BOSTON MEDICAL CENTER
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BMC HEALTHNET PLAN

MEMBER HANDBOOK

A list of your member benefits and services (*Covered Services List*) is included as a separate document. Make sure you keep this *Member Handbook* and the *Covered Services List* together.

INTRODUCTION

Welcome to BMC HealthNet Plan (the Plan)! This Member handbook will help you understand the benefits and Covered Services you get as a Plan Member. It will also explain how to contact us if you have any questions.

You can call BMC HealthNet Plan's Member services department to have a Spanish version of this Member handbook sent to you. Or, call to have this Member handbook read to you in any language. All written materials sent to Members are available in Spanish. They can also be read to you in any language. Call the Member services department at the number at the bottom of each page:

- For copies of materials in Spanish
- For oral (spoken) translations into other languages
- To have written materials read to you
- To receive a copy of this Member handbook in braille, large font or to request American Sign Language video clips.

All translation services for Members are free of charge.

English and Spanish versions of this Member handbook are also available on our Web site, bmchp.org.

Some words in this Member handbook have special meaning. These words are capitalized throughout the handbook. You can look up the meaning of these words in the glossary in section 15 of the Member handbook.

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For a list of your Member benefits and Covered Services, see the *Covered Services list* included with this *Member handbook*.

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SECTION 1

Overview of Your BMC HealthNet Plan Membership

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 health care and coordinate your care with Specialists, if necessary. You can choose your PCP from BMC HealthNet Plan's Provider Network. See section 5 of this Member handbook for more information about PCPs.

New Member orientation

BMC HealthNet Plan 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 customer service 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. You can find contact information at the bottom of every page in this handbook.*

Doctors and other healthcare Providers near you

We contract with doctors, hospitals, pharmacies, Behavioral Health and other healthcare Providers throughout most 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 health care.

You can find out more information about 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
- Primary Care Providers (PCPs)
- Hospitals
- Specialty Providers
- 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, 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, call our Member services department

Provider information

If you want more Provider information -- such as any malpractice, medical school or residency information -- contact the Massachusetts Board of Registration of 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 customer service center. The numbers are at the bottom of every page of this handbook.

About your Enrollment options

If you have questions about your health plan enrollment options with MassHealth – including BMC HealthNet Plan – please call the MassHealth customer service center. The number is at the bottom of the page. You may change your Managed Care plan at any time

Special help if you have certain health conditions

BMC HealthNet Plan offers special health programs to Members with certain health conditions. For example, we have programs for Members with:

- asthma
- cancer
- congestive heart failure
- depression
- diabetes
- high blood pressure
- HIV/AIDS
- obesity
- or who are pregnant

See Section 8 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 health care Provider to manage your care.

Get more!
Members of BMC HealthNet Plan get all the benefits that MassHealth provides. **See your *Covered Services list* in this handbook for a list of your BMC HealthNet Plan benefits**. Plus BMC HealthNet Plan Members get:

- Free health care information from highly trained registered nurses through our 24-hour Nurse Advice Line
- Free infant/toddler car seats
- Free bicycle helmets for kids
- Free manual breast pumps for nursing mothers

SECTION 2

Your BMC HealthNet Plan ID Card

A BMC HealthNet Plan Member ID Card will be mailed to you
Every BMC HealthNet Plan Member receives a BMC HealthNet Plan identification (ID) Card (ID Card) like the one shown below. 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 customer service 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 6 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 Web site, bmchp.org. Call MassHealth to order a new Mass Health card. The number is below. 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. The number is at the bottom of this page. We will verify your Eligibility for the Provider.

SECTION 3

Contacting your Providers, contacting us

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.
- 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. You will find the phone number at the bottom of this page.
- Our Web site, bmchp.org, contains a lot of important information, such as:
    - o *Find out about your coverage*
    - o *Search for a*

BMC HealthNet Plan Member Services Department
8:00 a.m. – 6:00 p.m., (Eastern Time) Monday-Friday 1.888.566.0010 (English and other languages) • 1.888.566.0012 (en Español) • 1.866.765.0055 (TTY/TDD for hearing impaired) • 1.800.421.1220 (relay operator for hearing impaired) • 1.888.217.3501 (Behavioral Health: mental health and substance abuse questions 24 hours a day/7 days a week managed by Beacon Health Strategies) • 1.888.727.9441 (Behavioral Health TTY/TDD for hearing impaired) • 1.800.973.6273 (Nurse Advice Line) • **Web Site** www.bmchp.org • www.beaconhealthstrategies.org (Behavioral health)

MassHealth Customer Service
8:00 a.m. – 5:00 p.m., Monday-Friday
1.800.841.2900 • 1.800.497.4648 (TTY/TDD for hearing impaired)

healthcare Provider
- o *Find a provider's hospital affiliation*
- o *Find health information*
- o *Read our Member newsletter*
- o *Find a pharmacy near you*

You may also send an e-mail to us from our Web site, 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 1-866-765-0055) or
MassHealth at 1-888-841-2900 (TTY/TDD 1-800-497-4648).

- ***Benefits questions***
  - o Refer to your Covered Services list in this handbook for more information about your benefits. Your Covered 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. The number is at the bottom of the page.
  - o 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 1-866-765-0055) or MassHealth at 1-888-841-2900 (TTY/TDD 1-800-497-4648).

- ***Health-related questions***
  - o 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 6 for more information on Emergency care.) Remember to call your PCP about your Emergency as soon as possible.
  - o 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.
  - o 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 health care 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 get 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 4

Your Benefits

How to obtain your benefits

The *Covered Services* list in this *Member handbook* shows that BMC HealthNet Plan covers most of your benefits. But MassHealth also directly covers some benefits even though BMC HealthNet Plan may coordinate them. That's why you should always carry both your BMC HealthNet Plan and MassHealth ID Cards.

Always check your *Covered Services* list to see what services are covered and what services are not covered. And, always show your BMC HealthNet Plan 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 health care 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 6 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 BMC HealthNet Plan before you visit most Specialists in BMC HealthNet Plan's 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, described below, where your PCP or Specialist does need to get Prior Authorization from BMC HealthNet Plan before you see a Specialist within BMC HealthNet Plan's 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
- Children's Hospital (all locations)
- Mount Auburn Hospital
- St. Elizabeth's Medical Center
- Tufts Medical Center
- Women and Infants Hospital of Rhode Island

When prior authorization is required, it will be granted for specialty care with specialists affiliated with the above 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:

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
- 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 health care 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 Authori-

If you would like to go to a Network Specialist affliated with:	Does my PCP or Network Specialist have to get Prior Authorization from BMC HealthNet Plan before I visit this network Specialist?	Will BMC HealthNet Plan approve a Prior Authorization for my visit?
Boston Medical Center	NO	NOT APPLICABLE
the same hospital as my PCP	NO	NOT APPLICABLE
any network hospital - **except** those hospitals listed in the box below	NO	NOT APPLICABLE
• Beth Israel Deaconess Medical Center-(all locations) • Carney Hospital • Children's Hospital-(all locations) • Mount Auburn Hospital • St. Elizabeth's Medical Center • Tufts Medical Center • Women and Infants Hospital of Rhode island	YES* (* Unless the network specialist is affiliated with the same hospital as your PCP.)	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 the Member's PCP

zation from BMC HealthNet Plan, 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 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 disagree 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 10 “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 10 “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 10 “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 BMC HealthNet Plan is unable to provide a specific covered service through a

BMC HealthNet Plan Network Provider. Requests must go through the Prior Authorization process described above. If BMC HealthNet Plan determines that the specific covered service is medically necessary and not available through a BMC HealthNet Plan Network provider, BMC HealthNet Plan will adequately cover the service in a timely manner with an out-of-Network Provider for as long as the service is medically necessary and not available through a BMC HealthNet Plan 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 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 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
Two Copley Place, Suite 600
Boston, MA 02116

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 BMC HealthNet Plan 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 BMC HealthNet Plan or 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 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.
- Manual breast pumps – A nursing mother needs a prescription from her healthcare Provider for a manual breast pump. Call the Member services department to find out how to get the manual breast pump.
- 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

BMC HealthNet Plan reviews 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 5

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 BMC HealthNet Plan must have a PCP. If everyone 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. Your PCP's name is on your BMC HealthNet Plan ID Card. 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 7 for information on how often to see your healthcare Provider.

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 health care 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, BMC HealthNet Plan will pay for your Second Opinion visit.

SECTION 6

Your Health Care

Emergencies and Urgent Care

Emergencies*

Whether you have a medical Emergency or a Behavioral Health Emergency, you should seek immediate care when there's no time to call your health care Provider.

You do not need approval from your health care 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 BMC HealthNet 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.

Examples of medical Emergencies

- Broken bones
- Throwing up continuously
- Throwing up blood
- Convulsions
- Chest pain
- Fainting or dizzy spells
- Heart attacks
- Loss of consciousness
- Poisoning
- Serious accidents
- Severe burns
- Severe pain
- Severe headaches
- Severe wounds
- Heavy bleeding
- Shortness of breath
- Stroke (this includes numbness or difficulty with speech)
- Sudden change of vision
- 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 for 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 Health care

Choosing Behavioral Health services

BMC HealthNet Plan has partnered with Beacon Health Strategies (Beacon) to manage and coordinate the 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.

Behaviroal 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, like diversionary and inpatient, must be authorized in advance for them to be covered. The Covered 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 (see the phone number listed at the bottom of this page) 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 Programs (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 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 BMC HealthNet Plan.

Health Risk Assessment

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

It is very important that you fill out the HRA and return it to us in the postage-paid envelope that's provided. You can also complete your HRA online via the Member self service section at bmchp.org. Filling out your HRA 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 HRA, a representative from BMC HealthNet Plan may call you and ask you to give us your Health Risk Assessment information. (See Section 11 for information about your PHI and your rights to keep it private.) The answers you give in the Health Risk Assessment help us to help you stay healthy, so please complete your HRA.

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 10, "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 health care Provider can give you more information about EPSDT schedules. (For more information on EPSDT, see Section 7.)

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 Health care

Emergency Behavioral Health care
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 Health Care
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 7 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 health care 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
BMC HealthNet Plan adopts, develops and implements Clinical Practice Guidelines (CPGs) relevant to its membership for providing appropriate, effective care to all our Members and includes 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 to have non-Emergency transportation arranged for them to go to health care visits. This is a service that BMC HealthNet Plan administers for MassHealth. 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 health care 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 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 Web site 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 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. BMC HealthNet Plan has 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.

Paying at the pharmacy

Unless you fall into one of the categories below, you will need to pay a Co-payment at the pharmacy for your prescription drugs. Please refer to your Covered 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

You 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 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) of $200. We'll send you a letter to let you know that you've reached your cap. If you have reached the $200 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 BMC HealthNet Plan's 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 Web site, 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

BMC HealthNet Plan 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. You can enroll with informedMail™ order pharmacy to start getting medications in the mail. Once you sign up, you can refill prescriptions by mail, phone, or online.

You can find more information about the mail-order pharmacy program in the special insert that came as part of this packet. You can also call informedMail™ at 1-800-881-1966.

Pharmacy programs

While most medications simply require a prescription from your healthcare Provider, BMC HealthNet Plan uses 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 the BMC HealthNet Plan Web site, bmchp.org. The formulary also lists the drugs that may not be covered. 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 BMC HealthNet Plan. 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 10 for Grievances and Appeals information.) If you want more information about the pharmacy programs, visit our Web site at bmchp.org. Or you can call our Member services department and ask for the pharmacy department.

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 10 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 BMC HealthNet Plan 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, 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 10 for Grievances and Appeals information.)

New-to-market medication program – BMC HealthNet Plan reviews new medications for safety and efficacy before we add them to our list of medications or formulary. (Efficacy means that the medica-

tion 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 10 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, 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 10 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, 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 10 for Grievances and Appeals information.)

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 BMC HealthNet Plan 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 BMC HealthNet Plan's 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 Web site at www.medicare.gov; (3) refer to the *Medicare and You Handbook; (4)* go to www.cms.com on the internet. Remember to carry all your ID Cards with you when you go to the pharmacy. When you file a prescription, please show your BMC HealthNet Plan Member ID Card and your Medicare Prescription ID card.

SECTION 7

Pregnancy, Family Planning, Preventive Care and Well Child Care, EPSDT, Children's Behavioral Health Initative, and Early Intervention

Pregnancy (prenatal) care

The health care 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 health care 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. BMC HealthNet Plan covers all these visits.

Family Planning Services

BMC HealthNet Plan covers Family Planning Services that include family planning medical services, family planning counseling, birth control advice, pregnancy tests, sterilization services, and follow-up health care.

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 check-ups 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 listed at the bottom of the page.

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 Basic, Essential or Family Assistance

If you or your child is under 21 years old and enrolled in MassHealth Basic, Essential or 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 Service list*). This coverage includes health care, 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 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 10 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.

BMC HealthNet Plan provides 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 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 listed at the bottom of the page.

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 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 Basic, Essential or 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 8

Care Management

BMC HealthNet Plan is 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 health care 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 health care Providers.

We also help you learn what benefits and community resources are available because we want to help you with more than just health care. Our experienced staff can link you with services such as transportation to health care 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 Health Care Coordination
- Care Management Select

In addition to our medical Care Management program, Beacon Health Strategies (Beacon) offers BMC HealthNet Plan Members Behavioral Health Care Management and Intensive Clinical Management (ICM) services. For Members with both medical and Behavioral Health care 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 cancer. 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 Health Care Coordination

The Health Care Coordination level offers Members a more involved approach. Care managers work with you and a team of health care 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
- Diabetes
- Congestive heart failure
- HIV/AIDS
- Obesity
- Pregnancy
- Hypertension
- Breast cancer

Care Management Select

Care Management Select manages Members with complex medical conditions. If you are at high risk for problems because of your health condition or have complex medical needs or special health care needs, you may be enrolled in Care Management Select. 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 health care 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 health care Providers. Entry into the program may happen through completing your Health Risk Assessment, our claims information, a referral from a hospital Care Manager or one of your providers, or self- referral.

To learn more:

- Call 1-866-853-5241 for medical Care Management.

Behavioral Health Care 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 Health care needs. Beacon can help with 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 Health Care 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 health care 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 Health care admission, and resources and support in your community. With your permission, we will collaborate with your PCP and/or other health care Providers and family members in order to assist you. Our ICM care plans are individually developed with you and your Behavioral Health care Providers and establish goals and the resources you need to achieve the goals.

For more information about Behavioral Health Care 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 Web site: www.bmchp.org

SECTION 9

Rights and Responsibilities

As a Member of BMC HealthNet Plan, you have certain rights concerning your health care. 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.

Your Rights

1. You have the right to be treated with respect and with recognition of your dignity and right to privacy. (See Section 11 "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 health care, 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 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 health care. 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 health care within the timeframes described in the "How Long It Should Take To Get an Appointment" part of Section 6, 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 the BMC HealthNet Plan Member services department, Beacon Health Strategies, and/or MassHealth customer service center about services you received from the Plan or from a health care 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 10, "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 health care 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 customer service 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.

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 your health care 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 Health Care Fraud" section that follows.
12. You must notify BMC HealthNet Plan's Member services department and the MassHealth customer service 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 customer service center if you change your address or phone number.

You are responsible for payment of services not included in the *Covered 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 10

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. The phone numbers are at the bottom of the page.

You also have the right to voice any concerns to MassHealth at any time. You may call a customer service representative at the MassHealth customer service center at one of the numbers at the bottom of the page.

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?" below). 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). The phone numbers are at the bottom of the page

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). The phone numbers are at the bottom of the page.

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:

- 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:

- BMC HealthNet Plan's Member services department at the number listed at the bottom of the page
- For Grievances related to Behavioral Health services, call our Behavioral Health Member line listed at the bottom of the page.

If you, or your Authorized Representative, want to submit a Grievance in writing, please mail it to:

BMC HealthNet Plan --
MassHealth
Two Copley Place, Suite 600
Boston, MA 02116
Attention: Member Grievances
Fax: 617-897-0805

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
Two Copley Place, Suite 600
Boston, MA 02116

BMC HealthNet Plan
Bourne Counting House
One Merrills Wharf
New Bedford, MA 02740

BMC HealthNet Plan
1350 Main St., 13th floor
Springfield, MA 01107

BMC HealthNet Plan
66 West St., Suite 205
Pittsfield, MA 01201

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) at the numbers below.

What is an Internal Appeal?

You, or your Authorized Appeal Representative, has 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 4.
- We did not notify you of an Internal Appeal decision within the timeframe described in Section 10.
- You're unable to obtain healthcare services within the timeframes described in Section 6 "Your Health Care".

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 the 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:

- BMC HealthNet Plan's Member services department at one of the toll-free numbers at the bottom of the page.
- Or you may call the Appeals department at (617) 748-6338.
- For Appeals related to Behavioral Health services, call our Behavioral Health Member line listed at the bottom of the page.

If you, or your Authorized Representative, want to submit a first level Internal Appeal in writing, please mail it to:

BMC HealthNet Plan --
MassHealth
Two Copley Place, Suite 600
Boston, MA 02116
Attention: Member Appeals
Fax: 617-897-0805

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 above.

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 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 five calendar days as described below. 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 five 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.

You, or your Authorized Representative, may request an Expedited (fast) Internal Appeal from BMC HealthNet Plan or Beacon Health Strategies (for Behavioral Health concerns). 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 your Authorized Representative in writing of the decision. We will also try to contact you be 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 five 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 five 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 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 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 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 it has 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 it decided your first level Internal Appeal; and
-
-
- Indicate in your request that you want to continue to get these services.

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 (see "How to File a Board of Hearings Appeal" below).

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, also want the Board of Hearings to handle your request as an Expedited (fast) fair hearing, 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 days 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 at the numbers listed at the bottom of the page.

You also have the right to voice any concerns to MassHealth at any time. You may call a customer service representative at the MassHealth customer service center at the number at the bottom of the page.

SECTION 11

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 the BMC HealthNet Plan Member services department.

This Notice of Privacy Practices, which was **effective April 14, 2003**, describes how we may use and communicate your Protected Health Information (PHI) to carry out treatment, payment or healthcare administration, and for other purposes that are permitted or required by law. 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 health care. For example, if you are being treated for a back injury, we may share information with your Primary Care Provider, 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 their observations. That way, the healthcare team will know how you responded to treatment.

For Payment: We may use and communicate PHI about you so that others may bill and receive payment for the treatment and services that you received.

For Health Care Administration: We may use and communicate PHI about you to support our normal business activities. For example, we may use your information to review and improve the services you receive, communicate information to personnel for review and learning purposes, and communicate your Protected Health Information to other organizations that help us with our business activities.

For Personal Communications: 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.

Fundraising Activities: 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.

Privacy Officer
BMC HealthNet Plan
Two Copley Place, Suite 600
Boston, MA 02116

In some limited situations, the law allows or requires us to use or communicate your health information for purposes beyond treatment, payment and operations.

Required By Law: We will communicate PHI about you when we are required to do so by federal, state or local law. This includes workers' compensation laws. We may release PHI about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health and Safety: We may communicate your PHI for public health reasons, for example to prevent or control disease and to report births and deaths.

Abuse or Neglect: We may communicate your PHI to a government authority if we reasonably believe you are a victim of abuse or neglect. We will only communicate this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent serious harm to you or someone else.

Health Oversight Activities: We may communicate PHI to a health oversight agency for activities authorized by law, including audits, investigations, inspections, and licensing purposes. We may have to do this for certain state and federal agencies to monitor the healthcare system, government programs and compliance with civil rights laws.

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.

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.

Military, Veterans, National Security and Intelligence: If 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.

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 health care or payment related to your care. For example, we may communicate PHI to a friend who brings you into an Emergency room.

Serious Threat to Health or Safety: We may use and communicate PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

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.

Research: Under certain circumstances, we may use and disclose your PHI for research purposes. For example, a research project may involve comparing the health and recovery of all Members who received a particular type of Care Management to those who received another for the same condition. Most research projects, however, are subject to a special approval process. This process requires an evaluation of the proposed research project and its use of PHI, and balances the research needs with our Members' need for privacy. Before we use or disclose PHI for research, the project will have been approved through this special approval process. However, this special approval process is not required when we allow researchers who are preparing a research project to look at information about patients with specific medical needs, so long as the PHI they review does not leave BMC HealthNet Plan

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.

Organ and Tissue Donation: If you are an organ donor, we may communicate your PHI to organizations that handle organ procurement, banking or transplantation for purposes of tissue donation and transplant.

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.

Business Associates: Some of our services and products are provided through contracts with business associates, and we may communicate your PHI to our business associates so that they may perform the job we have asked them to do. To protect your PHI, however, we require the business associates to properly safeguard your PHI.

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 medications, foods, supplements and other products and marketing information to support product recalls, repairs or replacement.

Your rights regarding Protected Health Information about you

Right to Access and Copy: You have the right to inspect and receive a copy of PHI that may be used to make decisions about your care. Usually, this includes medical and billing records. Psychotherapy notes may not be inspected or copied. To inspect or receive a copy of your records, you must submit a written request to the BMC HealthNet Plan Privacy Officer.

Privacy Officer
BMC HealthNet Plan
Two Copley Place, Suite 600
Boston, MA 02116

We may deny your request to inspect or receive a copy in certain very limited circumstances. If you are denied access to PHI, we will notify you in writing, and you may request that the denial be reviewed. If you request a review, a BMC HealthNet Plan attorney or other qualified BMC HealthNet Plan employee who was not involved in the original decision to deny your request to inspect or receive a copy of your records will re-evaluate your request, and respond to you in writing.

Right to Amend: If you believe that PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an

amendment for as long as the information is kept by or for BMC HealthNet Plan. 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.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the entities or persons (other than yourself) to whom the Plan has disclosed your health information without your written authorization. The accounting would not include disclosures for treatment, payment, health care operations, and certain other disclosures exempted by law. To obtain an accounting, you must submit your request, in writing, to the BMC HealthNet Plan Privacy Officer. 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 a restriction or limitation on the PHI we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. We are not required to agree with your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. BMC HealthNet Plan will notify you in writing whether we agree or not with your request. Please submit your request in writing to the BMC HealthNet Plan Privacy Officer. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit the Plan's use and/or disclosure of the information; (3) to whom you want the limits to apply (for example, disclosures to your spouse); and (4) your contact address.

Right to Request Confidential Communication: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by telephone at work or that we only contact you by mail at home. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests. To request confidential communication, you must complete and submit a *Request for Confidential Communication Form* to the BMC HealthNet Plan Privacy Officer. You can get a form by calling our Member services department.

Right to Obtain a Paper Copy or Electronic Version of This Notice: You have the right to a paper copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice of Privacy Practices at any time by contacting the Member Services Department. You may also obtain an electronic version of this Notice of Privacy Practices on our Web site, bmchp.org.

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

Authorizations for Other Uses and Disclosures of PHI

Uses or disclosures of your PHI for other purposes or activities not listed above will be made only with your written authorization (permission). If you provide us with written authorization to use or disclose your PHI, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by your written authorization. However, we are unable to take back any disclosures that have already been made with your authorization.

Compliance with laws

If more than one law applies to this Notice of Privacy Practices, we will follow the more stringent law.

Complaints

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

To file a complaint with our office, contact:

Privacy Officer
BMC HealthNet Plan
Two Copley Place, Suite 600
Boston, MA 02116

You will not be penalized for filing a complaint.

You may file a complaint under the HIPAA Privacy Rule with the Office of Civil Rights (OCR). Complaints must be filed in writing within 180 days of an alleged violation, unless OCR extends this time requirement for good cause. You can find additional information at the following Web site: http:www.hhs.

gov/ocr/hipaa, including the Health Information Privacy Complaint Form. You can file HIPAA Privacy complaints via email to OCRComplaint@hhs.gov or by mail to the following OCR

Regional Office:
Office for Civil Rights U.S. Department of Health & Human Services JFK Federal Building Room 1875
Boston, MA 02203

If you need help filing a complaint you can call OCR's toll free number 1-800-368-1019.

SECTION 12

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 health care professionals, and to avoid confusion. An Advance Directive allows you to legally express in writing your health care 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 Health Care Proxy.

Living Will

The Living Will lists medical procedures/types of health care 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.

Health Care Proxy

A Health Care 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 Health Care "Agent" or "Proxy."

Once you set up your Advance Directives, you can change your mind at any time.

To get the Health Care Proxy and Living Will forms, you can visit BMC HealthNet Plan's Web site at bmchp.org. BMC HealthNet Plan can also mail the forms to you. Call the Plan's Member services department.

SECTION 13

Disenrollment

Voluntary Disenrollment

You may end your coverage with BMC HealthNet Plan at any time. To disenroll from BMC HealthNet Plan, call MassHealth customer service. 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.

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 14

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 health care 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 888-257-1985 to find out how payment will be handled.

If you have comprehensive health insurance with another health plan,

including Medicare, you are not eligible for MassHealth benefits from Managed Care organizations, including BMC HealthNet Plan. If you fit this category, you will need to be disenrolled from BMC HealthNet Plan. MassHealth will notify you about this.

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. If you are not willing to help us, you will be liable to us for any expenses we may incur, including reasonable attorneys' fees, in enforcing our rights under this plan. 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.

SECTION 15
Glossary

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 health care.

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 health care 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 Commonwealth Care 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 offer 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 health care Providers – such as home health care 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 Health Care Coordination, Care Management Select, 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 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 Health care 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 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 – An Effective Date is 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 Mass Health.

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 lay person 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).
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 pre-

venting 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 health care or pharmacy services.

Grievance – A statement by a Member of dissatisfaction with care or services received.

Health Care 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 Risk Assessment – 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 in addition to 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 health care 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 health care.

MassHealth – A health care program operated by the Massachusetts Executive Office of Health and Human Services. The national health insurance program called Medicaid is called MassHealth in Massachusetts. BMC HealthNet Plan covers MassHealth Members under the Standard, CommonHealth, Basic, Family Assistance and Essential Plans.

MassHealth Basic – A MassHealth benefit plan that offers health benefits to certain individuals over the age of 18 and under the age of 65 who qualify under EOHHS's MassHealth Basic eligibility criteria which includes (1) persons who have been identified by the Department of Mental Health (DMH) as getting services or as being on a waiting list to get services from the DMH, are "long-term unemployed," and have income at or below 100% of the federal poverty level; or (2) persons who are getting Emergency Aid to the Elderly, Disabled and Children (EAEDC) through the Department of Transitional Assistance; or (3) persons who are receiving MassHealth Basic pending an appeal to the Board of Hearings of EOHHS's decision that they are no longer eligible for MassHealth.

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 Essential – A MassHealth benefit plan that offers health benefits to certain individuals or Members of a couple over the age of 18 and under the age of 65 who are long-term unemployed and who do not meet the eligibility criteria for MassHealth Basic.

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 age 18, pregnant women, and disabled individuals under age 65.

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 health care 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 Basic, Family Assistance or Essential plans.

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 health care 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, 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 lay person 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.

SECTION 16

INDEX

Details about Your Membership Card

Your Name

Your personal BMC HealthNet Plan Identification Number

Your personal doctor's name

Information that enables you to have prescriptions filled at any participating pharmacy

BMC HealthNet Plan's toll-free Member Services Department number

BMC HealthNet Plan Member Services Department
8:00 a.m. – 6:00 p.m., (Eastern Time) Monday-Friday 1.888.566.0010 (English and other languages) • 1.888.566.0012 (en Español) • 1.866.765.0055 (TTY/TDD for hearing impaired) • 1.800.421.1220 (relay operator for hearing impaired) • 1.888.217.3501 (Behavioral Health: mental health and substance abuse questions 24 hours a day/7 days a week managed by Beacon Health Strategies) • 1.888.727.9441 (Behavioral Health TTY/TDD for hearing impaired) • 1.800.973.6273 (Nurse Advice Line) • **Web Site** www.bmchp.org • www.beaconhealthstrategies.org (Behavioral health)

MassHealth Customer Service
8:00 a.m. – 5:00 p.m., Monday-Friday
1.800.841.2900 • 1.800.497.4648 (TTY/TDD for hearing impaired)

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BOSTON MEDICAL CENTER
HealthNet Plan

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 need help with translation or other help, call BMC HealthNet Plan at 1-888-566-0010.

¡IMPORTANTE! Esta información es acerca de sus beneficios de BMC HealthNet Plan. Es necesario que sea traducida inmediatamente. BMC HealthNet Plan se la puede traducir. Si necesita ayuda con traducción u otro tipo de ayuda, llame a BMC HealthNet Plan al **1-888-566-0012**. (SP) Las versiones impresas de los materiales para miembros están disponibles en español. Solicítelos llamando al mismo número telefónico.

សំខាន់៖ ពត៌មាននេះ ស្តីអំពីផលប្រយោជន៍នៃកម្មវិធីរ៉ាប់រងសុខភាព BMC HealthNet Plan ។ ពត៌មាននេះ ត្រូវការបកប្រែភ្លាមៗ ។ កម្មវិធី BMC HealthNet Plan អាចបកប្រែជូនអ្នកបាន ។ បើអ្នកត្រូវការអោយគេ ជួយបកប្រែ ជួយអ្វីផ្សេងៗទៀត សូមទូរសព្ទ័មកកម្មវិធី BMC HealthNet Plan តាមលេខ 1-888-566-0010. (CAM)

請注意！本文與你的 BMC HealthNet Plan 的福利有關，必須及時翻譯成中文。BMC HealthNet Plan 可以爲你翻譯。若您需要翻譯或其他方面的協助，請致電 **1-888-566-0010** 與 BMC HealthNet Plan 聯絡。(CHI)

TRE ENPOTAN! Enfòmasyon sa a konsène benefis BMC HealthNet Plan ou. Fòk yo tradwi l touswit pou w. BMC HealthNet Plan kapab tradwi l pou w. Si w bezwen èd ak tradiksyon an oubyen ak lòt bagay, rele BMC HealthNet Plan nan 1-888-566-0010. (HC)

ບັນຫາສຳຄັນ! ຂໍ້ຄວາມນີ້ເວົ້າເຖິງບັນດາຜົນປະໂຫຍດຂອງ BMC HealthNet Plan ແລະໄດ້ ປ່ຽນພາສາດຽວນີ້. BMC HealthNet Plan ອາດສົ່ງຂໍ້ຄວາມຂ່າວໃຫ້ທ່ານ. ກ້າຕ້ອງການຄວາມຊ່ວຍ ເຫຼືອກ່ຽວກັບການແປພາສາ ຫຼືການບໍລິການອື່ນໆ, ການຸນາເອີ້ນຫາ BMC HealthNet Plan ເລກທີ 1-888-566-0010. (LAO)

IMPORTANTE! Esta informação é sobre seus benefícios com a BMC HealthNet Plan Precisa ser traduzida imediatamente. BMC HealthNet Plan pode traduzi-la para si. Se precisar de ajuda com traduções ou outra ajuda qualquer, chame a BMC HealthNet Plan no telefone **1-888-566-0010**. (POR)

ВНИМАНИЕ! Данная информация касается полагающихся вам медицинских льгот по программе BMC HealthNet Plan. Ее необходимо срочно перевести. Перевод может быть выполнен представителем программы BMC HealthNet Plan. Если вам понадобится помощь с переводом или другие виды содействия, просьба позвонить в представительство программы BMC HealthNet Plan по бесплатному телефону 1-888-566-0010. (RUS)

QUAN TRỌNG! Tài liệu này nói về các quyền lợi của BMC HealthNet Plan và cần được chuyển ngữ ngay. BMC HealthNet Plan có thể chuyển ngữ tài liệu này cho quý vị. Nếu cần được giúp đỡ về việc chuyển ngữ hay các dịch vụ khác, xin gọi cho BMC HealthNet Plan tại số **1-888-566-0010**. (VTN)

Attention ! Ces renseignements concernent les services couverts par votre assurance BMC HealthNet Plan. Faites les traduire le plus rapidement possible. BMC HealthNet Plan peut le faire pour vous. Si vous désirez vous faire aider pour la traduction ou si vous avez d'autres questions, téléphonez à BMC HealthNet Plan au 1-888-566-0010. (FR)

هام! هذه المعلومات تتعلق بالامتيازات الممنوحة لك من ماسهيلس (BMC HealthNet Plan) و يجب أن ترجم حالاً. بإمكان ماسهيلس القيام بالترجمة لكم. إذا احتجت للترجمة، عليك الاتصال بماسهيلس (BMC HealthNet Plan) علي الرقم 1-888-566-0010 (AR) .(BMC HealthNet Plan)

Member Services Call Center
BMC HealthNet Plan
Two Copley Place, Suite 600
Boston, MA 02116

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