needs over time, even after you request assistance;
(d) you are homeless, the MassHealth agency’s records indicate you are homeless, and BMCHP cannot accommodate the geographic needs;
(e) you adequately demonstrate to the MassHealth agency that BMCHP substantially violated a material provision of its contract with the MassHealth agency;
(f) the MassHealth agency imposes a sanction on BMCP that specifically allows for members to disenroll from the MCO without cause;
(g) you adequately demonstrate to the MassHealth agency that BMCHP is not meeting your language, communication, or other accessibility needs or preferences; or
(h) you adequately demonstrate to the MassHealth agency that key network providers, including PCPs, specialists, or behavioral health providers, leave BMCHP’s network.

Disenrollment for loss of Eligibility
If you become ineligible for MassHealth coverage, MassHealth will disenroll you from BMC HealthNet Plan. You will no longer be eligible for coverage by BMC HealthNet Plan as of the date of your MassHealth Disenrollment. You may automatically be re-enrolled in BMC HealthNet Plan if you become eligible again for MassHealth within 6 months, as determined by MassHealth.

Disenrollment for cause
BMC HealthNet Plan will not request to disenroll a Member due to an adverse change in a Member’s health status or because of a Member’s utilization of medical services, diminished mental capacity or uncooperative or disruptive behavior resulting from his or her special needs. There may be instances where BMC HealthNet Plan may submit a written request to MassHealth to disenroll a Member from the Plan. MassHealth will determine when and if BMC HealthNet Plan’s request will be granted. If you are disenrolled from BMC HealthNet Plan, MassHealth will send you written notification of Disenrollment. You also will be contacted by MassHealth to choose another health plan.

Section 17. Coordination of Benefits/Subrogation

You must tell us if you have any other health insurance coverage in addition to MassHealth. You must also let us know whenever there are any changes in your additional insurance coverage. The types of additional insurance you might have include:
- Coverage from an employer’s group health insurance for employees or retirees, either for yourself or your spouse
- Coverage under workers’ compensation because of a job-related illness or injury
- Coverage for an accident where no-fault insurance or liability insurance is involved
- Coverage you have through veteran’s benefits
- “Continuation coverage” that you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their Dependents keep their group health coverage for a time after they leave their group health plan under certain conditions.)

BMC HealthNet Plan is the payer of last resort for payment of medical services involving Coordination of Benefits and third-party-liability or Subrogation. Please see the following sections for more information.

Coordination of Benefits
When you have other health insurance coverage, we work with your other insurance to coordinate your BMC HealthNet Plan benefits. The way we work with the other companies depends on your situation. This process is called Coordination of Benefits. Through this benefit coordination, you will often get your health insurance coverage as usual through us. If you have other health insurance, our coverage will always be secondary when the other plan provides you with healthcare coverage, unless the law states something different. In other situations, such as for benefits that are not covered by BMC HealthNet Plan, you may be able to get your care covered by an insurer other than us. If you have additional health insurance, please call us at 617-748-6188 to find out how payment will be handled.

Motor vehicle accidents and/or work-related injury/illness
If you are in a motor vehicle accident, you must use all of your auto insurance carrier’s medical coverage (including personal injury protection (PIP) and/or medical payment coverage) before we will consider paying for any of your expenses. You must send to us any explanation of payment or denial letters from an auto insurance carrier for us to consider paying a Claim that your Provider sends to us. In the case of a work-related injury or illness, the workers’ compensation carrier will be responsible for those expenses first. You must send to us any explanation of payment or denial letters from an auto insurance carrier for us to consider paying a Claim that your Provider sends to us.
Subrogation
If you are injured by the act or omission of another person, your BMC HealthNet Plan benefits will be subrogated. This means that we may use your right to recover money from the person(s) who caused the injury or from any insurance company or other party. If another person or party is, or may be, liable to pay for services related to your illness or injury that may have been paid for or provided by us, we will subrogate and succeed to all your rights to recover against such person or party 100 percent of the value of services paid for or provided by us. Claims incurred as a result of any Subrogation case should be submitted before any settlement. Claims for services rendered before a settlement that are not submitted before that settlement is reached may be denied.

In the event another party reimburses any medical expense we pay for, we will be entitled to recover from you 100 percent of the amount you got for such services from us. The amount you must pay back to us will not be reduced by any attorney’s fees or incurred expenses. To enforce our Subrogation rights under this Member handbook, we will have the right to take legal action, with or without your consent, against any party to secure recovery of the value of services provided or paid for by us for which that party is, or may be, liable. Nothing in this handbook will be interpreted to limit our right to use any remedy provided by law to enforce its rights to Subrogation under this Member handbook. We require you to follow all Prior Authorization requirements even when third-party-liability exists. Authorization is not a guarantee of payment.

Member Cooperation
As a Member of BMC HealthNet Plan, you agree to cooperate with us in exercising our rights to Subrogation and Coordination of Benefits. This means you must complete and sign all necessary documents to help us exercise our rights. This also means that you must give us notice before settling any Claim arising out of injuries you sustained by any liable party(s) for which we have provided coverage. You must not do anything that might limit our right to full reimbursement. These Subrogation and recovery provisions apply, whether or not the Member recovering money is a minor. We ask that you:

- Give us all information and documents we request
- Sign any documents we think are necessary to protect our rights
- Promptly assign us any money gotten for services for which we’ve provided or paid
- Promptly notify us of any possible Subrogation or benefit coordination potential

You also must agree to do nothing to prejudice or interfere with our rights to Subrogation or benefit coordination. Nothing in this Member handbook may be interpreted to limit our right to use any means provided by law to enforce our rights to Subrogation or benefit coordination under this plan.
Advance Directive – A written statement that tells a Provider what to do if an illness or accident takes away the Member’s ability to make decisions about his or her healthcare.

Adverse Action – The following actions or inactions by BMC HealthNet Plan or Beacon Health Strategies:

1. Denying or limiting coverage of a requested healthcare service;
2. Reducing or stopping coverage for a service that was previously approved;
3. Denying payment for a service because it was not Medically Necessary;
4. Not responding to an Authorization request in a timely manner;
5. Not being able to get healthcare within required timeframes; and
6. Not resolving an Appeal request within required timeframes.

Appeal – A request by a MassHealth Member/Authorized Representative to BMC HealthNet Plan or Beacon Health Strategies or the Office of Medicaid’s Board of Hearings for review of an action or inaction by the Plan.

Authorization – A special approval by BMC HealthNet Plan or Beacon Health Strategies for payment of certain Covered Services that is done prior to receiving the services.

Authorized Representative – someone authorized by you in writing to act on your behalf regarding a specific Grievance or Appeal.

Beacon Health Strategies – A partner of BMC HealthNet Plan that manages and coordinates the Behavioral Health (mental health and substance abuse) services for Members and manages the Behavioral Health Provider Network.

Behavioral Health – Mental health and substance abuse services.

BMC HealthNet Plan (the Plan) – A Managed Care organization providing coverage to MassHealth (Medicaid) and CommonwealthCare members. The Plan contracts with Providers and hospital systems throughout Massachusetts to deliver care to Members statewide.

BMC HealthNet Plan Network Provider – A Provider with which BMC HealthNet Plan has an agreement to provide Covered Services to Members.

Board of Hearings – the Board of Hearings within the Executive Office of Health and Human Services’ Office of Medicaid.

Board of Hearings (BOH) Appeal – A written request to the BOH, made by a Member or Authorized Representative to review the correctness of a Final Internal Appeal decision by BMC HealthNet Plan or Beacon Health Strategies.

Care Management – A program offered by BMC HealthNet Plan and Beacon Health Strategies (for Behavioral Health) to our Members who are most in need of assistance with managing multiple situations, services, and/or Providers at one time. The situations may be medical, behavioral, social and/or environmental in nature. The services may be preventive, wellness, disease, treatment or housing related. The Providers may include your or a family member’s PCP, Specialists, other healthcare Providers – such as home healthcare agencies – as well as staff from state agencies.

The BMC HealthNet Plan Care Management Program consists of four distinct program categories that provide services for our Members. The four program categories are Care Management Education and Wellness, Care Management Healthcare Coordination, Medical Complex Care Management, and Intensive Clinical Management (ICM).

Child Adolescent Needs and Strengths (CANS) Tool – A tool that provides a standardized way for Behavioral Health Providers to organize information gathered during Behavioral Health clinical assessments for Members under the age of 21 and during the discharge planning process from inpatient psychiatric hospitalizations and community based acute treatment services.

Children’s Behavioral Health Initiative (CBHI) – The Children’s Behavioral Health Initiative is an inter-agency initiative of the Commonwealth of Massachusetts’ Executive Office of Health and Human Services whose mission is to strengthen, expand and integrate Massachusetts state services into a comprehensive, community-based system of care, to ensure that families and their children with significant behavioral, emotional and mental health needs obtain the services necessary for success in home, school and community.

Claim – A bill from a Provider that describes the services that have been provided to a Member.

Clinical Practice Guidelines – Standards for care that BMC HealthNet Plan and Beacon Health Strategies use with its Provider Network to make sure that Members are getting the best care.

Community Service Agency (CSA) – There are 32 CSA’s across the state offering care coordination services to MassHealth eligible youth with serious emotional disturbance (SED) and their families/caregivers.

Continuity of Care – The process that ensures that Members do not have disruptions in their medical or Behavioral Healthcare due to switching health plans or Provider changes.

Continuing Services – The process of continuing to receive certain services from BMC HealthNet Plan or Beacon Health Strategies during an Appeal.

Coordination of Benefits – The process that BMC HealthNet Plan uses to work with any other health insurers Members may have.

Co-payment – Payments made by Members at the time of care.
Covered Services – The services and supplies covered by BMC HealthNet Plan and MassHealth described in the Covered and Excluded Services list in this Member handbook.

Dependent – A person who gets health coverage through another person, such as a spouse, parent, or grandparent.

Disenrollment – The process by which a Member’s BMC HealthNet Plan coverage ends.

Effective Date – The date on which an individual becomes a Member of BMC HealthNet Plan and is eligible for Covered Services. Generally one business day after BMC HealthNet Plan receives notification of Enrollment from MassHealth.

Eligibility – MassHealth enrollees qualified to receive MassHealth health coverage.

Emergency – A medical condition, whether physical 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 an Enrollee 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. § 1395dd(e)(1)(B).

Eligibility Determination – The process through which BMC HealthNet Plan determines whether an individual is eligible to receive Covered Services.

Enrollment – The process by which BMC HealthNet Plan registers individuals for membership.

EPSDT (Early and Periodic Screening, Diagnostic and Treatment) Services – Preventive care and treatment services provided by a Primary Care Provider on a periodic schedule. The schedule is determined by the age when each procedure is to be provided and includes a complete assessment (e.g. health screens), service coordination, crisis intervention and in-home services.

Expedited (fast) Internal Appeal – A 72-hour Appeal process.

Family Planning Services – Services directly related to preventing conception. They include birth control counseling, education about family planning, examination and treatment, laboratory examinations and tests, medically approved methods and procedures, pharmacy supplies and devices, sterilization, including tubal ligation and vasectomy. (Abortion is not a Family Planning Service.)

Final Internal Appeal – The second-level review of an Internal Appeal or, for a Member, or a Member’s Appeal Representative, who waives the second-level Internal Appeal, the first-level review of an Internal Appeal.

Fraud – An intentional deception or misrepresentation made by a person or corporation with the knowledge that the deception could result in some unauthorized benefit under the MassHealth program to himself or herself, the corporation or some other person. An example of Fraud is Members lending their BMC HealthNet Plan ID card to others so they can get healthcare or pharmacy services. Guiltance – A statement by a Member of dissatisfaction with care or services received.

Healthcare Agent or Proxy – The individual responsible for making healthcare decisions for a person in the event that person is unable to make decisions for him/her self.

Health Needs Assessment (HNA) – A questionnaire about a Member’s current health situation that helps BMC HealthNet Plan and Beacon Health Strategies provide the right care to Members.

Inpatient – Services requiring at least one overnight stay and generally applies to care in facilities such as hospitals and skilled nursing facilities.

Inquiry – Any question a Member has about BMC HealthNet Plan’s or Beacon Health Strategies’ operations.

Intensive Clinical Management (ICM) – A Care Management program provided by Beacon Health Strategies. ICM care managers, through collaboration with Members and their treatment Providers, work to ensure the coordination and optimization of care; assessment, care planning, discharge planning and mobilization of resources to Members who are dealing with Behavioral Health or psychosocial conditions, sometimes along with medical concerns.

Internal Appeal – A verbal or written request for BMC HealthNet Plan or Beacon Health Strategies to review an Adverse Action.

Living Will – A document that lists medical procedures that you do, or do not, want under certain circumstances if you become seriously sick or injured.

Managed Care – A system of healthcare delivery that is provided and coordinated by a Primary Care Provider (PCP). The goal is a system that delivers value by providing access to quality, cost effective healthcare.

MassHealth – A healthcare program operated by the Massachusetts Executive Office of Health and Human Services (“EOHHS”). In Massachusetts, the national health insurance program called Medicaid is called MassHealth. BMC HealthNet Plan covers MassHealth Members under the Standard, CommonHealth, Family Assistance and MassHealth CarePlus plans.

MassHealth CommonHealth – A MassHealth benefit plan that offers health benefits to certain disabled children under age 18, and certain working or non-working disabled adults between the ages of 18 and 64.

MassHealth Family Assistance – A MassHealth benefit plan that offers health benefits to certain eligible Members, including families and children under the age of 18.

MassHealth Standard – A MassHealth benefit plan that offers a full range of health benefits to certain eligible Members, including families, children under 18, pregnant women, and disabled individuals under age 65.
MassHealth CarePlus – individuals between the ages of 21 and 64 who qualify under MassHealth CarePlus eligibility criteria.

Medicare Part D – As a BMC HealthNet Plan MassHealth Member with Medicare coverage, your prescription drug benefit may be covered by a Medicare Prescription Drug Coverage (Part D) plan. Most of your prescription drugs will be covered under your Medicare Part D benefit.

Medically Necessary Services – those services 1) which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct or cure conditions in the Member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and 2) for which there is no comparable medical service or site of service available or suitable for the Member requesting the service that is more conservative or less costly; and 3) are of a quality that meets generally accepted standards of medical care.

Member – Any person enrolled in BMC HealthNet Plan and MassHealth.

Member ID Card – The card that identifies an individual as a Member of BMC HealthNet Plan. The Member ID Card includes the Member’s identification number and information about the Member’s coverage. Members will also receive an ID Card from MassHealth. Both ID Cards must be shown to Providers before receiving care.

Network – The group of Providers contracted by BMC HealthNet Plan to provide healthcare services to Members.

Notice of Privacy Practices – A detailed statement about how Member health information can and cannot be used.

Nurse Advice Line – A 24 hour/7 day a week telephone line that BMC HealthNet Plan Members can call to speak to a trained nurse about health questions.

Post Stabilization care – Care received following an Emergency situation.

PPHSD – Preventive Pediatric Healthcare Screening and Diagnosis. These are preventive care and treatment services that BMC HealthNet Plan covers for MassHealth Members under the age of 21 who are part of the Family Assistance plan.

Primary Care Provider (PCP) – A doctor or nurse practitioner selected by the Member or assigned by BMC HealthNet Plan to provide and coordinate a Member’s healthcare needs. Other healthcare Providers, such as registered nurses, physician’s assistant or nurse midwives, acting on behalf of and in consultation with a PCP, may provide Primary Care Services.

Prior Authorization – Approval given by BMC HealthNet Plan or Beacon Health Strategies for certain Provider visits or healthcare services in order for these to be covered. This approval must be obtained by your Provider before you go to certain Providers or before you get certain healthcare services.

Protected Health Information (PHI) – Information about you that may identify you and that relates to your health condition and/or related healthcare services.

Provider – A healthcare professional or facility licensed as required by state law. Providers include doctors, hospitals, laboratories, pharmacies, skilled nursing facilities, nurse practitioners, registered nurses, psychiatrists, social workers, licensed mental health counselors, clinical Specialists in psychiatric and mental health nursing, licensed alcohol and drug counselors, and others. BMC HealthNet Plan will only cover services of a Provider if those services are covered benefits and within the scope of the Provider’s license.

Provider Directory – An online search tool or printed booklet containing a list of BMC HealthNet Plan’s affiliated medical facilities and professionals, including Primary Care Providers, Specialists and Behavioral Health Providers.

Quality Improvement – A program designed to identify ways to improve the quality of care that Members receive.

Referral – A recommendation to receive care from a Provider.

Region – MassHealth divides the state into five geographic regions. Your region is the part of the state that you live in and also where you should choose a Primary Care Provider.

Routine Care – Care that is not Emergency or Urgent Care. Examples of Routine Care are physical exams and well-child care visits.

Second Opinion – The process by which a Member seeks an evaluation by another Provider to confirm the diagnosis and treatment plan of their primary Provider.

Service Area – The geographical area approved by MassHealth within which BMC HealthNet Plan has developed a Network of Providers to provide adequate access to Covered Services.

Specialist – A Provider who is trained and certified by the state of Massachusetts to provide specialty services. Examples include cardiologists, obstetricians and dermatologists.

Subrogation – The procedure under which BMC HealthNet Plan can recover the full or partial cost of benefits paid from a third person or entity, such as an insurer.

Urgent Care – Medical care required quickly to prevent a worsening of health due to symptoms that a prudent layperson would believe are not an Emergency but do require medical attention. Urgent Care does not include Routine Care.

Utilization Management – The process by which BMC HealthNet Plan reviews the clinical necessity, appropriateness, or efficiency of Covered Services, procedures, or settings.