Welcome to Ambetter from CeltiCare Health!

Welcome to healthy. We understand that your health is your top priority—it’s ours, too. As a member of Ambetter from CeltiCare Health, you’ll have the opportunity to experience benefits and wellness programs that enable you to lead a healthy, fulfilling life.

For detailed information on your new plan, use this Member Handbook.


Use this Member Handbook as a reference for detailed information on your benefits, the programs now available to you and other helpful information. With our continued education, access and support, it’s now easy for you to stay in charge of your health.
This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance.

CeltiCare Health Plan of Massachusetts, Inc., will accept you into our plan upon referral from the Health Connector regardless of your income, physical or mental condition, age, gender, sexual orientation, religion, physical or mental disability, ethnicity or race, previous status as a Member, pre-existing conditions, and/or expected health or genetic status.

NOTE: There are no pre-existing condition limitations or exclusions with CeltiCare Health Plan of Massachusetts, Inc.
OTHER LANGUAGES AVAILABLE

The information included in this manual is about your CeltiCare Health Plan of Massachusetts, Inc.™ (CeltiCare) benefits. If you need information in a different language, please call Member Services so we can help you at 1-877-687-1186 (TDD/TTY) 1-877-941-9234.

Spanish: La información incluida en este folleto es acerca de sus beneficios del Plan de Salud CeltiCare de Massachusetts (CeltiCare). Si necesita obtener la información en un idioma diferente, llame al Departamento de Servicios para Miembros al 1-877-687-1186 (TDD/TTY) 1-877-941-9234 para que podamos ayudarle.

Russian: Информация, содержащаяся в этом буклете, касается ваших льгот по программе медицинского страхования для жителей штата Массачусетс CeltiCare. Если вам требуется информация на другом языке, обратитесь, пожалуйста, за помощью в справочную службу для участников программы по телефону 1-877-687-1186 (TDD/TTY) 1-877-941-9234.

Cambodian: លំពែកផលិតផលរបស់អ្នកនៅក្នុង Plan របស់ CeltiCare នៅ រដ្ឋ Massachusetts (CeltiCare). ถ้าคุณต้องการข้อมูลในภาษาอื่น ๆ โปรดติดต่อกับบริการลูกค้าเพื่อให้ความช่วยเหลือที่ 1-877-687-1186 (TDD/TTY) 1-877-941-9234.

Chinese - Traditional: 本手冊中的資訊有關您的CeltiCare Health Plan of Massachusetts (CeltiCare)醫療計畫福利。如果您需要此資訊的其他語言版本，請致電會員服務部，以便我們為您提供協助，電話號碼是1-877-687-1186 (TDD/TTY) 1-877-941-9234。

Chinese - Simplified: “本手册中的信息有关您的CeltiCare Health Plan of Massachusetts (CeltiCare)医疗计划福利。如果您需要此信息的其他语言版本，请致电会员服务部，以便我们为您提供协助，电话号码是1-877-687-1186 (TDD/TTY) 1-877-941-9234。”

Haitian Creole: Enfòmasyon ki nan tiliv sa a, se sou avantaj nan CeltiCare Health Plan nan Eta Massachusetts (CeltiCare). Si w bezwen enfòmasyon nan yon lòt lang, rele Sèvis pou Menm yo nan 1-877-687-1186 (TDD/TTY) 1-877-941-9234, pou nou kapab ede w.

Laotian: "ຂ່າວຂັ້ນຂອງມີພາຍໃນທັງໝັດຂອງການຊ່ວຍຊູ່ຂອງຊ່ວຍຊູ່ຂອງ CeltiCare ຂອງ Eta Massachusetts (CeltiCare). ຈ່າວຂ່າວຂອງມີພາຍໃນທັງໝັດຂອງການຊ່ວຍຊູ່ຂອງຊ່ວຍຊູ່ຂອງ CeltiCare ແມ່ນ 1-866-895-1786 ເຊັ່ນ.

Portuguese - European: A informação incluída neste folheto diz respeito aos benefícios do seu Plano de Saúde CeltiCare de Massachusetts (CeltiCare). Se necessitar de informações numa outra língua, por favor ligue para os Serviços ao Associado através do número 1-877-687-1186 (TDD/TTY) 1-877-941-9234 para que o(a) possamos ajudar.
**Portuguese - Brazilian:** As informações contidas neste folheto referem-se aos benefícios do seu Plano de Saúde CeltiCare de Massachusetts (CeltiCare). Se precisar de informações em outro idioma, telefone para o Atendimento aos Clientes para que possamos ajudá-lo. O número é 1-877-687-1186 (TDD/TTY) 1-877-941-9234.

**Vietnamese:** Thông tin trong tập sách này nói về các quyền lợi của quý vị trong chương trình CeltiCare Health Plan of Massachusetts (CeltiCare). Nếu quý vị cần thông tin bằng ngôn ngữ khác, xin gọi ban Dịch Vụ Hội Viên để được giúp đỡ tại số 1-877-687-1186 (TDD/TTY) 1-877-941-9234.

**French:** L'information contenue dans ce livret concerne les avantages de votre assurance maladie CeltiCare du Massachusetts (CeltiCare). Si vous souhaitez ces informations dans une autre langue, veuillez appeler le Service pour les membres au 1-877-687-1186 (TDD/TTY) 1-877-941-9234.

**Polish:** Informacje zawarte w ninieszej broszurze dotyczą świadczeń w ramach planu opieki zdrowotnej CeltiCare Health Plan of Massachusetts (CeltiCare). W razie potrzeby otrzymania informacji w innym języku, udzielimy pomocy po skontaktowaniu się z Działem Usług Członkowskich (Member Services) pod numerem 1-877-687-1186 (TDD/TTY) 1-877-941-9234.

**Greek:** Οι πληροφορίες που παρέχονται στο παρόν φυλλάδιο αφορούν στις παροχές σας του Προγράμματος Υγείας CeltiCare της Μασαχουσέτης (CeltiCare). Αν χρειάζεστε πληροφορίες σε μια διαφορετική γλώσσα, παρακαλούμε καλέστε τις Υπηρεσίες Μελών στο τηλέφωνο 1-877-687-1186 (TDD/TTY) 1-877-941-9234 για να μπορέσουμε να σας βοηθήσουμε.

**Italian:** Le informazioni contenute in questo opuscolo riguardano i benefici del suo piano sanitario "CeltiCare Health Plan of Massachusetts (CeltiCare)". Se desidera informazioni in una lingua diversa, la preghiamo di chiamare Member Services al numero 1-877-687-1186 (TDD/TTY) 1-877-941-9234 per ricevere l'assistenza richiesta.

**Arabic:** المعلومات المذكورة في هذه الورقة تتعلق بمنافع برنامج تأمين صحي CeltiCare Health Plan of Massachusetts (CeltiCare). إذا احتجت لمعلومات بلغة أخرى، رجاء الاتصال بمكتب خدمات العملاء لكي تستطيع مساعدتك على الرقم 1-877-941-9234.
# Table of Contents

- Other Languages Available ............................................................................................................ 1
- Important Definitions ...................................................................................................................... 7
- **WELCOME** ................................................................................................................................. 17
  - Welcome to CeltiCare .................................................................................................................... 17
- Minimum Creditable Coverage Standards ................................................................................... 17
- Your **Evidence of Coverage** ...................................................................................................... 17
- Your Provider Directory .................................................................................................................. 17
- CeltiCare Website .......................................................................................................................... 18
- Quality Improvement (QI) ............................................................................................................... 19
  - Member Advisory Committee .................................................................................................... 19
- Interpreter Services ....................................................................................................................... 20
  - Your Member ID Card .................................................................................................................. 20
  - Sample Member ID Card .............................................................................................................. 20
- **HOW YOUR PLAN WORKS** .................................................................................................... 20
  - Service Areas Covered ............................................................................................................... 20
  - Member Services ......................................................................................................................... 21
  - Nurse Response® ....................................................................................................................... 21
- Membership and Eligibility Information ..................................................................................... 21
  - Enrollment Information ............................................................................................................... 22
  - Involuntary and Voluntary Disenrollment Information ............................................................... 23
  - Special Enrollment Period .......................................................................................................... 23
  - Newborn, Foster, and Adoptive Children Coverage ..................................................................... 24
  - Domestic Partner Coverage ....................................................................................................... 24
  - Termination of Coverage .......................................................................................................... 24
  - Contributory Plan Termination of Employer Group for Non-Payment of Premium .................... 25
  - Notification Requirements ........................................................................................................... 25
  - Continuation of Health Care Coverage ...................................................................................... 25
  - Special Enrollment Period: Small Group Employees ................................................................... 25
  - Extension of Continuation of Coverage ..................................................................................... 26
  - Continuation of Spousal Coverage ............................................................................................ 26
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance Program</td>
<td>57</td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>57</td>
</tr>
<tr>
<td>When You Are Pregnant</td>
<td>57</td>
</tr>
<tr>
<td>Pregnancy &amp; Maternity Services</td>
<td>57</td>
</tr>
<tr>
<td>Start Smart for Your Baby®</td>
<td>58</td>
</tr>
<tr>
<td>Care Management</td>
<td>58</td>
</tr>
<tr>
<td>MemberConnections®</td>
<td>59</td>
</tr>
<tr>
<td>CeltiCare Disease Management Programs</td>
<td>59</td>
</tr>
<tr>
<td>UTILIZATION MANAGEMENT</td>
<td>60</td>
</tr>
<tr>
<td>Review Criteria</td>
<td>60</td>
</tr>
<tr>
<td>New Technology</td>
<td>60</td>
</tr>
<tr>
<td>Experimental, Investigational and Clinical Trial Services</td>
<td>60</td>
</tr>
<tr>
<td>Prior Authorization for Services</td>
<td>61</td>
</tr>
<tr>
<td>Utilization Review</td>
<td>61</td>
</tr>
<tr>
<td>Second Medical Opinion</td>
<td>63</td>
</tr>
<tr>
<td>How to Get Medical Care When You Are Out of the Service Area</td>
<td>63</td>
</tr>
<tr>
<td>Out of Network Care</td>
<td>63</td>
</tr>
<tr>
<td>Referrals</td>
<td>64</td>
</tr>
<tr>
<td>Self-Referrals</td>
<td>64</td>
</tr>
<tr>
<td>Tertiary Services</td>
<td>65</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>66</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>66</td>
</tr>
<tr>
<td>Emergency Transportation Services</td>
<td>68</td>
</tr>
<tr>
<td>PHARMACY</td>
<td>68</td>
</tr>
<tr>
<td>Pharmacy Program</td>
<td>68</td>
</tr>
<tr>
<td>Preferred Drug List (PDL)</td>
<td>68</td>
</tr>
<tr>
<td>Prior Authorizations</td>
<td>68</td>
</tr>
<tr>
<td>Exclusions</td>
<td>69</td>
</tr>
<tr>
<td>Over-the-Counter Items</td>
<td>69</td>
</tr>
<tr>
<td>Step Therapy</td>
<td>69</td>
</tr>
<tr>
<td>Quantity Limits</td>
<td>69</td>
</tr>
<tr>
<td>Generic Drugs</td>
<td>70</td>
</tr>
</tbody>
</table>
### New Pages

- Newly Approved Products ........................................................................................................ 70
- Specialty Pharmacy Provider .................................................................................................... 70
- Filling a Prescription .................................................................................................................. 71
- Mail Order Pharmacy ................................................................................................................ 71
- Member Grievances & Appeals ............................................................................................... 71

### MEMBER SATISFACTION

- Internal Inquiry Process ........................................................................................................... 72
- Internal Grievance Process ....................................................................................................... 72
- How to File a Grievance .......................................................................................................... 73
- Internal Appeal Process .......................................................................................................... 74
- Standard/Non-expedited Internal Appeal ............................................................................... 74
- Expedited Internal Appeal ...................................................................................................... 76
- External Review ....................................................................................................................... 78

### Waste, Abuse, and Fraud (WAF) Program

- Authority and Responsibility ................................................................................................. 81
- What to Do When You Get a Bill ............................................................................................. 81
- Other Insurance ....................................................................................................................... 82
- Accidental Injury or Illness (Subrogation) ............................................................................. 82
- Member Rights ....................................................................................................................... 82
- Member Responsibilities ......................................................................................................... 85
- Advance Directives .................................................................................................................. 86

### NOTICE OF PRIVACY PRACTICES

- Privacy Notices ....................................................................................................................... 86
- How We Use or Share Your Health Records ........................................................................... 87
- Using Your Rights .................................................................................................................... 90

### AUTHORIZED REPRESENTATIVE FORM FOR APPEALS

- AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION .......................................................................................................................... 92
IMPORTANT DEFINITIONS

These definitions may or may not be applicable to you based on the health insurance plan you have chosen. Your Summary of Benefits will identify the specific benefits you have. If you have any questions, call Member Services. The Member Services contact information is at the bottom of every page in the manual.

Adverse Determination: A determination, based upon a review of information provided, by a carrier or its designated utilization review organization, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other healthcare services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of healthcare setting and level of care, or effectiveness.

Affordable Care Act (ACA): The consolidated Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. Legislation that enacts broad federal reforms for health insurance and requires the establishments of Exchanges.

Annual Deductible: The annual dollar amount that must be paid by you for certain covered services before CeltiCare becomes obligated to pay for covered services. The annual deductible can be for an individual or a family. If you have a family plan, the deductible can be met by eligible costs incurred by any combination of members enrolled under the same family plan. No one member in a family has to pay more than the individual deductible amount.

Annual Out-Of-Pocket Expense: The annual dollar amount that you will pay for covered services under a CeltiCare health plan, not including premiums. Except for applicable prescription drug deductibles and copayments, all other deductibles and copayments will count toward the annual out-of-pocket expense.

Annual Renewal Date: The date 12 months after the effective date of your health insurance plan.

Appeal: A form of grievance for review of an adverse determination.

Applied Behavior Analysis: The design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Authorized Representative: A person CeltiCare can document who has been authorized by the Member in writing to act on the Member’s behalf with respect to a grievance or internal appeal.

Autism Services Provider: A person, entity, or group that provides treatment of Autism Spectrum Disorders.

Autism Spectrum Disorders: Any of the pervasive developmental disorders as defined by the
most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, including Autistic Disorder and Pervasive Developmental Disorder(s) not otherwise specified. Clinical evaluations of individuals suspected of having an Autism Spectrum Disorder are generally considered Medically Necessary and may include neuropsychological evaluations or other tests to diagnose whether an individual has an Autism Spectrum Disorder. Treatment of Autism Spectrum Disorders may include the following care prescribed, provided, or ordered for an individual diagnosed with Autism Spectrum Disorders by a licensed physician or a licensed psychologist who determines the care to be Medically Necessary: habilitative or rehabilitative care; pharmacy care; psychiatric care; psychological care; and therapeutic care.

**Behavioral Health Manager:** A company, organized under the laws of the Commonwealth of Massachusetts or organized under the laws of another state and qualified to do business in the Commonwealth, which has a contractual arrangement with CeltiCare to provide or arrange for the provision of behavioral health services to voluntarily enrolled Members of the carrier.

**Behavioral Health Services:** Emergency, inpatient, intermediate, and outpatient mental health and substance use disorder services for the treatment of mental health and substance use disorders.

**Benefit Limit:** Day, visit, or dollar benefit maximums may apply to certain health care services or medical and surgical supplies. Refer to your *Summary of Benefits* to find any limits that apply to your coverage.

**Benefit Year:** The period of time beginning on the first day of the month for which a Member is eligible for coverage and ending after 12 months. For example, if a Member’s health insurance plan is effective 01/01/2014, the benefit year will end on 12/31/2014.

**CeltiCare Designated Tertiary Facility:** A CeltiCare defined medical center that provides specialized services not available in the community setting.

**CeltiCare Designated Tertiary Provider:** Any participating provider affiliated with a CeltiCare Designated Tertiary Facility.

**Coinsurance:** A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid.

- Once deductibles and coinsurance are paid, CeltiCare is responsible for the rest of the reimbursement for covered benefits up to allowed charges. The Member may also be responsible for any charges in excess of what the insurer determines to be "usual, customary, and reasonable."
- Coinsurance rates may differ if services are received from a participating provider (i.e., a provider with whom CeltiCare has a contract or an agreement specifying payment levels and other contract requirements) or if received by providers not in CeltiCare’s network.
- Coinsurance rates may also differ for different types of services.
Complaint: An inquiry made by or on behalf of a CeltiCare Member to CeltiCare or a CeltiCare subcontractor that is not explained or resolved to the insured’s satisfaction.

Commonwealth Health Insurance Connector Authority: The state’s designated Health Insurance Marketplace whose primary responsibility is to facilitate access to affordable health insurance coverage for eligible individuals and small employers. It is also known as the Health Connector.

Copayment (Copay): A form of medical cost sharing in a health insurance plan that requires a Member to pay a fixed dollar amount when a medical service is received. The insurer is responsible for the rest of the reimbursement.

- There may be separate copayments for different services.
- Deductibles may apply and must be met before copayments for certain services.

Cost-Sharing Reduction (CSR): The federal program which provides federal reductions to cost-sharing to a Member with a household income at or below a specified percent of the Federal Poverty Limit (FPL).

Coverage Effective Date: The date medical coverage becomes effective for a particular Member.

Covered Services/Benefits: Healthcare services a Member is entitled to receive under the terms of Member eligibility with CeltiCare (as described in the Member’s Evidence of Coverage).

Criteria: Written screening procedures, decisions, abstracts, clinical protocols, and practice guidelines used by a carrier to determine the medical necessity and appropriateness of healthcare services.

Creditable Coverage: Coverage of an individual under any of the following health plans with no lapse in coverage of more than 63 days: (a) a group health plan; (b) a health plan, including, but not limited to, a health plan issued, renewed, or delivered within or without the Commonwealth to an individual who is enrolled in a qualifying student health insurance program or a qualifying student health program of another state, (c) Part A or Part B of Title XVIII of the Social Security Act; (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (e) 10 U.S.C. 55; (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under 5 U.S.C. 89; (i) a public health plan as defined in federal regulations authorized by the Public Health Service Act (j) a health benefit plan under the Peace Corps Act (k) coverage for young adults or (l) any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996.

Custodial Care: Assistance provided to a person in performing the basic necessities of life or activities of daily living. The care is not meant to improve health or provide treatment of a disease, illness, accident, or injury.

Deductible: A fixed dollar amount during the benefit period - usually a year - that a Member pays before the insurer starts to make payments for covered medical services. Plans may have both per individual and family deductibles.
Some plans may have separate deductibles for specific services. For example, a plan may have a hospitalization deductible per admission.

Deductibles may differ if services are received from an approved provider or if received from providers not on the approved list.

Department of Insurance (DOI): The DOI administers the laws of the Commonwealth as they pertain to the protection of the insurance consumer through the regulation of the insurance industry. The DOI monitors financial solvency, licenses insurance companies and producers, and reviews and approves rates and forms.

Diagnostic Lab Tests: CeltiCare health plans provide coverage for diagnostic lab tests including the examination or analysis of tissues, liquids, or wastes from the body.

Diagnostic X-Ray and Imaging: Medically Necessary diagnostic x-rays and high tech imaging studies, such as Magnetic Resonance Imaging (MRI), Computerized Tomography (CT) and Nuclear Cardiology.

Eligibility Determination: An action, whether adverse or favorable, taken by the Medicaid agency, the Exchange (Health Connector), or a federal agency to determine if someone meets the stipulated requirements for a federal or state benefit.

Eligible Dependent: A lawful spouse or domestic partner (same or opposite sex) of the Member, a biological child of the Member or other covered dependent, foster children for whom the Member has been receiving foster care payments, newborn infants of a dependent, and adoptive children immediately from the date of the filing of a petition to adopt. Dependent child includes step child, legally adopted child from the date of a placement in the home, or a disabled adult child of the Member or spouse. Dependents are covered up to 26 years of age.

Eligible Employee: An employee who: (1) works on a full-time basis with a normal work week of 30 or more hours, and includes an owner, a sole proprietor, or a partner of a partnership; provided however, that such owner, sole proprietor, or partner is included as an employee under a health care plan of an eligible small business; and provided, however, that "eligible employee" does not include an employee who works on a temporary or substitute basis, and (2) is hired to work for a period of not less than 5 months.

Eligible Small Business or Group: Any sole proprietorship, firm, corporation, partnership, or association actively engaged in business who, on at least fifty percent of its working days during the preceding year, employed from among one to not more than fifty eligible employees, the majority of whom worked in the Commonwealth; provided, however, that a health carrier may offer health insurance to a business of more than 50 employees in accordance with the provisions of this chapter. In determining the number of eligible employees, a business shall be considered to be one eligible small business or group if: (1) it is eligible to file a combined tax return for purpose of state taxation, or (2) its companies are affiliated companies through the same corporate parent. Except as otherwise specifically provided, provisions of this chapter which apply to an eligible small business shall continue to apply through the end of the rating period in which an eligible insured no longer meets the requirements of this definition. An eligible small business that exists within a MEWA shall be subject to this chapter.
Elective: A planned, non-emergent service, procedure, or admission.

Emergency Medical Condition: A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of a body organ or part, or, with respect to a pregnant woman, as further defined in § 1867(e)(l)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

Enrollee: Eligible individuals, eligible employees and eligible dependents enrolled in a QHP and entitled to coverage thereunder.

Essential Community Provider (ECP): Providers that serve predominantly low-income, medically underserved individuals.

Essential Health Benefits (EHB): Benefits that must be provided in any health insurance plan in accordance with the provided benefits categories outlined by the Patient Protection and Affordable Care Act and the Commonwealth of Massachusetts.

Evidence of Coverage (EOC): Any certificate, contract, or agreement including riders, amendments, and supplementary inserts, issued to an Enrollee specifying the benefits to which the enrollee is entitled through coverage under their Health Insurance Marketplace QHP.

 Expedited Internal Appeal: A form of grievance for review of an adverse determination for which a decision is required expeditiously due to the Member’s health needs which cannot wait with the standard resolution time. Situations/conditions include: 1) Provider certifying a delay in receiving the requested service would result in a substantial risk of serious or immediate harm to the Member; 2) The Member is currently admitted as a patient in a hospital; 3) The Member has a terminal illness; or 4) A provider certifies a delay in receiving durable medical equipment would result in substantial risk of serious or immediate harm to the Member.

Experimental/Investigational: Any drugs, procedures, devices, and other healthcare services, medical or surgical supplies, or treatments determined to be either:

- Not generally accepted or endorsed by healthcare professionals in the medical community as safe and effective in treating the specified condition or illness for which the technology’s use is proposed, or
- Not proven through empirical scientific research to be safe and effective in treating the condition or illness for which the technology’s use is proposed.

Extended Care: Skilled inpatient services delivered in an acute rehabilitation hospital, skilled nursing facility or chronic hospital that are provided during the course of a chronic disease or the rehabilitation phase directly following an acute illness.

Facility: A licensed institution providing healthcare services or a healthcare setting, including, but
not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

**Federal Poverty Level (FPL):** The minimum amount of gross income an individual or family needs for food, clothing, transportation, shelter, and other necessities as defined in the poverty guidelines issued annually by the Department of Health and Human Services (HHS). Eligibility for subsidies on the Exchange is defined according to income as a percentage of FPL.

**Final Adverse Determination:** An adverse determination made after a Member has exhausted all remedies available through a carrier’s formal Internal Grievance Process.

**Formulary:** The list of drugs included as part of a health plan’s covered benefits.

**Grievance:** Any oral or written complaint submitted to CeltiCare that has been initiated by a Member, or the Member’s authorized representative, concerning any aspect or action of CeltiCare relative to the Member, including, but not limited to: review of adverse determinations regarding scope of coverage, denial of services, quality of care, and administrative operations. (Note: See internal appeal requests for reviews involving a medical necessity determination involving an adverse determination).

**Health Benefit Plan:** A health insurance plan that provides medical benefits coverage and may include dental, vision and other benefits.

**Health Connector:** The name commonly used to refer to the Commonwealth Health Insurance Connector Authority.

**Health Insurance Marketplace (HIM):** The term is used by the federal government to refer to health insurance exchanges. In Massachusetts, the HIM is the Health Connector.

**Infertility:** The condition of a presumably healthy individual who is unable to conceive or produce conception during a period of 1 year if the female is age 35 years or younger, or during a period of 6 months if the female is over the age of 35 years. If a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the 6 month or 1 year period, as applicable.

**In-Network Provider:** A provider who, under a contract with the carrier, including a dental or vision carrier, or with its contractor or subcontractor, has agreed to provide health, dental or vision care services to Members with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the carrier, including a dental or vision carrier. An In-Network Provider is also known as a participating provider.

**Inquiry:** Any communication by or on behalf of a Member to CeltiCare, or a CeltiCare subcontractor, that has not been the subject of an adverse determination, and that requests redress of an action, omission, or policy of CeltiCare.

**Inpatient:** A patient who is a registered bed patient in a hospital or other covered health care
facility. A patient who is kept overnight in a hospital for observation is not considered an inpatient even though the patient uses a bed. Observations stays are considered outpatient.

**MassHealth:** The medical assistance and benefit programs administered by the Commonwealth’s Executive Office of Health and Human Services (EOHHS). MassHealth encompasses Medicaid and SCHIP and pays for healthcare for certain low- and medium-income people living in Massachusetts.

**Maximum Out-of-Pocket (MOOP):** The total copayment amount a Member needs to pay for prescriptions and/or medical services during a benefit year.

**Medical Necessity or Medically Necessary:** “Medically Necessary” or “Medical Necessity” shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- a) in accordance with generally accepted standards of medical practice;
- b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- c) not primarily for the convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

**Medical Policy:** The Criteria that CeltiCare follows to determine that health care services and medical or surgical supplies are covered by a particular plan. Information about CeltiCare's medical policies can be found on the CeltiCare website at:
http://www.CeltiCareHealthPlan.com/for-providers/provider-resources/medical-policy/

**Member:** Person eligible to get health care coverage through the Health Connector and who chooses CeltiCare Health Plan of Massachusetts, Inc. for coverage.

**Merged Market:** Refers to the Commonwealth offering a single Merged Market with the same health insurance plans available to eligible individuals and small employers through the Non-group and Small Group segments.

**Neuropsychological Assessment/Evaluation:** A systematic evaluation of higher cognitive abilities such as intelligence, academic skill, memory, language, attention, problem-solving ability, and visual-motor skills, as well as sensorimotor and personality/emotional functioning.

**Non-Group:** Individual health insurance.
Non-Participating Provider: A provider who does not have a contract with CeltiCare or with its subcontractor to provide healthcare services to CeltiCare Members. A Non-Participating Provider is also known as an out-of-network provider.

Nurse Practitioner: A registered nurse who is a graduate of an approved program for the training of Nurse Practitioners, who has passed the national certifying exam or its equivalent and who is authorized to practice in an expanded role as a Nurse Practitioner. A Nurse Practitioner can be selected as a Primary Care Provider (PCP).

Office of Patient Protection (OPP): The office within the Health Policy Commission established to develop regulations and statutory requirements to govern managed care carriers internal grievance and the external review procedures.

Open Enrollment: The period during which an eligible individual may enroll in health benefit coverage through the Health Connector.

Out-of-Network Provider: A provider who does not have a contract with CeltiCare or with its subcontractor to provide healthcare services to CeltiCare Members. An Out-of-Network Provider is also known as a non-participating provider.

Out-of-Pocket Maximum (OOP Max): The total copayment amount a Member needs to pay for prescriptions and/or medical services during a benefit year.

Outpatient: A patient who is not a registered bed patient in a hospital or other health care facility. A patient who is kept overnight in a hospital solely for observation is also considered an outpatient.

Participating Provider: A provider who, under a contract with the carrier, including a dental or vision carrier, or with its contractor or subcontractor, has agreed to provide health, dental or vision care services to Members with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the carrier, including a dental or vision carrier. A Participating Provider is also known as an in-network provider.

Physician and Other Covered Professional Providers: Providers that are accepted to deliver health care to CeltiCare Members include certified registered nurse anesthetists, chiropractors, clinical specialists in psychiatric and mental health nursing, dentists, licensed audiologists, licensed dietitian nutritionists (or a dietitian or a nutritionist or dietitian nutritionist who is licensed or certified by the state in which the provider practices), licensed independent clinical social workers, licensed marriage and family therapists, licensed mental health counselors, licensed speech-language pathologists, nurse midwives, nurse practitioners, occupational therapists, optometrists, physical therapists, physicians, podiatrists, psychiatric nurse practitioners, psychologists, and urgent care centers.

Physician Assistant: A person who is a graduate of an approved program for the training of Physician Assistants who is supervised by a registered physician and who has passed the Physician Assistant national certifying exam or its equivalent. A Physician Assistant can be selected as a Primary Care Provider (PCP).
Preferred Drug List (PDL): List of drugs covered by the Plan.

Premium: The monthly amount due from the Member to pay for plan coverage.

Primary Care Provider (PCP): A provider selected by a CeltiCare Member (or assigned by CeltiCare if not selected by the Member) to provide and coordinate all of the Member’s healthcare needs, and to initiate and monitor referrals for specialty services when required. Primary Care Provider may be one of the following practitioner types: Family Practice, Internal Medicine, General Practice, Nurse Practitioner, Physician Assistant, or for female Members, Obstetrics/Gynecology.

Prior Authorization: A request for a certain service, procedure, drug, medical supply or device that requires medical necessity review prior to coverage.

Provider: A provider, other healthcare professional, or facility that is licensed, accredited, and/or certified to perform specified health services consistent with Massachusetts law and the individual specialty scope of professional practice.

Psychopharmacological: The use of drugs to treat mental and psychological disorders.

Qualified Health Plan (QHP): A health insurance plan that is licensed by the Commonwealth and has received the Health Connector’s Seal of Approval as meeting certain standards regarding quality, value, and coverage; and is offered through the Health Connector.

Referral: A special kind of pre-approval that must be obtained from a PCP by a Member prior to the Member seeing a specialist. A Referral is also known as requiring Prior Authorization.

Rehabilitation: Services that are provided to restore function lost or impaired as a result of an accidental injury or an illness.

Resident: A natural person living in the Commonwealth, but the confinement of a person in a nursing home, hospital, or other institution shall not by itself be sufficient to qualify a person as a resident.

Service Area: Established by the Health Connector, the area in which CeltiCare is certified to provide health and/or dental insurance coverage. No coverage will be provided for health care services or medical or surgical supplies that you receive outside of CeltiCare’s service area except for emergency or urgent care.

Small Group: Group health and/or dental insurance coverage offered by eligible employers.

Special Enrollment Period: A period during which a qualified individual or Member who experiences certain triggering events may enroll in, or change enrollment in, a QHP through the Health Connector outside of the initial and annual Open Enrollment Periods.

Speech-Language and Hearing Disorder Services: The plan covers diagnosis and treatment of speech, hearing, and language disorders to the extent Medically Necessary when provided by participating speech-language pathologists and audiologists.
**Summary of Benefits and Coverage (SBC):** The document that describes the covered benefits and cost sharing for a specific health benefit plan. A Summary of Benefits and Coverage (SBC) is also known as a **Summary of Benefits.**

**Telehealth:** The delivery of health related education through telecommunication technologies.

**Telemedicine:** The use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment. Telemedicine does not include the use of audio-only telephone, facsimile machine, or email.

**Temperomandibular Joint (TMJ) Syndrome:** Jaw pain, jaw muscle stiffness, limited movement or locking of the jaw, clicking or popping in the jaw, and a change in how the upper and lower teeth fit together. TMJ may be caused by arthritis, an injury to the jaw causing a fracture or a dislocation of the jaw, or by grinding of the teeth, or clenching of the jaw.

**Terminal Illness:** An illness that is likely, within a reasonable degree of medical certainty, to cause one's death within 6 months.

**Urgent Medical Condition:** Medical services required promptly to prevent impairment of health due to symptoms that a prudent layperson would believe require immediate attention, but are not life-threatening and do not pose a high risk of permanent damage to an individual's health. Urgent care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent care does not include Emergency Services or Primary Care.

**Utilization Review:** A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, healthcare services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, care management, discharge planning or retrospective review.

**Wellness Program or Health Management Program:** An organized system designed to improve the overall health of participants.
WELCOME

Welcome to CeltiCare
Thank you for making CeltiCare your choice for healthcare. This Evidence of Coverage contains an overview of your healthcare benefits, and is designed to make it easy for you to make the most of CeltiCare benefits and services. Your specific Summary of Benefits will give you more details on the cost sharing for all your covered benefits.

CeltiCare combines the strength of a national company with local partnerships with Massachusetts’ hospitals and physicians to ensure you get the highest quality of care. You may also visit our website at www.CeltiCareHealthPlan.com for more information and services.

We partner with the Health Connector to provide health care solutions you can afford. The Health Connector oversees the Health Insurance Marketplace (HIM) program. You may visit the Health Connector’s website at: www.MAHealthConnector.org.

MINIMUM CREDITABLE COVERAGE STANDARDS
Massachusetts Health Care Reform Law requires that Massachusetts residents, 18 years of age and older, must have health coverage that meets the Minimum Creditable Coverage Standards set by the Health Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information, call the Connector at 1-877-MA-ENROLL or visit the Connector website: www.MAHealthConnector.org.

This health plan meets Minimum Creditable Coverage Standards as part of the Massachusetts Health Care Reform Law and the federal Patient Protection and Affordable Care Act (ACA). If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards. Because these standards may change, review your health plan material each year to determine whether your plan meets the latest standards.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794, or visiting its website at www.Mass.gov/DOI.

YOUR EVIDENCE OF COVERAGE
The Evidence of Coverage (EOC) is CeltiCare’s contract with you. The Evidence of Coverage explains your rights, benefits, and responsibilities as a Member of our health plan. Please read this manual carefully. This manual tells you how to access healthcare services. It also gives you information on your CeltiCare benefits and services such as:

- What CeltiCare covers and does not cover
- How to get the care you need or your prescriptions filled
- What to do if you are unhappy about your plan or coverage

Member Services Department: 1-877-687-1186 (TDD/TTY) 1-877-941-9234
Log on to: www.CeltiCareHealthPlan.com
CHP-HIMFY2014 Effective Date: January 1, 2014
- Eligibility requirements
- The geographic service area of CeltiCare
- Materials you will receive from CeltiCare
- Paying your premiums

See your **Summary of Benefits** to find out what you will have to pay for your healthcare or prescriptions.

Call Member Services at 1-877-687-1186 to receive a copy of this EOC at no charge. If there are any major changes to the EOC, we will let Members know by mailing out an insert with new information and posting the latest edition on the CeltiCare website.

**YOUR PROVIDER DIRECTORY**

A listing of CeltiCare providers is available online at [www.CeltiCareHealthPlan.com/members/find-a-provider](http://www.CeltiCareHealthPlan.com/members/find-a-provider). CeltiCare has plan physicians, hospitals, and other healthcare providers who have agreed to provide you with your healthcare services. You may find any of our plan providers by completing the “Find a Provider” function on our website and selecting the “Commercial Network”. There you will have the ability to narrow your search by provider specialty, zip code, gender, whether or not they are currently accepting new patients, and languages spoken. Your search will produce a list of providers based on your search criteria and will give you other information such as address, phone number, office hours, and qualifications.

At any time, you can request a copy of the **Provider Directory** at no charge by calling Member Services at 1-877-687-1186. CeltiCare can also help you pick a primary care provider (PCP). We can make your choice of PCP effective on the next business day.

Call the PCP’s office if you want to make an appointment. If you need help, call Member Services at 1-877-687-1186. We can help you make the appointment.

**CELTICARE WEBSITE**

CeltiCare’s website helps you get the answers you need about your health coverage. Our website has resources and features that make it easy to get quality care. CeltiCare’s website can be accessed at [www.CeltiCareHealthPlan.com](http://www.CeltiCareHealthPlan.com). It also gives you information on your CeltiCare benefits and services such as:

- Finding a provider
- Programs to help you get and stay healthy
- A secure portal for you to check the status of your claims
- Online form submission
- CeltiCare programs and services
- The quarterly newsletter, *Better-for-You*
- Current events and news
QUALITY IMPROVEMENT (QI)

CeltiCare is committed to providing quality healthcare for you and your family. Our primary goal is to improve your health and help you with any illness or disability. Our program is consistent with National Committee on Quality Assurance (NCQA) standards and Institute of Medicine (IOM) priorities. To help promote safe, reliable, and quality healthcare, our programs include:

- Conducting a thorough check on providers when they become part of the CeltiCare provider network
- Monitoring Member access to all types of healthcare services
- Providing programs and educational items about general healthcare and specific diseases
- Sending reminders to Members to get annual tests such as a physical exam, cervical cancer screening, breast cancer screening, and immunizations
- Monitoring the quality of care and developing action plans to improve the healthcare you are receiving
- A Quality Improvement Committee which includes participating providers to help us develop and monitor our program activities
- Investigating any Member concerns regarding care received. For example, if you have a concern about the care you received from your provider or service provided by CeltiCare, please contact the Member Services Department

CeltiCare believes that getting Member input can help make the content and quality of our programs better. We conduct a Member survey each year that asks questions about your experience with the healthcare and services you are receiving.

Member Advisory Committee

Twice a year CeltiCare gathers Members to give us feedback on our services and programs. If you are interested in participating in the Member Advisory Committee, please let Member Services know.

How to Contact Us

CeltiCare Health Plan of Massachusetts
200 West Street, Suite 250
Waltham, MA 02451

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Member Services</td>
<td>1-877-687-1186</td>
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<tr>
<td>TDD/TTY line</td>
<td>1-877-941-9234</td>
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<tr>
<td>Fax</td>
<td>1-866-614-1953</td>
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<tr>
<td>Massachusetts Relay Services</td>
<td>1-800-439-0183</td>
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<tr>
<td>Substance Abuse/Mental Health</td>
<td>1-866-896-5053</td>
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<tr>
<td>Nurse Response®</td>
<td>1-877-687-1186</td>
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<tr>
<td>Vision</td>
<td>1-877-687-1186</td>
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<tr>
<td>Emergency</td>
<td>Call 911</td>
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INTERPRETER SERVICES

Some Members do not speak English. Others speak English, but it is not their preferred language. CeltiCare has a free service to help our Members who don’t feel comfortable speaking English. This service is very important because you and your provider must be able to talk about your medical or behavioral health concerns in a way you both can understand. Our interpreter services are provided at no cost to you. Interpreters can help with many different languages. This includes sign language, medical interpreters, and many others. We also have Spanish-speaking representatives. They can help our Spanish-speaking Members when they call. CeltiCare Members who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

To arrange for interpretation services, call Member Services at 1-877-687-1186 (TDD/TTY 1-877-941-9234).

Your Member ID Card

When you enroll in CeltiCare, we will mail a Member ID card to you within 5 business days of CeltiCare’s receipt of your enrollment with the Health Connector. This card is proof that you are enrolled in a CeltiCare plan. You need to keep this card with you at all times. Please show this card every time you go for any service under the CeltiCare program. The CeltiCare ID card will show your name, Member ID#, the phone number for Behavioral Health services, and copayments required at the time of service. If you do not get your CeltiCare ID card within a few weeks after you join our plan, please call Member Services at 1-877-687-1186. We will send you another card.

Sample Member ID Card

Front:

Back:

HOW YOUR PLAN WORKS

Service Areas Covered

Ambetter Health Insurance Plans from CeltiCare are health plans for individuals and small group employees. This means you are covered for benefits as long as you are a Massachusetts resident who resides within the CeltiCare service area and obtain covered services from our “Commercial Network.” CeltiCare covers all service areas in the Commonwealth of Massachusetts.
Massachusetts.

You can find more information regarding CeltiCare’s service area and participating providers on our website at www.CeltiCareHealthPlan.com. You can also contact the Health Connector Customer Service Center at 1-877-MA-ENROLL or 1-877-623-6765, Monday through Friday from 8:30 a.m. to 5:00 p.m. EST. For persons with total or partial hearing loss, please call TTY 1-888-213-8163 or visit www.MAHealthConnector.org.

**MEMBER SERVICES**

Our Member Services Department will tell you how CeltiCare works, and how to get the care you need. Calls received after business hours are routed directly to Nurse Response® which is available 24 hours a day 7 days a week, including holidays. The Member Services call center can help you with the following:

- Find a PCP
- Obtain a new ID card
- Obtain information about covered and non-covered benefits
- Obtain information about case management
- Obtain a list of health plan providers
- Report potential fraud issue
- Request new Member materials

We are open Monday through Friday from 8:00 a.m. to 5:00 p.m. EST.

**Nurse Response®**

Nurse Response is a free health information phone line. Nurse Response is ready to answer your health questions 24 hours a day – every day of the year. Nurse Response is staffed with registered nurses who are experienced and ready to help you with any health related questions you may have. The services listed below are available by contacting Nurse Response, CeltiCare’s 24-hour nurse hotline at 1-877-687-1186:

- Medical advice
- Health information library
- Advice about a sick child
- Answers to questions about your health
- Information about pregnancy

Sometimes you may not be sure if you need to go to the emergency room. Call Nurse Response; they can help you decide where to go for care.

**MEMBERSHIP AND ELIGIBILITY INFORMATION**

All eligible individuals and employees of small businesses that meet the Massachusetts small group law eligibility requirements are entitled to be enrolled through the Health Connector for CeltiCare Commercial Plans. CeltiCare will accept you into the CeltiCare Commercial Plan directly, or upon referral from the Health Connector, regardless of your income, physical or mental condition, age, gender, sexual orientation, religion, physical or mental disability, ethnicity or race,
Eligibility for Catastrophic Health Plan Coverage

To be eligible to enroll in CeltiCare’s Catastrophic Health Plan coverage, you must be an individual who:

- Is under age 30 before the plan year begins, OR
- Has been deemed exempt from the individual mandate because you do not have an affordable coverage option or you qualify for a hardship exemption.

Family coverage is available as long as each individual enrolled in the coverage meets the eligibility requirements for enrollment in a catastrophic plan.

Eligibility for Commercial Health Plan Coverage

To inquire about CeltiCare Ambetter Plan eligibility, enrollment options, and specific plan benefits please contact the Health Connector.

Commonwealth Health Insurance Connector Authority
P.O. Box 120089
Boston, MA 02112-9914
Telephone: 1-877-MA-ENROLL (1-877-623-6765)
TTY: 1-877-623-7773
www.MAHealthConnector.org
8:30 a.m. to 5:00 p.m. EST Monday - Friday

Enrollment Information

For individuals, Massachusetts law limits when you can purchase commercial health insurance, including CeltiCare Ambetter Health Insurance Plans. The law applies to individuals and families buying health insurance on their own, apart from an employer’s plan.

You can choose to select or change plans during the open enrollment period October 1, 2013 through to March 31, 2014. The dates for open enrollment for subsequent years may change.

- Some people may meet special conditions that will allow you to buy health insurance at any time of the year. You must act within 63 days of losing coverage because you:
  - Became ineligible for an employer’s plan and do not qualify for another employer’s plan or a government-subsidized plan
  - Became ineligible for your government-subsidized plan
  - Used up all of your COBRA or mini-COBRA benefits
- For more information on the open enrollment and qualifying events, go to www.Mass.Gov/DOI or visit www.MAHealthConnector.org for updates, or call the Health Connector at (877) 623-6765 (TDD/TTY 877-623-7773), Monday–Friday, 8:30 a.m. to 5 p.m.

Note: If you cancel your current benefit plan at any time outside of the open enrollment periods or renewal month, you may not be able to purchase other insurance with CeltiCare, or any other

Member Services Department: 1-877-687-1186 (TDD/TTY) 1-877-941-9234
Log on to: www.CeltiCareHealthPlan.com
Effective Date: January 1, 2014
insurance company, until the next open enrollment period. If you are unsure of your options, please contact CeltiCare Member Services before canceling your benefit plan.

You may call the CeltiCare Member Services Department Monday through Friday, 8 a.m. – 5 p.m.


**Involuntary and Voluntary Disenrollment Information**

CeltiCare must notify you on an annual basis of the voluntary and involuntary Member disenrollment rate. Voluntary disenrollment occurs when a Member elects to end benefit coverage. Involuntary disenrollment occurs when the Health Connector or CeltiCare terminates the Member’s coverage for one of the reasons outlined under the Termination of Coverage section of this EOC. Please contact CeltiCare Member Services at 1-877-687-1186 for more information.

**Special Enrollment Period**

If you have had a major change in your life, please contact CeltiCare Member Services. Some examples of major life changes are:

- You change in your name
- You move to a different address
- You change your telephone number
- You change your job
- You become pregnant

Life changes might affect your eligibility with CeltiCare. Call Health Connector Customer Service (1-877-623-6765) if you move to a new county in Massachusetts, or if you move out of the state.

A Member may change his/her health plan enrollment or coverage type outside of his/her renewal period, only under these specific circumstances:

- Marriage or registered as Domestic Partner in state or municipality
- Divorce, legal separation, annulment, or termination of Domestic Partnership
- Birth, adoption, or placement for adoption of a child
- Dependent spouse required to cover a child by court order
- Death of a spouse or dependent
- Covered dependent reaches the age limit for coverage, making him or her ineligible for coverage
- You, your spouse, or eligible dependent moves out of your health plan’s service area
- You, your spouse, or eligible dependent begins or returns from an unpaid leave of absence
- You, your spouse, or eligible dependent has a change in job status (for example: change from full-time to part-time employment or leaving employment) that affects benefit coverage under the employer’s plan, or a plan of your spouse’s or eligible dependent’s employer

A major life change must be reported to the Health Connector within 30 days of the event.
Newborn, Foster, and Adoptive Children Coverage

Coverage is provided for your newborn infant and a newborn infant of a covered dependent up to 96 hours after birth. Additional premium must be paid for coverage to continue for a newborn infant. Coverage is also provided for adoptive child(ren) of a Member from the date of the filing of a petition to adopt, and the child has been residing in the home of the Member as a foster child for whom the Member has been receiving foster care payments, or, in all other cases, adoptive child(ren) from the date of placement of the child for the purpose of adoption. Any additional premium must be paid for coverage to continue for foster or adopted dependents.

Newborn coverage will include the necessary care and treatment of medically diagnosed congenital birth defects, birth abnormalities, or premature birth up to 96 hours after birth. Premium payments must be received to continue coverage.

Notice of the birth or filing a petition to adopt a foster child or placement of a child for purposes of adoption must be provided to the Health Connector within 30 days of birth or filing of a petition to adopt. Failure to notify of the birth or filing a petition to adopt may result in loss of coverage.

For questions related to enrolling your newborn, please contact the Health Connector Customer Service Center at 1-877-MA-ENROLL or 1-877-623-6765, Monday through Friday, from 8:30 a.m. to 5:00 p.m. For persons with total or partial hearing loss, please call TTY 1-888-213-8163 or visit www.MAHealthConnector.org.

Domestic Partner Coverage

CeltiCare offers Domestic Partner Coverage. Contact CeltiCare Member Services for more information regarding Domestic Partner coverage.

Termination of Coverage

You could be terminated from coverage with CeltiCare if:

- You have not paid the required premium
- You commit an act of physical or verbal abuse, or other uncooperative or disruptive behavior, unrelated to your physical or mental condition, that poses a threat to any provider, any Member, or the plan or plan employee
- You commit an act of misrepresentation or fraud related to obtaining health care services, coverage, or payment for health care service
- You fail to comply in a material manner with the plan rules
- You fail to provide to CeltiCare or the Connector the information necessary to show continuing eligibility, or to enable the plan to provide coverage to you under the terms of this EOC
- You choose to end coverage by notifying the Health Connector
- You choose to relocate out of the service area

If you have questions about canceling your plan or termination of your coverage, please contact the Health Connector Customer Service Center at 1-877-MA-ENROLL or 1-877-623-6765, Monday through Friday, from 8:30 a.m. to 5:00 p.m. EST. For persons with total or partial hearing
Contributory Plan Termination of Employer Group for Non-Payment of Premium

Any employer group which fails to pay its monthly group health insurance premium by the 55th calendar day following the first day of the coverage month for which payment was due is subject to termination of its group coverage. Any employees participating in the Employer’s Group Coverage plan will also have their coverage terminated. Termination is retroactive to the last day of the coverage month for which premium was paid.

If you have questions about your participation in your Employer Group plan, contact the Health Connector Customer Service Center at 1-877-MA-ENROLL or 1-877-623-6765, Monday through Friday, from 8:30 a.m. to 5:00 p.m. EST. For persons with total or partial hearing loss, please call TTY 1-877-623-7773 or visit www.MAHealthConnector.org.

Notification Requirements

Written notification will be sent by CeltiCare to each subscriber, at the last-known address, if Employer Group Coverage terminates due to non-payment of premium. Notification will include the date on which the Employer Group plan was terminated; and that termination was for nonpayment of premium (including any additional fees or charges).

CeltiCare will honor claims, to the extent covered under the CeltiCare health plan, for covered health care services received by a member or a member’s covered dependent, prior to the notification date. Notice of termination will be effective 3 days after the date on which CeltiCare mailed notice.

THE FOLLOWING CONTINUATION OF COVERAGE PROVISIONS ONLY APPLY TO ENROLLEES BELONGING TO A SMALL GROUP BUSINESS.

Continuation of Healthcare Coverage

If you (the employee/individual), your spouse, and/or your dependent (qualified beneficiaries) has a change that would result in a loss of coverage under the Small Group health plan, coverage may be continued for you and/or your qualified beneficiaries. To be eligible for continuation of coverage, your Employer Group must already be participating in Small Group health insurance coverage and you and/or your qualified beneficiaries must live within the plan service area.

Special Enrollment Period: Small Group Employees

For purposes of this provision, “qualifying event” means with respect to a qualified beneficiary, any of the following events:

- Your employment ends (other than for reasons of gross misconduct) or work hours are reduced
- You are divorced or legally separated
- You become eligible for benefits under Title XVIII of the Social Security Act
- A dependent child ceases to be eligible under the terms of the health benefit plan

Member Services Department: 1-877-687-1186 (TDD/TTY) 1-877-941-9234
Log on to: www.CeltiCareHealthPlan.com

CHP-HIMFY2014 Effective Date: January 1, 2014
• Your retirement coverage from your employer ends due to bankruptcy of the employer

Continuation under this provision ends the earliest of:

• 18 months after the date if coverage ends due to termination of employment
• 36 months after the date of all other qualifying events, provided the qualifying event is not due to a bankruptcy proceeding affecting a retiree
• The date the employer ceases to provide a health benefit plan
• The date the required premiums are not paid
• The date a qualified beneficiary becomes covered under another health benefit plan that does not include a pre-existing condition limitation or exclusion
• The date the qualified beneficiary becomes eligible for Medicare
• Thirty days after the date a qualified beneficiary is no longer disabled

Extension of Continuation of Coverage
Continuation of coverage may be extended in the following instances:

• If the Social Security Administration determines that either you or your qualified beneficiary is disabled, coverage may be extended up to a maximum of 29 months
• If a qualified beneficiary experiences another qualifying event while receiving 18 months of continuation of coverage, they may be eligible for an additional 18 months of coverage for a maximum of 36 months

Continuation of Spousal Coverage
Your divorced or legally separated spouse shall remain eligible and coverage will continue under the health benefit plan so long as your participation in the health plan continues. Eligibility will end the earlier of the remarriage of either you or your spouse, or such time as provided in the judgment of divorce or separation.

If you remarry, your former spouse has the right, if provided in the divorce judgment, to continue to receive the same benefits that are available to you either by means of a rider to the family contract or the issuance of an individual contract. Additional premium may be required.

Continuation after Death or Layoff
If you lose coverage due to an involuntary layoff or death, the coverage under the health plan shall be continued for you, your spouse, and dependents for a period of 39 weeks from the date you become ineligible for coverage, or until you and your dependents become eligible for another group health plan, whichever comes first. You, your spouse, or dependents will be responsible for payment of the entire premium due.

If you lose coverage due to a plant closing or partial closing, coverage will continue for a period of 90 days from the date you become ineligible for coverage, or until you and your dependents become eligible for another group health plan, whichever comes first. You, your spouse, or dependents will be responsible for payment of the entire premium due.
PAYMENT INFORMATION

Annual Deductible
This is an annual dollar amount that must be paid by you for certain covered services before CeltiCare becomes obligated to pay for covered services. See your Summary of Benefits for any deductible applicable to your health plan.

The annual deductible can be for an individual or a family. If you have a family plan, the deductible can be met by eligible costs incurred by any combination of members enrolled under the same family plan. No one member in a family has to pay more than the individual deductible amount.

Annual Out-of-Pocket Expense
This is the annual dollar amount that you will pay for covered services under a CeltiCare health plan, not including premiums. Except for applicable prescription drug deductibles and copayments, all other deductibles and copayments will count toward the annual out-of-pocket expense. See the Summary of Benefits for your plan for the annual out-of-pocket expense applicable to your health plan.

Copayments
The amount you must pay for a covered service. You may have to pay a copayment to the provider for certain covered services at the time you receive the service. See the Summary of Benefits for your plan for copayments applicable to your health plan.

Note: Providers are not obligated to provide covered services if you fail or refuse to pay required copayments.

Timing of Out-of-Pocket Expenses
Copayments you have paid prior to the start of a benefit year will not be counted toward your annual out-of-pocket expense for your current benefit year. At the start of each new benefit year, your accumulation will become zero and you will start building again toward your annual out-of-pocket expense for that new benefit year.

For purposes of this section, the benefit year is the period of time beginning on the first day of the month for which a Member is eligible for coverage and ending after 12 months. For example, if a benefit plan is effective January 1, 2014, the benefit year will end on December 31, 2014.

Premiums
You may be required to pay a monthly premium directly to the Connector or to CeltiCare depending on what you chose when you enrolled. If you are paying premiums to the Health Connector, please follow the directions provided to you by the Health Connector for paying your premiums. If you choose to pay your premiums directly to CeltiCare, please call CeltiCare Member Services Monday – Friday 8 a.m. – 5 p.m. to discuss what method you want to use to pay that premium.
Grace Period

There is a 30-day grace period allowed for the payment of each premium after the first premium payment. During this period coverage will remain in force. If the premium is not paid during the grace period, coverage will terminate at the end of the grace period. This is called a lapse.

For Members who receive Advance Premium Tax Credits (APTC), After the first premium is paid, a grace period of 3 months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if advance premium tax credits are received.

We will continue to pay all appropriate claims for covered services rendered to the member during the first month of the grace period, and may pend claims for covered services rendered to the member in the second and third month of the grace period. We will notify HHS of the non-payment of premiums, the member, as well as providers of the possibility of denied claims when the member is in the second and third month of the grace period. We will continue to collect advance premium tax credits on behalf of the member from the Department of the Treasury, and will return the advance premium tax credits on behalf of the member for the second and third month of the grace period if the member exhausts their grace period as described above.

For Members who are not receiving Advance Premium Tax Credits (APTC) or a premium subsidy, Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a one (1) month grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Contract will stay in force; however, claims may pend for covered services rendered to the member during the grace period. We will notify HHS, as necessary, of the non-payment of premiums, the member, as well as providers of the possibility of denied claims when the member is in the grace period.

For questions regarding payment of your premiums, please call either:

- Health Connector Customer Service Center at 1-877-MA-ENROLL or 1-877-623-6765, Monday through Friday, from 8:30 a.m. to 5:00 p.m. EST. For people with partial or total hearing loss, call TTY 1-888-213-8163. Or...
- If you are paying your premiums directly to CeltiCare, please call CeltiCare Member Services at 1-877-687-1186 (TDD/TTY 1-877-941-9234).
BENEFITS

Covered Services
This section describes your CeltiCare covered benefits. To see what your copayments are for each covered service, see your "Summary of Benefits." With CeltiCare, you are entitled to receive the Medically Necessary services and benefits listed in this section. You are responsible for copayments, if required. You must pay copayments at the time of service. You are responsible for any non-covered services, deductibles, or coinsurance. Additionally, some covered services may require Prior Authorization by CeltiCare before services are provided. Check with your primary care provider, the ordering provider, CeltiCare Member Services, or online to see if the service requires Prior Authorization. Prior authorization needs to be obtained before the provision of services. Refer to the Prior Authorization section in this manual for more detail. Please refer to your "Summary of Benefits" for a full description of your covered benefits.

Medically Necessary Services
“Medically Necessary” or “Medical Necessity” refers to health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease; and
- not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than any alternative services that are at least as likely to produce the same results in the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

If you have any questions, call CeltiCare Member Services. We can give you more information about any of the covered services described in your "Summary of Benefits."

COVERED SERVICES DESCRIPTION
CeltiCare provides coverage for a broad range of Medically Necessary medical and behavioral health services to meet your healthcare needs. For a service to be covered and eligible for reimbursement, the service must be described in this section, prescribed by your treating provider or primary care provider, and authorized by CeltiCare when Prior Authorization is required.
Please refer to your plan **Summary of Benefits** and the Excluded Benefits section of this manual for applicable copayments, deductible, and exclusions. Certain services require your provider to obtain Prior Authorization prior to the rendering or delivery of the service. These include but are not limited to: services or visits to a non-participating provider, certain surgical procedures, and inpatient admissions. If you would like to obtain or verify the status of a service needing Prior Authorization, you may contact CeltiCare Member Services at 1-877-687-1186. Additional information regarding authorizations can be found in the Prior Authorization section of this manual.

**Medical Services**

**Abortion:** The voluntary termination of pregnancy (abortion) is covered, only as permitted under Massachusetts law (i.e., within a certain period of time following conception for defined circumstances), without authorization when performed by a CeltiCare participating reproductive health facility or provider. Abortion services by a non-participating provider require Prior Authorization from CeltiCare. Please contact your physician or CeltiCare Member Services at 1-877-687-1186 for assistance. Our bi-lingual staff is available 24 hours, 7 days a week to assist you in finding a provider of these services. You may also search our online [www.CeltiCareHealthPlan.com](http://www.CeltiCareHealthPlan.com) provider directory under Find-a-Provider for a listing of providers that perform these services. Your copayment, deductible, or coinsurance will be based on the location of the services (e.g., specialist office, clinic, outpatient surgery, or inpatient). Refer to the **Summary of Benefits** for applicable copayment, deductible, or coinsurance information.

**Ambulance Services:** Emergency ambulance ground transportation to the nearest medical facility for emergency care is covered (with applicable copays, deductible, or coinsurance). Ambulance transport to a hospital Emergency Room in non-emergency situations is not a covered service under CeltiCare. Sea or air ambulance service is covered when a ground ambulance cannot access you, or because of the emergency medical condition, it is necessary to use sea or air ambulance.

Non-emergency ambulance transportation to transport you from one facility to another facility may be covered (with applicable copays, deductible, or coinsurance) if Medically Necessary and Prior Authorized by CeltiCare. Transportation is not covered to or from medical appointments, via ambulance, taxi, chair lift, or public transportation.

**Autism Spectrum Disorders:** Autism Spectrum Disorder includes any of the pervasive developmental disorders, as defined by the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, including Autistic Disorder, and Pervasive Developmental Disorders, not otherwise specified. CeltiCare and Cenpatico cover all Medically Necessary assessments, evaluations (including neuropsychological evaluations), genetic testing or other tests to diagnose whether an individual has Autism Spectrum Disorder. CeltiCare and Cenpatico also covers the following Medically Necessary care prescribed, provided, or ordered for an individual diagnosed (by a licensed physician or licensed psychologist) with an Autism Spectrum Disorder:

- **Habilitation Care:** Professional, counseling, and guidance services and treatment programs, including but not limited to, Applied Behavioral Analysis supervised by a

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Effective Date: January 1, 2014  
CHP-HIMFY2014
board certified behavioral analyst, that are necessary to develop, maintain, and restore, to the maximum extent practicable, the functioning of an individual. Applied Behavior Analysis includes the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

- **Pharmacy Care:** Medications prescribed by a licensed physician and health-related services deemed Medically Necessary to determine the need or effectiveness of the medications.
- **Psychiatric Care:** Direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
- **Psychological Care:** Direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
- **Therapeutic Care:** Services provided by a licensed or certified speech, occupational, or physical therapists, or social workers. Speech, Occupational, and Physical therapy related to Autism Spectrum Disorders do not require Prior Authorization before treatment and do not count toward any benefit limitations for Speech, Occupational, and Physical therapy.

Genetic testing for the diagnosis and treatment of Autism Spectrum Disorders requires Prior Authorization from CeltiCare.

CeltiCare works with Cenpatico Behavioral Health (Cenpatico) to deliver Habilitative, Psychiatric, and Psychological Care for the treatment of Autism Spectrum Disorders. You may choose any provider contracted in Cenpatico’s commercial behavioral health network for the delivery of these services. These services may be subject to Prior Authorization from Cenpatico.

**Bariatric Surgery:** Bariatric surgeries include procedures that promote weight loss for the treatment of morbid obesity. Bariatric surgery is covered by CeltiCare when Prior Authorized and determined to be Medically Necessary by CeltiCare.

**Cardiac Rehabilitation:** Outpatient cardiac rehabilitation is covered when it is prescribed by a physician within 12 months of the date you are diagnosed with cardiovascular disease or of a cardiac event, and provided by a participating provider. Services covered include Phase II - outpatient convalescent phase of the rehabilitation program following hospital discharge and Phase III – outpatient phase of the program that addresses multiple risk reduction, adjustment to illness, and therapeutic exercise. There are no day or dollar limits associated with this service.

**Chiropractic Care:** Medically Necessary chiropractic care is covered up to 12 visits per year. Coverage includes diagnostic lab tests, x-rays (not including MRIs), CT scans and other imaging tests. Coverage also includes outpatient medical care services including spinal manipulation.

**Cleft Lip and Cleft Palate:** Repair and treatment of a cleft lip or cleft palate is covered for eligible Members under 18. Coverage includes medical, dental, oral, and facial surgery.
surgical management and follow up care by oral and plastic surgeons, orthodontic treatment, and structures for orthodontic treatment or prosthetic management therapy, speech therapy, audiology, and nutrition services as deemed Medically Necessary to the treatment of the cleft lip or cleft palate. Prior Authorization is required for all services related to Cleft Lip and Cleft Palate Repair and Treatment.

Clinical Trials for Cancer: CeltiCare covers all Medically Necessary patient care services provided as part of a qualified clinical trial to treat cancer in accordance with the Commonwealth of Massachusetts mandate. A patient care service is a health care item or service that is furnished to an individual enrolled in a qualified clinical trial, which is consistent with the usual and customary standard of care for someone with the patient’s diagnosis, is consistent with the study protocol for the clinical trial, and would be covered if the patient did not participate in the clinical trial. Patient care services associated with clinical trials may require Prior Authorization.

Dental Services-Adult [Off Exchange Plans Only]: Your plan may include an adult dental offering. CeltiCare has partnered with Delta Dental of Massachusetts to provide dental benefits to Adults when purchased in addition to your medical plan. Coverage may be provided for Adults including: exams, tooth cleanings, simple extractions, and x-rays provided by a Dentist who is in the Delta Dental of Massachusetts network. Your Delta Dental of Massachusetts Summary of Benefits will describe all of the covered services and cost sharing. Please refer to Pediatric Dental Services section for information on dental coverage for children under the age of 19.

Dental – Emergency Services: CeltiCare covers emergency dental services related to traumatic injury to sound, natural, and permanent teeth caused by a source external to the mouth, AND the emergency services are provided by a physician in a hospital Emergency Room or Operating Room within 48 hours of the injury. Services covered for emergent/emergency include x-rays and emergency oral surgery related to the repair of damaged tissues and/or the repositioning of displaced or fractured teeth.

Diabetic Service and Supplies: Medically Necessary services and supplies used in the treatment of diabetes are covered when prescribed by and obtained by a participating provider and/or when necessary with Prior Authorization from CeltiCare. Covered services and supplies include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and medical supplies such as urine and/or ketone strips, blood glucose monitor supplies(glucose strips) for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication. Please refer to the Pharmacy section of this manual to learn how to access our Preferred Drug List where you will find complete information on coverage for insulin pens, insulin, oral medications, and other diabetic supplies. Your provider may need to obtain Prior Authorization from CeltiCare for certain DME or Orthotic and Prosthetic devices and procedures, diagnostic testing, and services.
**Diagnostic X-Rays and Imaging:** Medically Necessary diagnostic x-rays are covered. High tech imaging studies, such as Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CT), Positron Emission Tomography (PET), and Nuclear Cardiology scans require Prior Authorization.

**Dialysis:** Dialysis performed at a hospital or a free standing dialysis facility is covered when provided by a participating provider. Coverage includes all related medical supplies, equipment, and services. When peritoneal dialysis is performed in the home, coverage is provided for the supplies; coverage is not provided for the costs of a person to assist with your dialysis, or the cost for power, water, or waste disposal systems. Home hemodialysis is not covered.

If you are planning on traveling temporarily out of the area, CeltiCare will cover up to 30 days for out of service area dialysis. Your provider must obtain Prior Authorization from CeltiCare for these services.

Regardless of your age, if you are receiving dialysis or have received a kidney transplant, you may be eligible for Medicare. To obtain information you may contact the Social Security Administration at 1-800-772-1213.

**Durable Medical Equipment (DME) and Supplies:** CeltiCare covers DME and supplies (including oxygen and respiratory equipment and supplies) that are:

- Made primarily to serve a medical purpose
- Able to stand repeated use
- Not generally useful in the absence of illness or injury
- Appropriate for home use
- Reasonable and necessary to sustain a minimum threshold of independent living

Authorization must be obtained by CeltiCare for the rental, purchase, replacement, and/or repair (less any applicable copayments, deductibles or coinsurance). If CeltiCare determines less costly DME exists to meet your needs, you may be responsible for costs above and beyond the amount for the less costly device. Certain DME requires Prior Authorization from CeltiCare by your provider.

DME ordered for a member during an authorized home health care plan is restricted to equipment that is specifically related to the illness or injury for which skilled home care plan is required, and which is integral to the skilled home health plan of care. DME needed beyond the authorized home care plan of care, or that is received after the authorized home care date span, and exceeds the benefit, is the responsibility of the member.

The following diabetic supplies are accessible through your DME benefit: voice synthesizers, glucose monitors, visual magnifying aids, insulin pumps, and insulin pump supplies. There is no benefit limit for these diabetic supplies.

**Early Intervention Services:** CeltiCare covers all Medically Necessary care related to early intervention services including occupational, physical and speech therapy, nursing care, and
psychological counseling, delivered by certified early intervention specialists, for dependents from birth until their third birthday. There is no maximum benefit for early intervention services, and no copayments, coinsurance, or deductibles are required.

**Emergency Services:** CeltiCare covers all Medically Necessary medical care related to an emergency medical or mental health condition without authorization or referral (less any applicable copayments, deductibles, or coinsurance). For further information on emergency services, please refer to the Emergency Services section of this manual.

**Extended Care, Skilled Nursing, Acute Rehabilitation, and Chronic Care:** Care in an extended facility is covered when Medically Necessary for up to the day limits outlined in your Summary of Benefits (less any applicable copayments, deductibles, or coinsurance). The extended care facility is required to obtain authorization from CeltiCare prior to the admission.

**Family Planning Services:** Family planning services include care, counseling, medical and surgical supplies, and services related to the prevention of conception. These services include: birth control counseling, education about family planning, examination, treatment, laboratory examinations and tests, medically approved methods and procedures, pharmacy supplies and devices, and sterilization, including tubal ligation and vasectomy.

CeltiCare covers the following family planning services from a participating physician (PCP, obstetrician, or gynecologist), nurse practitioner, or certified nurse midwife:

- Routine medical exams
- Diagnostic tests and pregnancy testing
- Birth control counseling
- Genetic counseling
- Prescription contraceptive methods approved by the United States Food and Drug Administration (birth control drugs, IUDs, diaphragms, cervical caps, insertion or removal of a levonorgestrel implant system, and injection of birth control drugs)
- Non-prescription contraceptives when given to you by a participating provider during an office visit

Under your CeltiCare prescription drug benefit, prescription contraceptives such as birth control pills and patches are covered. Note: You may have to pay a prescription drug copayment for certain prescription contraceptives applicable to your Specific Plan Benefit Description. For additional information on prescription drugs refer to the Pharmacy section of this manual. The copayment for office visits is waived when you have a diagnosis related to family planning.

The following services are not considered Family Planning related services:

- Abortion
- Reversal of voluntary sterilization
- Infertility Services- any services, supplies, or drugs related to the diagnosis or treatment of infertility
- Services or fees related to using a surrogate to achieve pregnancy
- Birth control devices, agents, or preparations that by law do not require a prescription (except when given to you by a participating provider during an office visit)
Hearing Aids for Children: CeltiCare covers the full cost of one (1) hearing aid, per hearing impaired ear for Members who are 21 years of age or younger, every 36 months with a written statement from the treating physician that the hearing aids are Medically Necessary. Coverage includes all related services prescribed by a licensed audiologist or hearing instrument specialist including the hearing aid, evaluation, fitting, adjustments, and medical supplies, including ear molds. Prior Authorization is required for all services related to Hearing Aids for Children.

Home Health Care: Home Health Care nursing and other therapeutic services are covered in your place of residence (including a homeless shelter or other temporary residence or a community setting) when:

- A physician certifies:
  - Service(s) are Medically Necessary
  - You are homebound and not able to leave your residence or leaving your residence to receive care and/or services requires substantial efforts
  - Services are part of your individual plan of care with defined medical goals
- Prior Authorization is obtained from CeltiCare by your provider

Services covered include skilled nursing, home infusion, physical therapy, occupational therapy, speech therapy, medical social work, nutritionists, home health aide services, durable medical equipment, and medical and surgical supplies.

Durable Medical Equipment (DME), provided in conjunction with a Home Health Care service, do not apply toward the annual DME benefit limits outlined in the Covered Services Descriptions.

Home health services provided in a hospital, nursing facility, intermediate care facility for the mentally retarded, or any other institutional facility providing medical, nursing, rehabilitative, or related care are not covered by CeltiCare. Homemaker, respite, heavy cleaning, or household repairs are not covered home healthcare services.

Hormone Replacement Therapy: Coverage is provided for outpatient services for peri- and post-menopausal women including outpatient prescription drugs or devices which have been approved by the United States Food and Drug Administration (FDA) under the same terms and conditions as for such other prescription drugs or devices.

Hospice: Hospice is a coordinated, integrated program developed by a multidisciplinary team of professionals to provide end-of-life care, which is primarily focused on relieving pain and symptoms specifically related to the terminally ill diagnosis of members with a life expectancy of six months or less. Most hospice services are provided at home, by a licensed certified hospice provider, under the direction of an attending physician, who may be the member’s primary care physician or the hospice medical director. Hospice services are provided under a plan of care designed by the multidisciplinary team to meet the needs of members who are terminally ill, as
well as their families.

Hospice services include skilled nursing, homemaker and home health aide services, physician services, physical, occupational and speech therapy, medical social services, volunteer services, nutritional, spiritual, psychosocial/supportive and bereavement counseling. Hospice includes drugs and biologicals (medical products made from natural sources, such as vaccines, blood and blood products, human cells and tissues, etc.) related to the management of the terminal illness, to relieve pain, provide hydration and to deliver enterals as a primary source of nutrition. Durable medical equipment and medical supplies are also included in hospice, when related to the management of the terminal illness.

To receive coverage for hospice, requirements include but are not limited to the following:

- A physician must submit written documentation that the member is terminally ill and has a life expectancy of 6 months or less and is no longer seeking curative treatment for their terminal diagnosis; and
- Prior Authorization has been obtained from CeltiCare for services to be delivered through a contracted hospice provider

Hospital Admissions and Stays for Acute Medical and/or Surgical Care: CeltiCare covers Medically Necessary admissions and hospital stays in a licensed hospital; so long as the care and services received are covered services and Medically Necessary (less any applicable copayments, deductible, or coinsurance). Certain admissions require your provider or the facility to obtain Prior Authorization from CeltiCare; all elective or scheduled admissions require Prior Authorization from CeltiCare by your provider before admission.

Hypodermic Syringes or Needles: CeltiCare covers Medically Necessary hypodermic syringes or needles. Refer to the Preferred Drug List (PDL) for your plan benefit.

Imaging: Diagnostic imaging such as CT/PET Scans and MRIs are covered when the service is Prior Authorized and the service is performed by a participating provider.

Immunizations and Vaccinations: Medically Necessary immunizations and vaccinations are covered when provided by a participating provider.

Infertility Treatment: Coverage is provided for the diagnosis and treatment of infertility, including, but not limited to, diagnostic procedures or testing; FDA approved oral and injectable medications; artificial insemination; egg and inseminated egg procurement and placement; in-vitro fertilization; gamete or zygote intra-fallopian transfers; intracytoplasmic sperm injection; sperm and egg cryopreservation, preparation or thawing, assisted hatching, evaluation or storage; banking of sperm or inseminated eggs while the Member is under active infertility treatment. There are no benefit limitations to infertility treatment. Infertility treatment requires Prior Authorization from CeltiCare.

Inpatient Hospital Services: Coverage is provided for costs associated with the services received as part of a hospital stay of at least one night. Coverage is provided for physician and surgical costs associated with procedures performed as part of a hospital stay of at least one
Laboratory Services: CeltiCare covers Medically Necessary diagnostic testing in an office, outpatient hospital, or independent diagnostic or laboratory facility (less any applicable copayments, deductible, or coinsurance). Certain diagnostic tests require your provider to obtain Prior Authorization before services are rendered such as breast, ovarian, colorectal, or melanoma genetic testing.

Maternity Services: CeltiCare covers outpatient and inpatient pre-and post-partum care including exams, prenatal diagnosis of genetic disorders, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and hospital stays for delivery or other Medically Necessary reasons (less any applicable copayments, deductible, or coinsurance). This does not include costs that are associated with achieving pregnancy through surrogacy (having a gestational carrier); or costs associated with a planned home birth. Certain prenatal genetic tests may require Prior Authorization.

An inpatient stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery. CeltiCare also covers one home healthcare visit following your delivery by a registered nurse, physician, nurse midwife, nurse practitioner, or physician assistant, and additional home healthcare visits if Medically Necessary. Other maternity benefits include parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.

Prenatal and Postnatal Care: CeltiCare covers the costs associated with prenatal and postnatal treatment, services, and medical and surgical supplies. Medical care is provided for any female Member and services must be provided by a participating provider. This does not include costs that are associated with achieving pregnancy through surrogacy (having a gestational carrier).

Coverage includes:
- Semiprivate room and board and medical services during the time the mother is an inpatient in a hospital
- Nursery charges for the newborn
- An inpatient stay that is no less than 48 hours for a vaginal delivery and 96 hours for a Caesarian section
- Delivery of one or more than one baby
- Prenatal and postnatal medical care provided by a physician or nurse midwife
- Pediatrician charges when one has been requested to attend the delivery due to suspected complications
- Childbirth classes up to $90 for one childbirth course and $45 for each refresher course which must be paid by you in advance and then will be reimbursed by CeltiCare

Note: no benefits are provided for home births.

Medical Formulas: Non-prescription enteral formula, special medical formulas, or low protein
food products are covered when ordered by your physician, when they are Medically Necessary to treat, and when Prior Authorized by CeltiCare:

- Malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, or chronic intestinal pseudo-obstruction
- Inherited diseases of amino acids and organic acids
- Phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, or methylmalonic academia
- Pregnant women with phenylketonuria

**Medical Supplies:** CeltiCare covers the cost of certain types of medical supplies. You must obtain these from a participating provider. Certain Medical Supplies may require Prior Authorization from CeltiCare by your provider. Medical supplies include:

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

**Mental Health:** See Behavioral Health Services section.

**Neuropsychological Assessment and Psychological Testing Services:** These services may be provided by a behavioral health provider with Prior Authorization.

**Newborn/Dependent Care:** Care and treatment of medically diagnosed congenital defects, birth abnormalities, or premature birth are covered for the first 96 hours. After 96 hours, coverage continues for enrolled newborns.

**Nutritional Counseling:** Medical nutritional counseling is counseling services to prevent and treat illnesses by promoting healthy eating habits, scientifically evaluating your diet, and making suggestions for diet modification. Nutritional screening helps to identify if you are at risk, and offer you preventive or therapeutic dietary therapy to produce a positive result in the role nutrition plays in improving health outcomes. Nutritional counseling is covered for chronic disease states in which dietary adjustment has a therapeutic role, when it is prescribed by your physician and furnished by a participating provider. Nutritional counseling services provided in a home care setting require Prior Authorization from CeltiCare.

**Off-Label Uses of Prescription Drugs for Cancer and HIV/AIDS:** CeltiCare will cover drugs for the treatment of cancer or HIV/AIDS treatment when the off-label use of the drug has not been approved by the federal Food and Drug Administration (FDA) for that indication, if the drug is recognized for treatment of the condition in one of the standard reference compendia, in the medical literature, or by the State of Massachusetts Insurance Commissioner unless contraindicated by the FDA for the treatment of the condition it will be used. Your provider is required to obtain Prior Authorization from CeltiCare for the off-label use of drugs for cancer and HIV/AIDS treatment.
Office Visits: Office visits to see your participating CeltiCare primary care provider (PCP), specialist, nurse, or physician assistant is covered (less any applicable copayments, deductible, or coinsurance). Your PCP may need to obtain a Prior Authorization from CeltiCare for office visits or services by certain specialist providers prior to the visit or services being rendered.

Oral Chemotherapy: Coverage is provided for prescribed, orally administered chemotherapy that kill or slow the growth of cancer in a manner not less favorable than coverage for intravenous chemotherapy. Prior Authorization is required except when prescribed by an oncologist.

Orthotics: Non-dental braces and other mechanical or molded devices are covered by CeltiCare when Medically Necessary to support or correct any defects of form or function of the human body due to surgery, disease, or injury. Arch supports, shoe inserts, therapeutic and molded shoes (not attached to a brace), and inserts are covered for diabetics only and must be prescribed by a participating podiatrist or other qualified provider; and furnished by a participating podiatrist, orthotist, prosthetist or pedorthist. Certain orthotic devices require Prior Authorization from CeltiCare before receiving related orthotic services. Orthotics are covered less any applicable copayment, deductible, or coinsurance.

Outpatient Facility: Treatments that occur at a medical facility, such as an ambulatory surgery center, when the Member is treated but is not a registered bed patient, are covered. This does not include removal of wisdom teeth whether or not they are embedded in the bone.

Outpatient Surgery Physician/Surgical Services: Covered treatments that occur at a medical facility and are performed by a participating surgeon, physician, and medical professionals providing surgical services are covered. This does not include removal of wisdom teeth whether or not they are embedded in the bone.

Pediatric Dental Services [Off Exchange Plans Only]: CeltiCare has partnered with Delta Dental of Massachusetts to provide pediatric dental coverage to our members. The Delta Dental of Massachusetts plan covers one complete initial oral exam, periodic oral exams (two per 12 month period), tooth cleanings (two per 12 month period), fluoride treatments, restorative services, simple and surgical extractions, x-rays provided by a Dentist who is in the Delta Dental of Massachusetts network. Orthodontia is excluded other than Medically Necessary orthodontia as determined by Delta Dental of Massachusetts. Your Delta Dental Summary of Benefits will describe all of the covered services and cost sharing.

Pediatric Specialty Services: CeltiCare covers pediatric specialty care services when provided by a CeltiCare Network Provider who has expertise in specialty pediatrics.

Podiatry: CeltiCare covers non-routine podiatry care, service, treatment and/or procedures from a CeltiCare participating physician or podiatrist. Routine foot care is only covered for Members with diabetes.

Prescription Drugs: Costs for prescription medications are covered including generic drugs, preferred brand drugs, non-preferred brand drugs, and specialty drugs with specific guidelines.

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CHP-HIMFY2014 Effective Date: January 1, 2014
as explained in the Pharmacy section of this manual. Drugs that are considered experimental are not included. See the Pharmacy section for more detail.

**Preventive and Primary Health Care Services for Children:** CeltiCare covers immunizations and preventive services that are Medically Necessary based on the recommendations made by the Advisory Committee on Immunization Practices (ACIP) and the Massachusetts Health Quality Partners (MHQP). The following services are covered for an enrolled child from the date of birth through attainment of 6 years of age:

- Physical exam, history, measurement, sensory screening, neuropsychiatric evaluation and development screening, and assessment at the following intervals:
  - Six times during the child’s first year after birth
  - Three times during the next year
  - Annually until age 6
- Hereditary and metabolic screening at birth
- Newborn Hearing Screening test prior to discharge from the hospital or birthing center.
- Immunizations, tuberculin tests, hematocrit, hemoglobin, blood lead screening or other blood tests and urinalysis as recommended by the physician

You can find a list of all children’s preventive health care services CeltiCare covers at [www.CeltiCareHealthPlan.com](http://www.CeltiCareHealthPlan.com).

**Preventive Health Care Services:** Routine exams and services performed by your participating primary care, obstetric, family, nurse practitioner, or other participating health care professional to keep you healthy are covered by CeltiCare. There are no copayments for preventive healthcare services, which include but are not limited to, general health and/or annual gynecological exams, immunizations, laboratory and radiology diagnostic testing, hearing exam and/or screening, cytologic (PAP smear) screening, health education, nutritional counseling and mammography (at least a baseline mammogram for women between the ages of 35 and 40; a mammogram on an annual basis for women 40 years of age and older). Adult preventive health care visits are limited to one visit during the benefit year.

CeltiCare covers immunizations and preventive services that are Medically Necessary based on the recommendations made by the Advisory Committee on Immunization Practices (ACIP) and the Massachusetts Health Quality Partners (MHQP). You can find a list of all adult preventive health care services CeltiCare covers at [www.CeltiCareHealthPlan.com](http://www.CeltiCareHealthPlan.com).

**Prosthetic Devices:** CeltiCare covers prosthetic devices, such as breast prosthesis and artificial limb devices to replace, in whole or in part, an arm or leg, including evaluation, fabrication, and fitting from a participating provider when Prior Authorized by CeltiCare. Scalp hair prosthetics (wigs) worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia are covered. Coverage is provided for scalp hair prosthesis based on medical necessity and when Prior Authorized by CeltiCare.

**Psychopharmacological Services:** This benefit will be covered in a manner identical to all other medical services.
Radiation and Chemotherapy: Radiation and/or chemotherapy are covered when services are provided by a CeltiCare participating provider. Certain radiation and chemotherapy treatments may require Prior Authorization from CeltiCare before treatment.

Radiology Services: CeltiCare covers Medically Necessary diagnostic testing in an office, outpatient hospital, or independent diagnostic radiology facility (less any applicable copayments, deductible, or coinsurance). Radiology services performed for preventive purposes have no deductibles, copayments, or coinsurance. Certain high tech diagnostic imaging procedures require your provider to obtain authorization from CeltiCare prior to the services being rendered such as CT, MRI, PET, and Nuclear Cardiac Scans.

Skilled Nursing Services: Coverage is provided for Medically Necessary inpatient treatment, services, and medical and surgical supplies received at a skilled nursing facility up to 100 days per benefit year when Prior Authorized by CeltiCare.

Speech-Language and Hearing Disorder Services: The plan covers diagnosis and treatment of speech, hearing, and language disorders when determined Medically Necessary by CeltiCare and provided by participating speech-language pathologists and audiologists. This coverage includes: diagnostic tests, including hearing exams and tests; speech/language therapy; and medical care to diagnose or treat speech, hearing, and language disorders. There is no benefit maximum on Speech-Language and Hearing Disorder Services. No benefits are provided when these services are furnished in a school based setting. Speech-Language and Hearing Disorder Services require Prior Authorization by CeltiCare.

Substance Abuse Services: See Behavioral Health Services section.

Surgery: CeltiCare covers Medically Necessary surgery performed in an office, hospital, or ambulatory surgery center (less any applicable copayments, deductible, or coinsurance). Cosmetic surgery is only covered if the surgery is required to restore bodily function, or to correct a functional physical impairment following an accidental injury, prior surgical procedure, or congenital/birth defect. Certain surgical procedures may require authorization prior to the service being performed such as, but not limited to: an elective surgery performed at a hospital as an inpatient; surgery at or by a non-participating provider; surgical procedures which are potentially cosmetic such as blepharoplasty, breast reconstruction, breast reduction, mastectomy for gynecomastia, treatment of varicose veins; other surgeries such as transplants and bariatric surgery. For additional Information regarding authorization, please refer to the Prior Authorization section of this manual.

Telemedicine: Diagnosis, consultation, or treatment done through remote communications are covered and subject to the same Prior Authorization requirements as any other Medically Necessary office visit.

Therapy – Outpatient Physical and Occupational,: CeltiCare covers short term physical and occupational therapy in an office, outpatient hospital, or free standing outpatient rehabilitation facility when received through a participating provider and authorization obtained from CeltiCare.
by your treating provider. Physical therapy and occupational therapy have a combined benefit limit of 60 visits per benefit year. Covered therapy services include diagnostic evaluation and therapeutic intervention that are designed to improve, develop, correct, rehabilitate, or prevent the worsening of functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries.

**TMJ Syndrome:** Coverage for the treatment of TMJ is provided when diagnostic x-rays or imaging, such as an MRI, support the diagnosis of TMJ. Services related to the diagnosis and treatment of TMJ may require Prior Authorization by CeltiCare.

**Tobacco Cessation:** CeltiCare provides a tobacco cessation program that includes individual telephonic coaching support, educational materials and nicotine supplement coverage. Coverage is also provided for face-to-face counseling services provided by a CeltiCare network provider. Members will be considered eligible for the program if they are currently using tobacco in any form and willing to set a quit date within thirty days of enrolling with the program. Members can self-refer to the program, be referred by a provider, or recommended by case manager or other health plan program. When prescribed by your doctor, tobacco cessation coverage includes prescription medications such as; Chantix (when approved by CeltiCare), Zyban, nicotine inhalers, and nicotine nasal sprays. Over the counter nicotine replacement patches, gums, and lozenges are covered without prior approval.

For more information on CeltiCare’s Tobacco Cessation Program or to enroll, contact CeltiCare at 1-877-687-1186.

**Transplant:** Non-experimental human organ and stem cell transplants, including bone marrow transplants or transplants for persons who have been diagnosed with metastatic breast cancer are covered when the specific transplant criteria has been met, CeltiCare has authorized the transplant in advance, and the transplant is provided by a participating provider or a provider approved in advance by CeltiCare. Covered transplant services include:

- Recipient transplant evaluation and diagnostic testing
- Human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish Member’s bone marrow transplant donor suitability including the costs of testing for A, B, or DR antigens, or any combination thereof, consistent with rules, regulations, and criteria established by the department of public health
- Donor search costs incurred within an established organ donor registry
- Donor costs if the costs are not covered by other insurance (including donor evaluation, donor preparation, and donor surgery and recovery)

**Urgent Care:** Medically Necessary treatment at a participating provider is covered.

**Wellness Benefits:** CeltiCare supports healthy lifestyles. Our goal is to help you stay healthy by encouraging you to achieve your personal fitness and weight loss goals through regular exercise and healthy eating habits. Members who participate in approved fitness and weight loss programs are eligible to receive reimbursement for certain costs associated with these programs. To receive your reimbursement, send your request for reimbursement along with any
supporting documents no later than 3 months after the benefit year for which you are requesting the benefit.

**Fitness Benefit:** CeltiCare may reimburse members up to 12 months of their monthly membership dues with certain fitness gyms or health clubs. If you prefer to exercise outdoors, CeltiCare will reimburse you for a pair of running shoes. You can choose only one of these fitness benefits per benefit year. Members can participate in either of the fitness benefits without needing to satisfy any specific health outcomes or demonstrate improvement in health conditions to receive reimbursement for the program of your choice.

- **Exercise Facility:** CeltiCare will reimburse members for their monthly membership dues based on the gym or health club they select. If you choose to join a gym or health club, you are not eligible for the running shoe fitness benefit. CeltiCare does not reimburse for annual membership fees, startup fees, costs for club initiation, late fees, or other fees. Members can receive reimbursement for up to 1 full year of monthly membership dues based on the fitness gym or health club they choose. For a complete listing of eligible fitness gyms or health clubs and to determine the reimbursement level, please contact CeltiCare Member Services or visit our website at www.CeltiCareHealthPlan.com. Cannot find your gym or club on our list; call us so we can help. Reimbursement levels for the fitness benefit are as follows:
  - Value memberships: Reimbursed up to 12 months per member per benefit year.
  - Standard memberships: Reimbursed up to 6 months per member per benefit year.
  - Premium memberships: Reimbursed up to 3 months per member per benefit year.

- **Qualifications:** You must be a member and active participant of the gym or fitness center and demonstrate regular use each month for that you want reimbursement, exercising a minimum of 8 times per month. This benefit is available to individual memberships only and does not cover family memberships. To get your reimbursement, you need to:
  - Send in receipts showing monthly dues payment;
  - Send verification of regular participation at the gym or club for each month that you want reimbursement; and
  - Submit this information and a Wellness claim form to CeltiCare for reimbursement.

**Running shoes:** CeltiCare will reimburse members for one pair of running shoes once per member per benefit year. If you chose the running shoes fitness benefit you are not eligible for the exercise facility benefit. Members qualify for reimbursement of the cost of their running shoes by completing the activities in one of the bullets listed below. You may select your running shoes from a list of pre-qualified manufacturers and styles. For a complete listing of CeltiCare’s approved manufacturers and styles, please contact CeltiCare Member Services or visit our website at www.CeltiCareHealthPlan.com. In order to receive reimbursement for your running shoes, you must complete at least one of the following running activities:
Complete a full marathon
- Complete two half marathons
- Complete four 5K marathons

**Qualifications:** You must complete at least one of the above activities in order to be eligible for the benefit. To get your reimbursement you need to:
- Send proof that you completed the running activity, such as sending a screen shot of marathon website with your posted results;
- Select your pair of running shoes from CeltiCare’s pre-qualified list of running shoe manufacturers and styles;
- Purchase your running shoes and obtain a receipt; and;
- Submit this information and a Wellness claim form to CeltiCare for reimbursement

**Weight Loss Benefit:** CeltiCare will reimburse members the registration fee, when applicable, and weekly dues for joining a Weight Watchers® program.

- **Program:** CeltiCare will reimburse members for completing a 12 week session of Traditional Weight Watchers® meetings or Weight Watchers At Work program. Reimbursement is limited to one 12 week program per member per benefit year. The Weight Watchers Online, Weight Watchers At Home, or other weight loss programs do not qualify for reimbursement. Fees paid for food, books, videos, scales, or other items not included as part of the Weight Watchers program are not covered.
- **Qualifications:** You must join an approved Weight Watchers program and complete at least 10 of the 12 weeks of meetings in order to be eligible for the benefit. To get your reimbursement, you need to:
  - Send a copy of your participation card showing you attended at least 10 sessions;
  - Send a receipt showing payment for the 12 week program membership and registration fee if applicable;
  - Submit this information and a Wellness claim form to CeltiCare for reimbursement.

**BEHAVIORAL HEALTH SERVICES**

**Mental Health and Substance Abuse Services**

All Mental Health and Substance Abuse benefits are provided on a non-discriminatory basis to all enrollees for the diagnosis and active treatment of Medically Necessary mental, emotional, and substance use disorders, as described in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* that are scientifically recognized and approved by the Commissioner of Mental Health in consultation with the Commissioner of the Division of Insurance. Deductible, copayments, and treatment limits for Behavioral Health Services will be applied in the same manner as physical health services.
If you need Behavioral Health Services, CeltiCare works with Cenpatico Behavioral Health (Cenpatico) to deliver the appropriate services. Cenpatico manages CeltiCare’s behavioral health program. You may choose any provider in Cenpatico’s Behavioral Health Network and do not need a referral from your PCP to initiate services.

Inpatient, Intermediate, and Outpatient Mental Health and Substance Abuse services are covered in accordance with medical necessity and may be subject to Prior Authorization. Cenpatico uses InterQual® Criteria for all Mental Health medical necessity determinations and American Society of Addictive Medicine (ASAM) guidelines for all Substance Abuse medical necessity determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not Medically Necessary will be made by a qualified licensed mental health professional. The medical necessity guidelines are can be found at Cenpatico’s website. Cenpatico will offer benefits on a non-discriminatory basis for individuals seeking diagnosis and treatment for mental and emotional disorders following any type of assault or violent act, including rape or an assault with intent to commit rape when the diagnosis and treatment costs exceed the maximum compensation awarded by the Commonwealth of Massachusetts.

Cenpatico will provide coverage to enrollees who are requiring services for the pediatric population by persons with recognized expertise in pediatric psychiatry or pediatric mental health counseling.

Cenpatico defines Inpatient, Intermediate and Outpatient Mental Health and Substance Abuse Services as follows:

**Inpatient Mental Health and Substance Abuse Services:** 24 hour medically-monitored services, delivered in a licensed general hospital, a psychiatric hospital, or a substance abuse facility, that provide evaluation and treatment for an acute psychiatric condition or substance use diagnosis, or both.

**Intermediate Mental Health and Substance Abuse Services:** Non-inpatient services are services that provide more intensive and extensive treatment interventions when outpatient services alone are not sufficient to meet the patient’s needs. Intermediate care is based on medical necessity: the authorization of benefits does not affect the minimum benefits mandated for inpatient care or outpatient visits for non-biologically based conditions. Intermediate services include but are not limited to In-home Therapy Services, Clinically Managed Detoxification Services, Crisis Stabilization, Residential Treatment, Partial Hospitalization Programs and Intensive Outpatient Programs.

**Outpatient Mental Health and Substance Abuse Services:** Services provided in-person in an ambulatory care setting. Outpatient services may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the Department of Public Health, a public community mental health center, a professional office or home–based services. Such services delivered in such offices or settings are to be rendered by a licensed mental health professional (a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, marriage and
family therapist within the lawful scope of practice for such therapist, or a licensed nurse mental health clinical specialist) acting within the scope of his/her license in the Cenpatico Behavioral Health Network.

Criteria: Cenpatico utilizes established level of care guidelines and medical necessity criteria which take into account legal and regulatory requirements such as InterQual and ASAM, when making clinical determinations. The Cenpatico Provider Advisory Committee reviews the criteria annually. Committee members consider the current practice guidelines of recognized mental health professional organizations and consumer advocacy groups, current scientific and evidence-based knowledge, and current and acceptable practice standards for behavioral health services when developing and reviewing criteria and will seek input from outside practitioners and clinical experts within the various departments and business units of Cenpatico.

Covered services requiring Prior Authorization from Cenpatico include:

- Inpatient hospitalization for mental health or substance abuse, including detoxification
- Observation bed
- Partial Hospitalization Program (PHP)
- Intensive Outpatient Program (IOP)
- Residential Treatment for Mental Health and Substance Abuse
- Electroconvulsive Therapy (ECT)
- Psychological Testing and Neuropsychological Testing

Providers participating in Cenpatico’s Behavioral Health Network do not need to obtain Prior Authorization from Cenpatico for traditional Outpatient services, including medication management visits.

Please call Cenpatico at 1-866-896-5053 if you need help finding a provider.

*If COBRA coverage is selected, then all plan benefits will be available. If COBRA is not selected, any premium paid to continue mental health benefits beyond age 19 will continue Chapter 80 benefits only, and COBRA eligibility will not be extended.

VISION SERVICES

Routine Vision
Routine eye exams, prescriptions eyeglasses, and initial supply contact lenses are available to children under age 19. Adults age 19 or older are covered for exams every 24 months. Vision benefits are managed through OptiCare. For information regarding your specific copayments and/or deductible please refer to your specific plan information listed in the Summary of Benefits.

Children may receive one routine eye exam and eyewear once every 24 months. Eyewear includes either one pair of eyeglasses or contacts or initial supply of standard contacts.
• **Eyeglasses**
  Covered lenses include single vision, lined bifocal, or lined trifocal, in glass or plastic. Covered lens add-ons include standard polycarbonate lenses, scratch resistance, and anti-reflective coating. If you require a more complex prescription lens, contact OptiCare for Prior Authorization. Lens options such as progressive lenses, high index tints and UV and coating are not covered.

  For your maximum allowance for eyeglass frames please refer to your specific plan information listed in the *Summary of Benefits*. OptiCare providers offer a wide range of frames that are at no cost to you.

  Should you choose to select a frame that is more than your maximum benefit, you will be financially responsible for the difference.

• **Contact Lenses**
  Coverage includes evaluation, fitting, and initial supply of standard contact lenses. If you elect contact lenses in lieu of glasses, please refer to your specific plan information listed in the *Summary of Benefits* for your maximum allowance for contacts.

  For additional information about covered vision services, participating OptiCare providers, call Member Services at 1-877-687-1186.

**Non-Routine Vision**
Eye exams for the treatment of medical conditions of the eye are covered when the service is performed by a CeltiCare participating provider (optometrist or ophthalmologist). Covered services include office visits, testing, and treatment of eye conditions producing symptoms that if left untreated may result in the loss of vision.
EXCLUDED BENEFITS

**Services NOT Covered**
The following are examples of excluded services and benefits; this is not intended to be an exhaustive list:

<table>
<thead>
<tr>
<th>Non-Covered Services</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>Benefit coverage is not provided for acupuncture unless authorized as part of a substance abuse program.</td>
</tr>
<tr>
<td>Alternative Medicine</td>
<td>Benefit coverage is not provided for alternative medicine including, but not limited to, homeopathy, naturopathy, traditional Chinese medicine, and Ayurveda.</td>
</tr>
<tr>
<td>Benefits from Another Source</td>
<td>Benefit coverage is not provided for services and supplies to treat an illness or injury for which you have the right to benefits under other government programs. These include services from: the Veterans Administration for an illness or injury connected to military service; schools; or, programs set up by other local, state, federal, or foreign laws or regulations that provide or pay for healthcare services and supplies, or that require care or treatment to be furnished in a public facility. No benefit coverage is provided if you could have received governmental benefits by applying for them on time. Additionally, no benefit coverage is provided for services which payment is required to be paid by a Workers’ Compensation plan or an employer under state or federal law.</td>
</tr>
<tr>
<td>Biofeedback</td>
<td>Benefit coverage is not provided for biofeedback except if authorized for urinary incontinence.</td>
</tr>
<tr>
<td>Cosmetic Services and Procedures</td>
<td>No benefit coverage is provided for cosmetic surgery <em>unless</em> required to restore bodily function or correct a functional physical impairment following an accidental injury, prior surgical procedure, or congenital/birth defect.</td>
</tr>
<tr>
<td>Custodial and Personal Care Services</td>
<td>Benefit coverage is not provided for care that is furnished mainly to help a person with activities of daily living and does not require day-to-day attention by medically trained persons.</td>
</tr>
<tr>
<td>Educational Evaluation, Testing, and Treatment Services</td>
<td>Benefit coverage is not provided for educational testing and evaluations.</td>
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<tr>
<td>Non-Covered Services</td>
<td>Description</td>
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<tr>
<td>Excluded Service Locations</td>
<td>Benefit coverage is not provided for services provided to enrollees in jail, prison, a house of correctional or custodial facility, or in long-term residential treatment.</td>
</tr>
<tr>
<td>Exams and Services Required by a Third Party</td>
<td>Benefit coverage is not provided for physical, psychiatric and psychological examinations, drug testing or other testing or services required by a third party, including but not limited to, employment, insurance, licensing, recreational or sport activities, and court-ordered or school ordered exams.</td>
</tr>
<tr>
<td>Exercise Equipment and Supplies</td>
<td>Benefit coverage is not provided for charges related to the use, rental, or purchase of exercise equipment and devices or related supplies.</td>
</tr>
<tr>
<td>Experimental or Investigational Procedures and Related Services</td>
<td>Benefit coverage is not provided for healthcare services that are received for or related to care that is determined by CeltiCare to be an experimental or investigational service or procedure.</td>
</tr>
<tr>
<td>Foot Care</td>
<td>Benefit coverage is not provided for routine foot care services except for diabetics.</td>
</tr>
<tr>
<td>Hypnotherapy and Hypnosis</td>
<td>Benefit coverage is not provided for hypnotherapy or hypnosis.</td>
</tr>
<tr>
<td>Lodging and Transportation</td>
<td>Benefit coverage is not provided for lodging and non-emergency or unauthorized transportation associated with receiving medical services.</td>
</tr>
<tr>
<td>Long-Term Nursing Home Care</td>
<td>Benefit coverage is not provided for long-term or custodial nursing home care.</td>
</tr>
<tr>
<td>Massage and Aqua Therapy</td>
<td>Benefit coverage is not provided for massage or relaxation therapy. Aqua therapy is not covered in group sessions or via programs offered at health clubs, gyms, sports clubs, related physical fitness facilities, or provided by a personal trainer.</td>
</tr>
<tr>
<td>Maternity Services Outside of the CeltiCare Service Area</td>
<td>Benefit coverage is not provided for routine maternity services, including prenatal and postpartum care, when you are traveling outside of the CeltiCare service area, unless Prior Authorization has been obtained from CeltiCare before services are delivered. Home births that are planned are not covered.</td>
</tr>
<tr>
<td>Non-Emergency Care when</td>
<td>Benefit coverage is not provided for any medical treatment or supplies that are provided to you outside the United States unless that treatment or those</td>
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<tr>
<td>Non-Covered Services</td>
<td>Description</td>
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<tr>
<td>Traveling Outside the U.S.</td>
<td>supplies are provided as part of emergency services.</td>
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<tr>
<td>Non-Participating Providers</td>
<td>Benefit coverage is not provided for services provided by a non-participating provider except those provided due to an emergency medical or behavioral health condition or Prior Authorized by CeltiCare.</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>Benefit coverage is not provided for the prevention or correction of abnormally positioned or aligned teeth.</td>
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<tr>
<td>Other Non-Covered Services</td>
<td>Benefit coverage is not provided for:</td>
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<td>• Any service or supply that is not described as a covered benefit for your plan type</td>
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<td>• Any service or supply that is not Medically Necessary except voluntary termination of pregnancy, voluntary sterilization, prescription contraceptive medications, and preventive health services</td>
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<td>• A provider’s charge for shipping and handling or taxes</td>
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<td>• A provider’s charge to file a claim</td>
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<td></td>
<td>• A provider’s charge for copies of your medical records</td>
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<td>• Medications, devices, treatments, and procedures that have not been demonstrated to be medically effective</td>
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<td>• Services to accommodate your religious preference; to improve athletic performance; to promote a desired lifestyle; or to improve your appearance or your feelings about your appearance</td>
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<td>• Services for which there would be no charge in the absence of insurance</td>
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<td>• Special equipment needed for sports or job purposes</td>
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<td>• Services or supplies provided by an immediate family Member</td>
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<td>• Services related to, or provided in conjunction with, a non-covered service, such as professional fees, medical equipment, medications, and facility charges</td>
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<td></td>
<td>• Services received when not enrolled with CeltiCare</td>
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<td></td>
<td>• Services that can safely and effectively be obtained in a less intensive setting, level of care, or for which a more cost-effective alternative exists</td>
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<tr>
<td></td>
<td>• Services received outside the service area except as specifically described in this EOC</td>
</tr>
<tr>
<td></td>
<td>• Services provided by non-participating providers, except as specifically allowed in this EOC</td>
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<tr>
<td></td>
<td>• Services that do not conform to CeltiCare’s clinical review criteria and guidelines</td>
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<tr>
<td>Non-Covered Services</td>
<td>Description</td>
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</tbody>
</table>
| Personal Comfort and Convenience Items or Services | Benefit coverage is not provided for personal comfort or convenience items or services that are furnished for your personal care or for the convenience of your family. The following items are generally deemed personal comfort or convenience items:  
  - Air conditioners  
  - Air purifiers  
  - Bath/bathing equipment such as aqua massagers and turbo jets  
  - Bed lifters that are not primarily medical in nature  
  - Beds and mattresses and non-hospital type adjustable beds  
  - Chair lifts  
  - Computers and/or computer software  
  - Computerized communication devices  
  - Cushions, pads, and pillows except those described as covered  
  - Dehumidifiers  
  - Elevators  
  - Electronic or myoelectronic limbs  
  - Heating pads and/or hot water bottles  
  - Home type bed baths requiring installation  
  - Hospital beds in full, queen, and king sizes  
  - Hygienic equipment that does not serve a primary medical purpose  
  - Non-medical equipment otherwise available to the Member that does not serve a primary medical purpose  
  - Private room charges greater than the rate for a semi-private room, except when a private room is Medically Necessary  
  - Pulse tachometers  
  - Replacement or repair of durable medical equipment, prosthetic, or orthotic devices due to loss, intentional damage, negligence, or theft  
  - Room humidifiers  
  - Spare or back-up equipment  
  - Special clothing except Medically Necessary equipment or devices such as gradient pressure support aids, mastectomy bras, stump socks, and therapeutic molded shoes for diabetic foot disease  
  - Whirlpool equipment generally used for soothing or comfort measures  
  - Telephones, radios, and televisions  
  - Home monitoring or medical alert system |
<p>| Pre-Implantation Genetic Testing | Benefit coverage is not provided for pre-implantation genetic testing or related services performed on gametes or embryos. |</p>
<table>
<thead>
<tr>
<th>Non-Covered Services</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Duty Services</td>
<td>Benefit coverage is not provided for private duty services including, but not limited to, those provided by a nurse (Licensed Professional Nurse or Registered Nurse) nursing assistant, nursing aid, private care attendant, or personal care attendant.</td>
</tr>
<tr>
<td>Refractive Eye Surgery</td>
<td>Benefit coverage is not provided for eye surgery such as, but not limited to, laser surgery, radial keratotomy, and orthokeratology to treat conditions such as myopia, hyperopia, and astigmatism which can be corrected by non-surgical means.</td>
</tr>
<tr>
<td>Respite Care</td>
<td>Benefit coverage is not provided for respite care except when provided as part of a hospice program Prior Authorized by CeltiCare.</td>
</tr>
<tr>
<td>Reversal of Voluntary Sterilization</td>
<td>Benefit coverage is not provided for the reversal of any voluntary sterilization procedure.</td>
</tr>
<tr>
<td>Self-Monitoring Devices</td>
<td>Benefit coverage is not provided for self-monitoring devices, including personal medical response systems, except blood glucose monitoring devices for Members with diabetes (insulin dependent or non-insulin dependent) and gestational diabetes.</td>
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<tr>
<td></td>
<td>Peak flow meters used in the monitoring of asthma control.</td>
</tr>
<tr>
<td>Sexual/Gender Reassignment</td>
<td>Benefit coverage is not provided for sexual reassignment surgery (sex change or reversal of a sex change) and all related drugs and procedures.</td>
</tr>
<tr>
<td>Snoring Treatments and Procedures</td>
<td>Benefit coverage is not provided for the treatment or reduction of snoring such as laser-assisted uvulopalatoplasty, somnoplasty, and snore guards.</td>
</tr>
</tbody>
</table>

If you have questions about any of these services, call us. We can be reached at 1-877-687-1186 (TDD/TTY 1-877-941-9234). A Member Services Representative will help you understand your benefits.
HOW TO OBTAIN HEALTHCARE

Primary Care Provider (PCP)
CeltiCare believes that seeing your PCP is important. When you enroll in CeltiCare you must choose a PCP. This is the provider you see on a regular basis to take care of your basic medical needs. You should receive all of your basic medical care from your PCP. You can call your PCP when you are sick and do not know what to do. If you have never seen your PCP, as soon as you join CeltiCare you should call your PCP, introduce yourself as a new Member, and make an appointment for a preventive visit. It is best to not wait until you are sick to meet your provider for the first time. Seeing your provider for regular check-ups helps you find problems early. Your PCP should provide all of your primary care.

Your PCP will:

- Make sure that you receive all Medically Necessary services in a timely manner
- Follow-up on the care you receive from other medical providers
- Take care of coordinating specialty care and services offered by CeltiCare
- Provide any ongoing care you need
- Update your medical record, which includes keeping track of all the care that you get from all providers
- Provide services in the same manner for all patients
- Give you regular physical exams as needed.
- Provide preventive care visits
- Give you regular immunizations as needed
- Make sure you can contact him/her or another provider at all times
- Discuss what advance directives are and file the directive appropriately in your medical record

Physician Profiling Information
Information about licensed physicians (including malpractice history) is available from the Commonwealth of Massachusetts Board of Registration in Medicine at www.MassMedBoard.org.

Choosing Your PCP
The CeltiCare Provider Directory is available online at www.CeltiCareHealthPlan.com on the “Find a Provider” page. The Provider Directory lists all participating PCPs along with their addresses, phone numbers, and languages other than English the provider may speak. As a CeltiCare Member, you have the freedom to choose any participating CeltiCare Family Practice, General Practitioner, Internal Medicine, Nurse Practitioner, or Physician Assistant provider for your PCP; female Members may also choose a participating Obstetrician/Gynecologist (OB/GYN) as a PCP. Should you receive services from a Nurse Practitioner, your benefit
coverage and copayment amounts are the same as the coverage and copayments listed for services provided by other participating providers. Please refer to your specific Summary of Benefits for copayment information.

If you want to know more about the PCP you would like to select, please call Member Services at 1-877-687-1186 (TDD/TTY) 1-877-941-9234. You may also see a list of participating providers at www.CeltiCareHealthPlan.com on the “Find a Provider” page.

Making an Appointment with Your PCP
Once you have selected a PCP, make an appointment to meet with your provider. This will give you and your provider a chance to get to know each other. Your provider can give you medical care, advice, and information about your health. To make an appointment with your PCP, you need to call your PCP’s office. Remember to take your Member ID card with you every time you go to the provider’s office. If you have difficulty getting an appointment with or seeing your provider, please call Member Services at 1-877-687-1186 (TDD/TTY) 1-877-941-9234.

PCP Appointments
You should be able to get an appointment with your PCP for:

- Routine PCP visits within 45 calendar days
- PCP urgent same day or within 48 hours
- Non-urgent symptomatic care within 10 days of request

Specialist Appointments
Specialist visits should be provided for:

- Urgent care appointments within 48 hours
- Non-urgent symptomatic care within 30 days of request
- Non-symptomatic care within 60 days

Behavioral Health Service Appointments
You should be able to get an appointment with a Behavioral Health provider for:

- Emergency Services as soon as possible from an emergency room, emergency services program or other healthcare provider of emergency services.
- Urgent care within 48 hours for non-emergency or routine services.
- All other Behavioral Health Services within 14 calendar days.

NOTE: You may obtain emergency Behavioral Health Services, including calling the local pre-hospital emergency medical service system by dialing the 911 emergency telephone number or its local equivalent, if you have an emergency behavioral health condition that would be judged by a prudent layperson to require pre-hospital emergency services. We do not discourage you from using the local pre-hospital emergency medical service system’s 911 emergency.
You will not be denied coverage for medical and transportation expenses incurred as a result of such emergency behavioral health condition.

If Cenpatico requests that you contact your Cenpatico Case Manager, CeltiCare, or your PCP within 48 hours of receiving emergency services, notification requirements will be fulfilled if the attending Emergency Room provider communicates with Cenpatico, CeltiCare, or your PCP.

**After Hours Appointments with Your PCP**
You can call your PCP’s office for information on receiving after hours care in your area. If you have a medical problem or question and cannot reach your PCP during normal office hours, you can call Nurse Response, CeltiCare’s 24 hour medical nurse line at 1-877-687-1186 (TDD/TTY) 1-877-941-9234, to speak to a nurse. If you have an emergency, call 911 or go to the nearest Emergency Room.

**NOTE:** Except for emergency and family planning care, all services must be obtained through CeltiCare participating providers or Prior Authorized non-participating providers.

**IMPORTANT:** If you cannot keep an appointment, please call the provider’s office to cancel at least 24 hours in advance. If you need to change an appointment, call the provider’s office as soon as possible. They can make a new appointment for you. If you need help getting an appointment, call Member Services at 1-877-687-1186 (TDD/TTY) 1-877-941-9234.

**Changing Your PCP**
CeltiCare offers Members the freedom of choice in choosing any available primary care provider in our network. When you joined CeltiCare, you may have selected a PCP. If you did not, we assigned you to a PCP. You can change your PCP up to 3 times per benefit year without a reason. If you change your PCP, we will send you a **PCP Change Notification** confirming your new PCP’s name, address, and phone number. You do not need a new Identification (ID) Card. If you need help changing your PCP or selecting a new PCP, call Member Services.

**What to Do if Your Provider Leaves the CeltiCare Network**
If your PCP is planning to leave the CeltiCare provider network, we will send you a notice at least 30 days before the date when your provider is scheduled to leave the CeltiCare network of participating providers. Please contact Member Services at 1-877-687-1186 (TDD/TTY) 1-877-941-9234 as soon as you are aware that your PCP is leaving the CeltiCare network so we can help you choose a new PCP. Once you have chosen a new PCP, we will send you a new Member ID card identifying your new PCP. CeltiCare will permit you to continue to be covered for health services, consistent with the terms of this EOC, by the PCP for up to 30 days after the PCP is disenrolled. If you are in your second or third trimester of pregnancy when your PCP is disenrolled, you may continue to see your PCP until you have delivered your baby and

**Member Services Department:** 1-877-687-1186 (TDD/TTY) 1-877-941-9234  
**Log on to:** www.CeltiCareHealthPlan.com  
CHP-HIMFY2014  
**Effective Date:** January 1, 2014
completed your first postpartum visit, provided that your PCP’s disenrollment from CeltiCare is not for quality related reasons or for fraud. If you are terminally ill, you may continue to see your PCP indefinitely.

If you have been seeing a specialist who disenrolls from the CeltiCare provider network, please call Member Services at 1-877-687-1186 (TDD/TTY) 1-877-941-9234 and we will work with you to ensure your care continues. We will assist you in locating another specialist within the CeltiCare network.

In order to continue to provide coverage as noted above, the PCP or specialist has to agree to:

- Accept reimbursement from CeltiCare at the rates prior to giving dis-enrollment notice as payment in full, and to not impose copayments that would exceed your copayments if the provider had not disenrolled
- Adhering to CeltiCare quality assurance standards and to providing necessary medical information related to the care
- Adhering to CeltiCare’s policies and procedures, including procedures regarding referrals, authorization requirements, and as applicable the provision of services pursuant to a treatment plan approved by CeltiCare

**Continuity and Transition of Care - New Members**

Members new to CeltiCare who are in an active, on-going covered course of treatment with a provider or nurse practitioner that is not a participating CeltiCare provider may be permitted to continue to receive care and benefit coverage consistent with this EOC for up to 30 days from your effective date.

If you are a new Member in your second or third trimester of pregnancy when you enrolled with CeltiCare, you may continue to see your provider until you have delivered your baby and completed your first postpartum visit even if he or she is not contracted with CeltiCare and the provider’s contract termination or dis-enrollment with CeltiCare is not for quality related reasons or for fraud. If you are a Member who is terminally ill, you may continue to see your provider indefinitely, but your PCP must request Prior Authorization from CeltiCare in order for you to continue seeing a non-participating provider under these circumstances.

CeltiCare makes continuity of care determinations for new and existing Members based on established criteria.

CeltiCare will allow the Member’s PCP to authorize a standing referral for specialty healthcare provided by a CeltiCare participating provider when:

- Your PCP determines that such referrals are appropriate
- The CeltiCare participating specialty provider agrees to a treatment plan for you, and provides your PCP with all necessary clinical and administrative information on a regular basis
• The healthcare services to be provided are consistent with the terms of this Evidence of Coverage

Reminder: Except for emergency services, CeltiCare does not provide coverage for care delivered by non-participating providers. In certain situations, Prior Authorization may be granted for such services if they are requested by your PCP not otherwise available within the CeltiCare “Commercial Network.” For more information, please see the Out of Network Care section of this manual.

HEALTH MANAGEMENT

Balance Program
Balance is a free and confidential service to help you and your family juggle the daily needs of work, life, and health. Balance offers resources to help you remove life barriers and focus on a healthier you. The program includes a website with customized information on work-life topics such as finances, stress, and emotional wellbeing, as well as healthy living, fitness, and, and CeltiCare disease management program offerings. Information on the Balance Program can be found in your Welcome Packet and on our website at www.CeltiCareHealthPlan.com. Please call Member Services at 1-877-687-1186 (TDD/TTY) 1-877-941-9234 for more information.

Family Planning Services
Family planning services are directly related to the prevention of conception. These services include: birth control counseling, education about Family Planning, examination and treatment, laboratory examinations and tests, medically approved methods and procedures, pharmacy supplies and devices, and sterilization, including tubal ligation and vasectomy. (Abortion is not a Family Planning Service). See the Family Planning under Covered Services for more information.

When You Are Pregnant
Keep these important points in mind if you are pregnant now or want to become pregnant:

• Go to the provider as soon as you think you are pregnant. It is important for you and your baby’s health to see a provider as early as possible. Seeing your provider early will help your baby get off to a good start. It’s even better to see your provider before you get pregnant to get your body ready for pregnancy.

• Maintain healthy lifestyle habits, which include exercising, eating balanced healthy meals, and resting for 8-10 hours at night.

Pregnancy & Maternity Services
There are things you can do to have a safe pregnancy. See your provider about any medical problems you have such as diabetes and high blood pressure. Do not use tobacco, alcohol, or

Member Services Department: 1-877-687-1186 (TDD/TTY) 1-877-941-9234
Log on to: www.CeltiCareHealthPlan.com

CHP-HIMFY2014 Effective Date: January 1, 2014
drugs now or while you are pregnant. CeltiCare recommends you see your provider before becoming pregnant if you have experienced the following problems:

- Three or more miscarriages
- Premature birth (this means the baby came before 37 weeks of pregnancy)
- Stillborn baby

If you think you are pregnant, call the Member Service Department.

**Start Smart for Your Baby®**

Start Smart for Your Baby (Start Smart) is our special program for women who are pregnant and do not qualify for MassHealth. We want to help you take care of yourself and your child through this whole process. Information will be given by mail, telephone, and through the Start Smart website [www.StartSmartForYourBaby.com](http://www.StartSmartForYourBaby.com). Our Start Smart staff can answer questions and give you support if you are having a problem. We can even arrange for a home visit if needed.

We have many ways to help you have a healthy pregnancy. Before we can help, we need to know you are pregnant. We can help you enroll in MassHealth if you qualify for maternity coverage. Please call us at 1-877-687-1186 (TDD/TTY) 1-877-941-9234 as soon as you learn you are pregnant. We will help you set up the care you and your baby need.

**Care Management**

We understand some Members have special needs. CeltiCare offers our Members with complex medical needs Care Management services that are Member-centered, family-focused, and culturally competent. Our Care Managers are registered nurses or social workers. They can help you better understand and manage your health condition, coordinate services, and help locate community resources. A Care Manager will work with you and your provider to help you get the care you need. If you have a severe medical condition, the Care Manager will work with you, your PCP, and managing providers to develop a plan of care that may include alternative treatments that are not normally covered. If the alternative treatment plan provides the most appropriate Medically Necessary care, the CeltiCare Medical Director may authorize the care providing that:

- The Member has a severe medical condition and is expected to require prolonged medical treatment
- The alternative services are a substitute for more costly covered services that are being provided or proposed to be provided
- The additional services are Medically Necessary
- The Member agrees to the alternative treatment plan

CeltiCare maintains the right to terminate the alternative care plan at any time when it is determined that the alternative care plan is no longer appropriate, effective, or contributing to the improvement of the Member’s condition, or no longer meets the above criteria.
If you feel that you could benefit from Care Management services, you or a family Member may contact CeltiCare. To request Care Management services please call Member Services at 1-877-687-1186 (TDD/TTY) 1-877-941-9234.

**MemberConnections®**

MemberConnections is an outreach program that promotes preventive health, and connects Members to quality healthcare and community social services. Connections Representatives are specialty trained staff that work collaboratively with our Care Management staff to provide additional outreach and support to our Members. They can help you determine which providers are available in your area, find support services, and help arrange for needed services. To make contact with a Care Manager please call 1-877-687-1186 (TDD/TTY) 1-877-941-9234.

**CeltiCare Disease Management Programs**

CeltiCare offers disease education and self-management services to Members with chronic conditions. CeltiCare provides telephonic outreach, education, and support to help eligible Members learn how to control their condition more effectively, have fewer complications, and self-manage their condition on an outpatient setting. Disease education and self-management support includes, but are not limited to:

- Active and coordinated physician/specialist participation,
- Focus on the Member and caregiver ability to self-manage chronic conditions,
- Coordination with CeltiCare Care Managers for intensive case management program,
- Ensuring that Members with more than one eligible condition will be enrolled in the appropriate program, and
- Use of evidence-based, nationally recognized clinical practice guidelines.

CeltiCare provides disease education and self-management programs for the following chronic conditions:

- Asthma (pediatric and adult),
- Coronary artery disease (adults only),
- Diabetes (pediatric and adult),
- Depression,
- High blood pressure,
- High cholesterol,
- Low back pain, and
- Pregnancy

For more information on available Disease Management Programs or to enroll in one of the available programs, contact CeltiCare at 1-877-687-1186.
UTILIZATION MANAGEMENT

Review Criteria
Criteria are established and periodically evaluated and updated with appropriate involvement from providers who are Members of the CeltiCare Utilization Management Committee. Utilization review decisions are made in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria. Criteria are used for the approval of medical necessity, but not for the denial of services. A CeltiCare Medical Director reviews all potential medical necessity denial decisions.

Please note that CeltiCare takes steps to ensure that decisions regarding the provision of healthcare services are based solely on appropriateness of care and services, and the existence of coverage. CeltiCare has policies in place to ensure:

- Decision making is based only on appropriateness of care and service, and existence of coverage
- The organization does not specifically reward practitioners or other individuals for issuing denials of coverage or service care
- Financial incentives for decision makers do not encourage decisions that result in underutilization

A Member or the treating providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management Department at 1-877-687-1186 (TDD/TTY) 1-877-941-9234.

NEW TECHNOLOGY
CeltiCare evaluates new technology, including medical procedures, drugs, and devices, and the new application of existing technology for coverage determination. Investigational and experimental procedures, services and devices are not covered. In determining a coverage policy for new technology, CeltiCare considers published peer-reviewed medical literature, opinions and recommendations from specialists and specialty societies and certain nationally recognized parties, who routinely offer evaluations of new technology.

Experimental, Investigational and Clinical Trial Services
Investigational and experimental procedures, services and devices are not covered, with the exception of Clinical Trials to treat cancer in accordance with the Commonwealth of Massachusetts mandate.

Member Services Department: 1-877-687-1186 (TDD/TTY) 1-877-941-9234
Log on to: www.CeltiCareHealthPlan.com
Effective Date: January 1, 2014

CHP-HIMFY2014
Prior Authorization for Services

Prior Authorization means pre-approval for services. Prior Authorization is necessary for services that must be approved by CeltiCare before you get the service. Check with your primary care provider, the ordering provider, or CeltiCare Member Services to see if the service requires authorization. When a Prior Authorization request from your provider is received by CeltiCare, it is reviewed by our nurses and providers. We will let your provider and you know if the service is approved or denied. For more information about the review process including the timeframes for making a decision and notifying you and your provider of the decision please refer to the following Utilization Review section.

Utilization Review

CeltiCare has a Utilization Review Program that reviews services to make sure the services you are getting are the best way to help you feel better or improve your condition. Medical services, medical and surgical supplies, and drugs are reviewed to determine if the services are covered for your plan type, Medically Necessary, and provided in the most clinically appropriate and cost-effective manner. The following methods are used to accomplish this goal.

Prospective Utilization Review: Services proposed to be provided are reviewed and approved prior to the service being performed. Examples include: elective inpatient admissions, certain outpatient or home care services, and outpatient surgical services. An initial determination will be made within 2 business days of obtaining all necessary information. “Necessary information” includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that may be required. We will notify your provider by telephone within 24 hours of making a decision followed by a written confirmation within 2 business days to both you and your provider for services that have been approved, and within 1 business day for services that have been denied or not approved as requested.

Concurrent Utilization Review: This process is used to review ongoing services or treatment plans as they are occurring, and to determine when treatment may no longer be Medically Necessary. An example is the ongoing review of an inpatient admission. This process includes discharge planning to be sure services you need after your discharge are arranged and provided. In some cases the concurrent reviewer may refer you to our Care Management Department for ongoing support. Some conditions such as HIV/AIDS, high-risk pregnancy, or Members with disabilities may qualify for Care Management services. An initial determination will be made within 1 business day of obtaining all necessary information. “Necessary information” includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that may be required. For services that are:

- Approved - We will notify your provider by telephone within 1 business day of making a decision followed by a written confirmation to your provider which will include the extended number of days or next review date within 1 business day.
• Not approved - We will notify your provider by telephone within 1 business day followed by a written confirmation to you and your provider (including instructions for filing an Internal Appeal if you are in disagreement with the decision) within 1 business day.

NOTE: You are not financially responsible for inpatient services you got prior to receiving an adverse determination notice; however, you may be financially responsible for services you get 1 calendar day and beyond the date you received the adverse determination notice.

Retrospective Utilization Review: CeltiCare may perform a retrospective review to assure the information provided at the time of authorization was correct and complete, or instances where authorization and/or timely notification was not obtained by CeltiCare prior to services being rendered due to extenuating circumstances. An initial determination will be made within 30 calendar days of obtaining all necessary information. “Necessary information” includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that was obtained. We will notify your provider through written correspondence.

Reconsideration: When your provider is first informed that a service has been denied, CeltiCare will offer your provider the opportunity to ask for the service to be reconsidered by our Medical Director. The reconsideration will occur within 1 business day of receiving the request from your provider. If the denial is not reversed, you or your authorized representative (including provider) may request an Internal Appeal. The reconsideration process is not a prerequisite to a Grievance or Internal Appeal.

Adverse Determination Notices: A denial of services based on medical necessity is an adverse determination. An adverse determination is defined as a determination, based upon a review of information provided, by CeltiCare, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other healthcare services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of healthcare setting, and level of care or effectiveness.

In the event an adverse determination is made, you will be provided written notification of the determination within the specified timeframes listed for a prospective, concurrent, or retrospective review. The written adverse determination notification will include:

- The specific medical and scientific reasons for the adverse determination, including the specific reason(s) you’re presenting symptoms or condition, diagnosis, and treatment interventions, or other medical evidence, fail to meet the relevant medical review criteria.
- Other covered alternative treatment, service(s), or medical or surgical supplies if applicable.
- The specific information, criteria, guidelines, or standards of care used in making the determination and availability of the criteria used to make the decision.
- Information including timeframes for submitting an Internal Appeal of the decision or making further inquiry.

Member Services Department: 1-877-687-1186 (TDD/TTY) 1-877-941-9234
Log on to: www.CeltiCareHealthPlan.com

Effective Date: January 1, 2014

CHP-HIMFY2014
Second Medical Opinion
You have the right to a second opinion about the necessity of a covered service a participating physician has prescribed for you. This means talking to a different provider about an issue to see what they have to say. The second provider is able to give you their point of view. This may help you decide if certain services or methods are best for you. If you want to hear another point of view, tell your PCP.

You may choose any CeltiCare participating provider to give you a second opinion. The only charge to you is any applicable copayment. Your PCP or CeltiCare Member Services Representative can help you find a provider to give you a second opinion. If CeltiCare is unable to find a provider in the CeltiCare network, we will help you find a provider outside the network. If you need a second opinion from a provider outside the network, the only charge will be the applicable copay.

Any tests that are ordered for a second opinion must be given by a provider in the CeltiCare network. Your PCP will look at the second opinion and help you decide on the best treatment plan.

How to Get Medical Care When You Are Out of the Service Area
If you are temporarily out of the area and have a medical or behavioral health emergency, call 911 or go to the nearest Emergency Room. Be sure to call us and report your emergency within 48 hours. You do not need prior approval.

Routine or maintenance care is not covered outside the service area. CeltiCare will cover emergency and urgent care provided in or out of the service area.

The two situations where you are covered for services outside of the service area are as follows:

- You are temporarily out of the service area and you have a medical or behavioral health emergency. You can go to any Emergency Room if you have a true medical or behavioral health emergency. If you are seen at a hospital outside the service area for an emergency, in order to obtain any additional services or follow-up care outside the service area, Prior Authorization from CeltiCare is required. You may also need to contact your PCP to get a referral if you need to see a specialist.
- It is determined that you need special care that you cannot receive in the service area. If CeltiCare approves, the cost of the care you get outside the service area will be covered.

Out of Network Care
You should always see a provider who is participating with CeltiCare. If you need to see a provider that is not participating with CeltiCare, you need to coordinate care with your PCP. An appointment with a non-participating provider must be prior approved by CeltiCare before
getting non-emergency or non-urgent treatment from a provider who is not in the CeltiCare network. Your PCP will need to call CeltiCare to obtain the authorization for you if he/she determines the referral to be appropriate for Medically Necessary services. If your services are provided by a non-participating provider that has been approved by CeltiCare, your copayment and deductible will be the same as if the service was provided by a participating provider, whether or not the service is performed in a location that is in the CeltiCare network. However, if you fail to obtain a Prior Authorization from CeltiCare for a service or services from a non-participating provider, no benefit, coverage, or reimbursement will be made by CeltiCare. You will be financially responsible for payment of the service(s) from the non-participating provider. If you are not sure if a provider is in the CeltiCare network, call Member Services at 1-877-687-1186 (TDD/TTY) 1-877-941-9234. CeltiCare will notify you when the authorization is approved. Refer to the Emergency Care section of this manual if you need emergency service.

**Referrals**

You may need to see a certain provider for specific medical problems, conditions, injuries, and/or diseases. Talk to your PCP first. Your PCP will refer you to a participating specialist who can diagnose and/or treat your specific problem. Do not go to a specialist without being referred by your PCP. The specialist will not be able to see you without approval from your PCP except for those things listed in the Self-Referrals section of this manual. The Specialist will communicate back to your PCP about your condition, treatment, and any need for follow up care. To ensure that you will not be responsible for payment, always make sure you have a referral from your PCP before you seek care with a specialist.

The following are services that require a referral from your PCP:

- Specialist services, including standing or ongoing referrals to a specific provider
- Diagnostic tests (X-Ray and lab)
- High tech imaging (CT scans, MRIs, PET scans, etc.); requires Prior Authorization from CeltiCare
- Scheduled outpatient hospital services
- Planned inpatient admission; requires Prior Authorization from CeltiCare
- Clinic service
- Renal dialysis (kidney disease); non-participating providers require Prior Authorization from CeltiCare
- Durable Medical Equipment (DME); requires Prior Authorization from CeltiCare
- Home healthcare; requires Prior Authorization from CeltiCare

The specialist may not refer you to any other providers without Prior Authorization from CeltiCare.

**Self-Referrals**

You may self-refer for certain covered services. You are not required to obtain a referral from your PCP or authorization from CeltiCare for these services. You may receive benefit coverage, minus applicable cost sharing, for your Plan Type without a referral when services are received.

**Member Services Department:** 1-877-687-1186 (TDD/TTY) 1-877-941-9234

**Log on to:** www.CeltiCareHealthPlan.com

**Effective Date:** January 1, 2014

CHP-HIMFY2014
from a participating CeltiCare provider for:

- Annual preventive gynecological health examinations by an obstetrician, gynecologist, certified nurse midwife, or family practitioner; including subsequent obstetric or gynecological services determined to be Medically Necessary as a result of the examination.
- Maternity care (except for routine services when you are outside of the service area).
- Medically Necessary evaluations and resultant healthcare services for acute gynecological conditions. For emergency gynecological conditions see the Emergency Care section of this manual.
- OB/GYN services, including those of a CeltiCare participating Certified Nurse Midwife, Women’s Health Specialist, Federally Qualified Health Center (FQHC), or Certified Nurse Practitioner (CNP).
- Routine outpatient mental health and chemical dependency/substance abuse office visits.
- Family Planning Services and medical and surgical supplies.

Services for which you may self-refer and receive benefit coverage, minus applicable cost sharing, for your Plan whether or not the provider is a participating provider with CeltiCare include:

- Emergency services, including ground emergency ambulance transportation for true emergency care.

For more information on emergency services, refer to the Emergency Care section of this manual.

**TERTIARY SERVICES**

A Prior Authorization is required before receiving non-urgent/non-emergency outpatient services at a CeltiCare Designated Tertiary Facility or by a CeltiCare Designated Tertiary Provider. Designated Tertiary Facilities and Providers can change at any time. If you have questions or for more information please contact CeltiCare Member Services at 1-877-687-1186 (TDD/TTY) 1-877-941-9234.

Tertiary Services will be approved if requirements for medical necessity are met and one of the following is also met:

- A referral is made from a community-based specialist to a CeltiCare Designated Tertiary Facility or a CeltiCare Designated Tertiary Provider of the same or similar specialty, for services or expertise not available in the community
- A service is required that is not available in the community and can only be provided in a...
CeltiCare Designated Tertiary Facility or by a CeltiCare Designated Tertiary Provider

- You are involved in ongoing treatment provided at a CeltiCare Designated Tertiary Facility or by a CeltiCare Designated Tertiary Provider, are seeking services within the first 30 days of enrollment with CeltiCare for services that would otherwise be available in a community, may be covered through the first 30 days of enrollment
- You are receiving short-term follow-up care after discharge from a CeltiCare Designated Tertiary Facility for conditions that led to the admission
- Your PCP is a CeltiCare Tertiary PCP

Urgent Care

Urgent Care is not Emergency Care. Urgent Care is needed when you have an injury or illness that must be treated within 48 hours. It is usually not life threatening, yet you can’t wait for a routine provider’s office visit.

Only go to the Emergency Room if your provider tells you to go, or you have a life-threatening emergency. **When you need Urgent Care, follow these steps:**

- Call your PCP. The name and phone number are on your CeltiCare ID card. An after-hours number may also be listed. Your PCP may give you care and directions over the phone.
- If it is after hours and you cannot reach your PCP, call Nurse Response at 1-877-687-1186 (TDD/TTY) 1-877-941-9234; you will be connected to a nurse. Have your CeltiCare ID card number ready. The nurse may help you over the phone or direct you to other care. You may have to give the nurse your phone number. During normal office hours, the nurse will assist you in contacting your PCP.

If you are told to see another provider or go to the nearest hospital Emergency Room, bring your CeltiCare ID card. Ask the provider to call your PCP or CeltiCare.

Emergency Care

CeltiCare covers emergency medical and behavioral health services 24 hours a day, 7 days a week when provided in or out of the service area. Emergency services are required to treat an accidental injury or an onset of what reasonably appears to be a medical condition. An emergency arises when the lack of medical attention could be expected by a reasonable layperson to result in jeopardy to a Member’s health, or in the case of a pregnant woman, the health of her and her unborn child.

**Emergency rooms are for emergencies.** If you can, call your provider first. If your condition is severe, call 911 or go to the nearest hospital. If you are not sure if it is an emergency, call your PCP. Your PCP will tell you what to do. If your PCP is not available, an on-call provider can help. There may be a message telling you what to do. You can also call Nurse Response, our 24-hour medical advice line at 1-877-687-1186 (TDD/TTY) 1-877-941-9234 if you have questions.
For emergency care, it is okay if the hospital does not belong to the CeltiCare network. You can use any hospital to receive emergency services. However, you or someone acting on your behalf must call your PCP and CeltiCare within 48 hours of your admission. This helps your PCP to provide or arrange for any follow-up care that you may need. Depending on your plan type, copayments may apply for emergency care received in an Emergency Room. We will help you get follow-up care and answer your questions if you call us at 1-877-687-1186 (TDD/TTY) 1-877-941-9234.

Here are some examples of when to go to the emergency room and when it may not be required.

**When to go to the Emergency Room**

- Broken bones
- Gun or knife wounds
- Bleeding that will not stop
- You are pregnant, in labor, and/or bleeding
- Severe chest pain or heart attack
- Drug overdose
- Poisoning
- Bad burns
- Shock (you may sweat, feel thirsty, dizzy, or have pale skin)
- Convulsions or seizures
- Trouble breathing
- Suddenly unable to see, move, or speak

**When NOT to go to the Emergency Room**

- Flu, colds, sore throats, and earaches
- A sprain or strain
- A cut or scrape not requiring stitches
- To get more medicine or have a prescription refilled
- Diaper rash

**NOTE:** You may obtain emergency behavioral health services, including calling the local pre-hospital emergency medical service system by dialing the 911 emergency telephone number or its local equivalent, if you have an emergency behavioral health condition that would be judged by a prudent layperson to require pre-hospital emergency services. We do not discourage you from using the local pre-hospital emergency medical service system using the 911 emergency telephone number, or its local equivalent.

You will not be denied coverage for medical and transportation expenses incurred as a result of such emergency behavioral health condition.

If Cenpatico has requested that you contact Cenpatico, CeltiCare, or your PCP within 48 hours of receiving emergency services, notification will be considered given if the attending Emergency Room provider has communicated with Cenpatico, CeltiCare, or your PCP.
Emergency Transportation Services
CeltiCare covers emergency ambulance ground transportation to the nearest hospital for emergency care. Ambulance transport to the hospital Emergency Room in non-emergency situations is not a covered service under CeltiCare. Ambulance transportation from one healthcare facility to another is covered only when Medically Necessary, arranged and approved by a CeltiCare provider, and Prior Authorized by CeltiCare. Transportation is not covered to or from medical appointments.

PHARMACY
Pharmacy Program
CeltiCare is committed to providing appropriate, high quality, and cost effective drug therapy to all CeltiCare Members. CeltiCare works with providers and pharmacists to ensure that medications used to treat a variety of conditions and diseases are covered. CeltiCare covers prescription medications and certain over-the-counter medications when ordered by a CeltiCare provider. The pharmacy program does not cover all medications. Some require Prior Authorization or have limitations on age, dosage, and maximum quantities.

Preferred Drug List (PDL)
The CeltiCare PDL is the list of the drugs CeltiCare covers. The PDL applies to drugs you receive at retail pharmacies and mail order pharmacies. The CeltiCare PDL is continually evaluated by the CeltiCare Pharmacy and Therapeutics (P&T) Committee to promote the appropriate and cost-effective use of medications. The Committee is composed of the CeltiCare Medical Director, CeltiCare Pharmacy Program Director, and several Massachusetts primary care providers and specialists.

For the most current CeltiCare PDL you may call Member Services at 1-877-687-1186 (TDD/TTY, please call 1-877-941-9234) or visit the CeltiCare website www.CeltiCareHealthPlan.com.

Prior Authorizations
Some medications listed on the CeltiCare PDL may require Prior Authorization. This means that CeltiCare may require additional information from your provider the first time he or she prescribes these medications for you. CeltiCare will cover the medication if it is determined that:

- There is a medical reason you need the specific medication.
- Depending on the medication, other medications on the PDL have not worked.

All reviews are performed by a licensed clinical pharmacist using the criteria established by the CeltiCare P&T Committee.

If CeltiCare does not grant Prior Authorization, we will notify you and your provider, and provide

Member Services Department: 1-877-687-1186 (TDD/TTY) 1-877-941-9234
Log on to: www.CeltiCareHealthPlan.com

Effective Date: January 1, 2014

CHP-HIMFY2014
information regarding the Appeal process. Refer to the Member Grievances and Appeals section that follows for more information. If you want more information about our Pharmacy Program, visit our website at www.CeltiCareHealthPlan.com or call us at 1-877-687-1186 (TDD/TTY 1-877-941-9234).

Exclusions
The following drug categories are not part of the CeltiCare PDL:

- Experimental or investigational drugs
- Immunizations and vaccines (except flu vaccine)
- Drug Efficacy Study Implementation (DESI) and Identical, Related and Similar (IRS) drugs that are classified as ineffective
- Infusion therapy and supplies
- Oxygen, blood, and blood plasma
- Oral vitamins and minerals (except those listed in the PDL)
- Drugs and other agents used for cosmetic purposes or for hair growth
- Erectile dysfunction drugs prescribed to treat impotence
- Drugs eligible for coverage under Medicare Part D
- Over-the-Counter (OTC) drugs (except those listed in the PDL)

Over-the-Counter Items
The CeltiCare PDL covers a variety of over-the-counter (OTC) medications. All covered OTCs appear in the CeltiCare PDL with an "OTC with Rx" designation. OTC with Rx means that CeltiCare PDL OTCs are covered when you have a prescription from a licensed provider that meets all the legal requirements for a prescription.

Step Therapy
Some medications listed on the CeltiCare PDL may require specific medications to be used before you can receive the prescribed medication, a process known as step therapy. If CeltiCare has a record that the prescribed medication was tried first, the step therapy medications are automatically covered. If CeltiCare does not have a record that the prescribed medication was tried, your provider may be required to provide additional information.

If CeltiCare does not grant authorization for the prescribed step therapy medication, we will notify you and your provider, and provide information regarding the Appeals process.

Quantity Limits
To make sure the drugs you take are safe, CeltiCare may limit how much of your medication you can get at one time. If your provider feels you have a medical reason for getting a larger amount than is typically prescribed for that medication, he or she can ask for Prior Authorization from CeltiCare.
If CeltiCare does not grant Prior Authorization, we will notify you and your provider, and provide information regarding the Appeals process.

Generic Drugs
When generic drugs are available, the brand-name drug will not be covered without Prior Authorization from CeltiCare. Generic drugs have the same active ingredient, work the same as brand-name drugs, and have lower copayments. If you and your provider feel a brand-name drug is Medically Necessary, your provider can ask for Prior Authorization from CeltiCare.

We will cover the brand-name drug according to our clinical guidelines if there is a medical reason you need the particular brand-name drug. If CeltiCare does not grant Prior Authorization, we will notify you and your provider, and provide information regarding the Appeals process.

The provision is waived for the following products due to their narrow therapeutic index (NTI) as recognized by current medical and pharmaceutical literature:

- Aminophylline
- Amiodarone
- Carbamazepine
- Clozapine
- Cyclosporine
- Digoxin
- Disopyramide
- Ethosuximide
- Flecainide
- L-thyroxine
- Lithium
- Phenytoin
- Procainamide
- Propafenone
- Theophylline
- Thyroid
- Valproate Sodium
- Valproic Acid
- and Warfarin.

Newly Approved Products
We review new drugs for safety and effectiveness before adding them to the CeltiCare PDL. During this period, access to these medications will be considered through the Prior Authorization process.

If CeltiCare does not grant Prior Authorization, we will notify you and your provider, and provide information regarding the Appeals process.

Specialty Pharmacy Provider
Certain medications that are high cost and/or are designed to treat chronic and often complex diseases such as Multiple Sclerosis, Cancer, and Hepatitis C are only covered when supplied by Caremark, which is CeltiCare’s specialty pharmacy provider. Our Pharmacy Program Director and Medical Director oversee the clinical review of these specialty medications, and Caremark provides you with the following services:

- Delivering drugs to your home or to your provider’s office.
- Providing staff pharmacists who can help you 24 hours a day, 7 days a week, to answer your questions and offer help with your drugs.
- Giving you information, materials, and ongoing support to help you take the drugs to appropriately manage your health condition.

Specialty drugs are not available at retail pharmacies or through our mail order program.

Member Services Department: 1-877-687-1186 (TDD/TTY) 1-877-941-9234
Log on to: www.CeltiCareHealthPlan.com
Effective Date: January 1, 2014
CHP-HIMFY2014
Filling a Prescription
You can have your non-specialty prescriptions filled at a participating pharmacy or by CeltiCare’s mail order pharmacy.

- If you decide to have your prescription filled at a participating pharmacy, you can locate a pharmacy near you by using the CeltiCare Provider Directory available at the www.CeltiCareHealthPlan.com “Find a Doctor” page. You may also call a Member Services Representative to help you find a pharmacy. At the pharmacy you will need to provide the pharmacist with your prescription and your CeltiCare ID card.
- If you decide to have your prescription maintenance medication filled by the mail order pharmacy, please contact a CeltiCare Member Service Representative to help you.

Please contact CeltiCare Member Services at 1-877-687-1186 (TDD/TTY 1-877-941-9234) if you have questions about filling your prescriptions.

Mail Order Pharmacy
CeltiCare offers a 90 day supply (3 month supply) of maintenance medications by mail by partnering with RxDirect, a mail order pharmacy. These maintenance medications are used to treat long-term conditions or illnesses. You can find a list of covered maintenance medications on our website at www.CeltiCareHealthPlan.com. Detailed information on how to order up to a 90-day supply can be found on the website: http://www.CeltiCareHealthPlan.com/for-members/plan-information/member-forms/. To transfer a current prescription, or to have a new prescription sent directly to our mail order pharmacy, please have your provider call RxDirect at 1-800-785-4197. You may also contact a CeltiCare Member Service Representative at 1-877-687-1186 (TDD/TTY 1-877-941-9234) if you have any questions.

If you want more information about our pharmacy program, visit our website at www.CeltiCareHealthPlan.com or call us at 1-877-687-1186 (TDD/TTY 1-877-941-9234).

Member Grievances & Appeals
Decisions about your benefit coverage are made by CeltiCare. If you are unhappy with a grievance response or a Prior Authorization decision, you may file an appeal. Instructions on how to file an appeal will be included in the letter you receive containing the decision. The request must be made in writing by your provider to CeltiCare, and sent to the appropriate address.

Please contact CeltiCare Member Services at 1-877-687-1186 (TDD/TTY 1-877-941-9234) if you have questions about the Appeals process.
MEMBER SATISFACTION

We hope our Members will always be happy with us and our providers. If you are not happy with your medical, dental or vision services, please let us know. CeltiCare has steps for handling any problems you may have. CeltiCare offers our Members the following processes to achieve satisfaction:

- Internal Inquiry Process.
- Internal Grievance Process.
- Internal Appeal Process.
- External Review by the Office of Patient Protection.

CeltiCare maintains records of each Grievance/Appeal filed by a Member or by the Member’s authorized representative, and responses thereto, for a period of 7 years; which records shall be subject to inspection by the Commissioner of Insurance and the Massachusetts Health Policy Commission’s Office of Patient Protection (OPP).

Internal Inquiry Process

CeltiCare offers an Internal Inquiry process for Members. An inquiry allows Members the opportunity to voice concerns regarding any action, policy, or procedure of CeltiCare, a CeltiCare affiliate, or healthcare provider. Most inquiries can be resolved immediately. However, if you are not satisfied, or CeltiCare has not been able to provide resolution within 3 business days of your inquiry, you have the right to utilize our formal Internal Grievance process.

The Inquiry process is not be used for review of a Quality of Care issue or an Adverse Determination (denial involving Medical Necessity). If your concern involves the quality of care you received from a CeltiCare provider, Member Services will refer your concern directly to our Internal Grievance Process. If your concern involves an Adverse Determination, Member Services will refer your concern directly to our Internal Appeals Process.

Internal Grievance Process

CeltiCare wants to fully resolve your problems or concerns. CeltiCare will not hold it against you, or treat you differently, if you file a Grievance. A Grievance is a formal complaint about actions taken by CeltiCare or a CeltiCare provider. Grievances are any oral or written complaint submitted to CeltiCare that has been initiated by you, or your authorized representative, concerning any aspect or action of CeltiCare, relative to you, including but not limited to, review of Adverse Determinations regarding scope of coverage, denial of services, quality of care, and administrative operations. A Grievance involving the review of an Adverse Determination (disagreement with a Medical Necessity determination) is an Appeal and the steps for an Internal Appeal are followed.
How to File a Grievance

Filing a Grievance will not affect your healthcare services. We want to know your concerns so we can improve our services.

To file a Grievance, call Member Services at 1-877-687-1186 (TDD/TTY) 1-877-941-9234. You can also write a letter and mail or fax your Grievance to CeltiCare at 1-866-614-1951. Be sure to include:

- Your first and last name
- Your Member ID number
- Your address and telephone number
- Why you are unhappy (with as much specific information as possible).
- Any supporting documentation
- What you would like to have happen (desired outcome)

You have up to 180 calendar days to file a Grievance. The 180 calendar days start on the date of the situation you are not satisfied with. We would like for you to contact us right away so we can help you with your concern as soon as we can. A Grievance may be filed in writing by mail at the address below, or by fax at 1-866-614-1951. You can also call us at 1-877-687-1186 (TDD/TTY) 1-877-941-9234 or file the Grievance in person at:

Grievances and Appeals Coordinator  
CeltiCare Health Plan of Massachusetts, Inc.  
200 West Street, Suite 250  
Waltham, MA 02451

If you submit your Grievance by phone or in person, a Member Services Representative will write a summary of your Grievance and send you a copy within 48 hours (unless the time limit is waived or extended by mutual written agreement between you, or your authorized representative, and CeltiCare). This summary serves as both a written record of your Grievance as well as an acknowledgement. If you file a written Grievance, the Appeals and Grievance Coordinator will send you a letter within 15 business days letting you know that we have received your Grievance and the expected date of resolution.

If someone else is going to file a Grievance for you, we must have your written permission for that person to file a Grievance or Appeal on your behalf. You will need to obtain and fill out an Authorized Representative Form, and return it to us so we will know who you have granted permission to represent you. The Authorized Representative Form can be obtained by calling Member Services at 1-877-687-1186 (TDD/TTY) 1-877-941-9234 or by visiting our website at www.CeltiCareHealthPlan.com.

If you have any proof or information that supports your Grievance, you may send it to us and we
will add it to your case. You may supply this information to CeltiCare by email, fax, in person, or other written method. You may also request to receive copies of any documentation that CeltiCare used to make the decision about your care, Grievance, or Appeal.

We may need to obtain additional information to review your request. If a signed Authorization to Release Information is not included with your Grievance, a form will be sent to you for your signature. If a signed authorization is not provided within 30 business days of the request, CeltiCare may issue a decision on the Grievance without review of some or all of the information. When a signed request is received by your authorized representative, appropriate proof of the designation must be provided.

You can expect a resolution and a written response within 30 business days of your Grievance. If CeltiCare needs more than 30 business days to resolve the Grievance, we will contact you to receive written approval for additional time. The length of the extension will be mutually agreed upon, and will not last longer than 30 business days from the date of the agreement.

There will be no retaliation against you or your representative for filing a Grievance or Appeal.

**Internal Appeal Process**

An Internal Appeal is a form of Grievance for review of an Adverse Determination. An Adverse Determination is a decision that was made, based on review of information that was provided, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other healthcare services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of healthcare setting and level of care, or effectiveness. An Internal Appeal is reviewed as either a Standard/Non-expedited Internal Appeal or as an Expedited Internal Appeal. If a decision on an Appeal is required immediately due to your health needs, an expedited Appeal may be requested. A Member, or a Member’s authorized representative, may request an Expedited External Review at the same time as they are requesting an Expedited Internal Appeal. The following outlines the process for each.

**Standard/Non-expedited Internal Appeal**

**Internal Appeal Submission and Acknowledgement**

An Internal Appeal can be filed by you or your authorized representative (with your written consent) up to 180 calendar days after the receipt of an Adverse Determination letter. An Internal Appeal may be submitted by calling us at 1-877-687-1186 (TDD/TTY) 1-877-941-9234, electronically by fax at 1-866-614-1951, or in writing by mail or in person at the address below:

Grievances and Appeals Coordinator  
CeltiCare Health Plan of Massachusetts, Inc.  
200 West Street, Suite 250  
Waltham, MA 02451

An Internal Appeal submitted by phone or in person will be received by a Member Services Representative who will write a summary of the Internal Appeal request and forward a copy to

**Member Services Department**: 1-877-687-1186 (TDD/TTY) 1-877-941-9234  
**Log on to**: www.CeltiCareHealthPlan.com  
**Effective Date**: January 1, 2014  
CHP-HIMFY2014
you within 48 hours (unless the time limit is waived or extended by mutual written agreement between you, or your authorized representative, and CeltiCare).

An acknowledgement letter will be sent within 15 business days of receipt of the Internal Appeal.

**Internal Appeal Continuation of Care**

If you are still receiving the services that are under appeal, and the services are covered services, the services may continue until a decision is made on the Internal Appeal. CeltiCare will pay for the cost of continued services regardless of the outcome minus any applicable copays or deductibles. This continuation of coverage or treatment applies only to those services which, at the time of the service initiation, were approved by CeltiCare and were not terminated because benefit coverage for the service was exhausted.

**Internal Appeal Review**

The content of the Internal Appeal request including all clinical care aspects involved will be fully reviewed and documented. You or your authorized representative will have the right to submit comments, documentation, records, and other information relevant to the Internal Appeal in person or in writing. A provider or other appropriate clinical peer of a same-or-similar specialty will evaluate medical necessity decision of a Final Adverse Determination.

CeltiCare will review, resolve, and provide you, or your authorized representative, with written notification of the decision for a pre or post-service non-expedited Internal Appeal within 30 calendar days of receipt of the Internal Appeal, or within 30 calendar days of the submission of a signed authorization for the release of medical records and treatment information.

**Internal Appeal Determination Notification**

A standard Internal Appeal is resolved, and a written response sent to you and your authorized representative within 30 calendar days of our receipt of the Internal Appeal, or if medical information is needed within 30 calendar days of receiving a signed Authorization to Release Medical Records form. If the Internal Appeal request was not over-turned or resolved to you or your authorized representative’s satisfaction, an External Review by an independent External Review agency may be requested. The External Review agency contracts with the OPP. Information for pursuing an External Review is included in the Internal Appeal determination letter. If you do not receive a response to your Internal Appeal within the timeframes outlined, or those that are mutually agreed upon, your Appeal will be deemed to be decided in your favor.

The written notification of the resolution of the standard Internal Appeal will include:

- The specific medical and scientific reasons for the Adverse Determination
- A discussion of the Member’s presenting symptoms or condition, diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant

**Member Services Department:** 1-877-687-1186 (TDD/TTY) 1-877-941-9234

**Log on to:** www.CeltiCareHealthPlan.com

CHP-HIMFY2014 Effective Date: January 1, 2014
• Criteria and/or clinical guidelines or standards of care used in making the determination
• Information for obtaining an independent External Review through the OPP including the timeframe for filing
• A copy of the form prescribed by the OPP for the request of an External Review

An Internal Appeal not handled timely will be deemed over-turned.

**Internal Appeal Reconsideration**
CeltiCare may offer you or your authorized representative the opportunity for reconsideration of a Final Adverse Determination where relevant medical information:

• Was received too late to review within the 30 calendar day timeframe; OR
• Was not received, but is expected to become available within a reasonable time period following the written resolution

When you or your authorized representative chooses to request reconsideration, you or your authorized representative must agree in writing to a new time period for review, but in no event greater than 30 business days from the agreement to reconsider the Internal Appeal.

Should you or your authorized representative request reconsideration, the time period for requesting an External Review will begin on the date of the resolution of the reconsideration.

**Expeditied Internal Appeal**

**Expeditied Internal Appeal Qualifying Conditions**
If a decision on an Appeal is required urgently (within 48 hours) due to your health needs which cannot wait with the standard resolution time, an Expeditied Internal Appeal may be requested. An Expeditied Internal Appeal may be requested if:

• A provider certifies a delay in receiving the requested service would result in a substantial risk of serious or immediate harm to you;
• You are currently admitted as a patient in a hospital, and the Appeal is filed prior to discharge;
• You have a terminal illness; or
• A provider who orders the use of durable medical equipment certifies that its use is Medically Necessary, a denial of coverage for the equipment would create a substantial risk of serious harm, and that the risk is so immediate that receiving the requested equipment should not be delayed. The provider must also specify the immediate and severe harm that would occur if the requested durable medical equipment is not received within 48 hours, and must specify a reasonable time period for CeltiCare to provide a response.
The Expedited Internal Appeal will be initiated if it is filed prior to discharge, or by 4:00 p.m. of the next calendar day following receipt of the Adverse Determination.

CeltiCare will automatically reverse the decision to denying coverage for services or durable medical equipment, pending the outcome of the Appeals process.

**Expedited Internal Appeal Submission**

An Expedited Internal Appeal is requested in the same manner as a Standard Internal Appeal. For an Expedited Internal Appeal in which you are currently an inpatient in a hospital, a healthcare worker or hospital representative may act as your authorized representative without a signed written consent from you.

**Expedited Internal Appeal Continuation of Care**

If you are currently receiving covered services, you may continue to receive services at CeltiCare’s expense through the completion of the Expedited Internal Appeal process if the Expedited Internal Appeal is filed timely and was previously authorized by CeltiCare.

**Expedited Internal Appeal Review**

The content of the Expedited Internal Appeal request, including all clinical care aspects involved, will be fully investigated and documented. You or your authorized representative will have the right to submit comments, documentation, records, and other information relevant to the Expedited Internal Appeal in person or in writing. A provider or other appropriate clinical peer of a same-or-similar specialty will evaluate the medical necessity decision of a Final Adverse Determination.

**Expedited Internal Appeal Determination Notification**

An Expedited Internal Appeal will be reviewed, resolved, and written notification of the decision provided to you or your authorized representative:

- Within 48 hours, if a provider certifies in writing that a delay in receiving the requested service would result in a substantial risk of serious or immediate harm
- Before discharge, if you are currently admitted as a patient in a hospital
- Within 72 hours, if you are terminally ill
- Within 48 hours, if a provider who orders the use of durable medical equipment certifies in writing that its use is Medically Necessary, a denial of coverage for the equipment would create a substantial risk of serious harm, and that the risk is so immediate that receiving the requested equipment should not be delayed. The provider must also specify the immediate and severe harm that would occur if the requested durable medical equipment is not received within 48 hours, and must specify a reasonable time period for CeltiCare to provide a response.

Written notification of the resolution of the Internal Expedited Appeal will include:
• The specific medical and scientific reasons upon which the adverse determination was based
• A discussion of the Member’s presenting symptoms or condition, diagnosis, and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant medical review criteria
• Other covered alternative treatment, service(s), or medical and surgical supplies, if applicable.
• Criteria and/or clinical guidelines or standards of care used in making the determination.
• For an Adverse Final Determination, information for obtaining an External Review and continuation of services through the OPP, including the timeframe for filing.
• A copy of the form prescribed by the OPP for requesting an External review.

An Expedited Internal Appeal not handled timely will be deemed over-turned.

**Expedited Appeal Reconsideration (Conference) - Services for Member’s with Terminal Illness**

If the Expedited Internal Appeal or Expedited External Review is not overturned and you have a terminal illness, you or your authorized representative may request a conference. You or your authorized representative may request the conference in the same manner as an Internal Appeal. If a conference is requested, it will be scheduled within 10 business days of CeltiCare’s receipt of the request unless the provider, after consulting with CeltiCare’s Medical Director, decides the effectiveness of the requested service(s) would be materially reduced; in which case the conference will be scheduled within 5 business days. You and/or your authorized representative may attend the conference. A written determination will be sent to you or your authorized representative following the conference.

**External Review**

**External Review Submission**

If you, or your authorized representative, are not satisfied with the final outcome of the Internal Appeal, Expedited Internal Appeal, or Expedited External Review, an External Review of the decision by the Massachusetts Health Policy Commission’s Office of Patient Protection (OPP) may be requested.

Members, or a Member’s authorized representative, can request an External Review in the following situations:

• Member receives a Final Adverse Determination
• The benefit/service is a covered benefit/service and is not on the excluded list included in the Evidence of Coverage (EOC)

You or your authorized representative may request the External Review or the Expedited External Review. Forms and instructions for submitting the request will be included with the
Final Adverse Determination we send. Members do not have to wait for the Final Adverse Determination letter in order to submit a request for an Expedited External Review; this can be submitted at the same time that the Member submits a request for an Expedited Internal Appeal. For Non-expedited External Reviews, the required forms must be completed then submitted to the OPP within 4 months of the receipt of the Final Adverse Determination we send. Non-expedited External Reviews will be completed, and a decision sent within 60 calendar days of the external agency’s receipt of the request unless accepted as an Expedited External Review.

An Expedited External Review may be requested if:

- A provider certifies in writing a delay in receiving the requested service would result in a substantial risk of serious or immediate harm to you
- You are currently admitted as a patient in a hospital
- You are terminally ill
- A provider certifies in writing a delay in receiving requested durable medical equipment would result in a substantial risk of serious or immediate harm to you
- The Member is requesting an Expedited External Review

The request for an Expedited External Review can be submitted at the same time that a Member, or the Member’s authorized representative, requests an Expedited Internal Appeal. If the OPP determines the request qualifies for Expedited Review, a determination will be made within 4 business days of the External Review agency receipt of the request.

If the External Review relates to the denial of ongoing services, you or your authorized representative may request from the OPP for services to continue during the External Review process. For non-expedited external reviews, such a request must be made before the end of the second business day following the receipt of the Final Adverse Determination letter sent. If the OPP decides coverage should continue because substantial harm could occur to you if coverage ended, CeltiCare will continue coverage at our expense, minus applicable copays and deductibles.

If you have questions, concerns, would like additional information regarding Member rights, or have questions about the External Review process you can contact the OPP:

Health Policy Commission
Office of Patient Protection
2 Boylston Street, 6th Floor
Boston, MA 02116
Phone: (800) 436-7757, Fax: (617) 624-5046
Email: HPC-OPP@state.ma.us
Website: www.mass.gov/hpc/opp

Member Services Department: 1-877-687-1186 (TDD/TTY) 1-877-941-9234
Log on to: www.CeltiCareHealthPlan.com

CHP-HIMFY2014 Effective Date: January 1, 2014
The following information is also available from the OPP:

- A list of sources of independently published information assessing Member satisfaction and evaluating the quality of healthcare services offered by the health plan.
- The percentage of providers who voluntarily and involuntarily terminated participation contracts with the health plan during the previous calendar year for which such data has been compiled and the 3 most common reasons for voluntary and involuntary provider disenrollment.
- The percentage of premium revenue expended by the health plan for healthcare services provided to Members for the most recent year for which information is available.
- A report detailing, for the previous calendar year, the total number of: 1) filed Grievances, Grievances that were approved internally, Grievances that were denied internally, and Grievances that were withdrawn before resolution; and 2) External Appeals pursued after exhausting the Internal Grievance process and the resolution of all such External Appeals.

**External Review Determination Notification**

If the external review agency overturns CeltiCare’s decision, in whole or in part, we will issue a written notice to you or your authorized representative within 5 business days of receipt of the written decision from the review agency. Such notice to the Member shall:

- Acknowledge the decision of the review agency.
- Advise you of any additional procedures for obtaining the requested coverage or services.
- Advise you of the date by which the payment will be made, or the authorization for services will be issued by CeltiCare or the utilization review organization.
- Advise you of the name and phone number of the person at CeltiCare who will assist you with final resolution of the Grievance.

**Conference for Members with Terminal Illness**

If an Adverse Determination is not overturned during an Expedited Internal Appeal request or during an Expedited External Review from a Member with a terminal illness, the Member, or Member’s authorized representative, may request a Conference in the same manner as an Internal Appeal. If a Conference is requested, it will be scheduled within 10 business days of CeltiCare’s receipt of the request unless the provider, after consulting with CeltiCare’s Medical Director, decides the effectiveness of the requested service(s) would be materially reduced; in which case the Conference will be scheduled within 5 business days. The Member and/or the Member’s authorized representative may attend the Conference. A written determination will be sent to the Member or Member’s authorized representative following the conference.
WASTE, ABUSE, AND FRAUD (WAF) PROGRAM

Authority and Responsibility
CeltiCare is serious about finding and reporting fraud and abuse. Our staff is available to talk to you about this. You can also tell the Health Connector about it. Here is the CeltiCare address and phone number:

CeltiCare Health Plan of Massachusetts, Inc.
Compliance Department
200 West Street, Suite 250
Waltham, MA 02451
Fraud & Abuse Hotline: 1-866-685-8664

The Fraud & Abuse Hotline is answered by an independent third party and is available 24 hours a day, 7 days a week.

Fraud means that a Member, provider, or another person is misusing the program resources. This could include things like:

- Loaning, selling, or giving your Member ID card to someone
- Misusing benefits
- Wrongful billing by a provider
- Any action to defraud the program

Your healthcare benefits are given to you based on your eligibility for the program. You must not share your benefits with anyone. Providers must report any misuse of benefits to CeltiCare. CeltiCare must also report any misuse or wrongful use of benefits to the Health Connector. If you misuse your benefits, you could lose them altogether. The Health Connector may also take legal action against you if you misuse your benefits.

Abuse means physical, sexual, or emotional harm or injury. It also means neglect or exploitation by others.

Your safety and well-being are very important to us. If you or your family has any concerns, please call us right away.

If you think a provider, Member, or another person is misusing the program's resources, tell us immediately. We will take action against anyone who does this. CeltiCare will take your call about waste, abuse, and fraud seriously. Call CeltiCare’s Fraud and Abuse Hotline at 1-866-685-8664. You do not need to give your name.

What to Do When You Get a Bill
It is important that you review and understand this certificate of coverage, out-of-pocket costs that you are responsible for in receiving services, and other reimbursement policies associated
with your health care coverage. If you have any questions, please call CeltiCare. Our staff will be happy to answer any questions you may have about your coverage and costs.

Be sure to talk with your doctor about services that are covered and services that are not covered. You will receive a document, called an explanation of benefits or EOB, which provides information about the services received by the Member, what the coverage is for the service(s), and what cost is covered by CeltiCare. The EOB shows what your health care provider billed CeltiCare. The EOB should be kept in a safe place should you need to reference this information.

If you are responsible for any part of the remaining cost, you will receive a bill from your health care provider. Please call CeltiCare and speak with our staff when you have any questions about your EOB or a bill for your health care services.

Other Insurance
You must let CeltiCare and the Health Connector know if you have insurance coverage with another company. CeltiCare arranges payment of covered services with other insurance plans when you have other primary insurance. Coordination of Benefits (COB) is the process CeltiCare uses to arrange the payment of services. The COB process involves two or more insurance plans. In many cases, if you have another primary insurance, CeltiCare’s health insurance will be the secondary insurance plan.

CeltiCare may contact you to arrange for payments with other insurance if you have another insurance plan. If you have any questions on the COB process, please contact CeltiCare Member Services at 1-877-687-1186 (TDD/TTY) 1-877-941-9234.

Accidental Injury or Illness (Subrogation)
If a CeltiCare Member has to see a provider for an injury or illness that was caused by another person or business, you must call CeltiCare Member Services at 1-877-687-1186 (TDD/TTY) 1-877-941-9234 to let us know. For example, if you are hurt in a car accident, by a dog bite, you fall and are hurt in a store, or have an injury at work then another insurance company might have to pay the provider and/or hospital bills. When you call, we will need the name of the person at fault or your employer, their insurance company, and the names of any attorneys involved.

Member Rights
Members, legal guardians of Members, and legally authorized surrogates for Members have certain rights and responsibilities. It is important that you know your rights and responsibilities.

**Information:** You have the right to get from your primary care provider (PCP) information about what might be wrong (to the level known), treatment, and any known likely results. Your PCP can tell you about treatments that may or may not be covered by the plan, regardless of the cost. You have a right to know about any costs you will need to pay. This should be told to you in words you can understand. When it is not appropriate to give you

**Member Services Department:** 1-877-687-1186 (TDD/TTY) 1-877-941-9234

**Log on to:** www.CeltiCareHealthPlan.com

82  **Effective Date:** January 1, 2014  CHP-HIMFY2014
information for medical reasons, the information can be given to a legally authorized person. Your provider will ask for your approval for treatment unless there is an emergency and your life and health are in serious danger.

- You have the right to see your medical records.
- You have the right to be informed of changes within our CeltiCare network.
- You have the right to be kept informed of CeltiCare health plans covered and non-covered services, program changes, how to access services, PCP assignment, providers, Advance Directive information, referrals and authorizations, benefit denials, Member rights and responsibilities, and other CeltiCare rules and guidelines. CeltiCare will notify you at least 60 days before the effective date of the modifications. Such notices shall include the following:
  - Any changes in clinical review criteria
  - A statement of the effect of such changes on the personal liability of the insured for the cost of any such changes
- You have a right to information about CeltiCare and CeltiCare’s health plans.
- You have the right to a current list of CeltiCare providers. You can also get information on your providers’ education, training, and practice.
- You have the right to talk to your provider about new uses of technology. You can also ask CeltiCare for information on our quality plan, how Members use the plan, and how we review new technology.

**Respect & Dignity:** You have the right to have considerate, respectful care at all times. You have the right to have assistance in a prompt, courteous and responsible manner. You have the right to be treated with dignity when receiving care. You have the right to be free from harassment by the health plan or the plan's providers if there are any business disagreements between the plan and provider.

- You have the right to select a health plan or switch health plans, within the Health Connector guidelines, without any threats or harassment.

**You have the right to privacy.**

**Access:** You have the right to adequate access to qualified health professionals.

- You have the right to access treatment or services that are Medically Necessary regardless of age, race, creed, sex, sexual preference, national origin or religion.
- You have the right to access Medically Necessary, urgent, and emergency services 24 hours a day and 7 days a week.
- If you have a disability, you have the right to receive information in a different format in compliance with the Americans with Disabilities Act.

**Informed Consent:** Members, or their legal guardians or legal representatives, have the right to join in decision making about their healthcare. This includes working on
any treatment plans and making care decisions. You should know any possible risks, problems related to recovery, and the likelihood of success. You shall not have any treatment without consent freely given by you or your legally authorized surrogate decision-maker. You will be informed of your care options. You have the right to know who is approving, and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly. You have a right to refuse treatment. You have the right to a candid discussion of appropriate clinically or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.

**Grievance:** You have the right to file an Appeal or Grievance if you have had an unsatisfactory experience with CeltiCare or with any of our participating providers, or if you disagree with certain decisions made by CeltiCare.

**External Review:** You have the right to apply for an independent External Review with the Massachusetts Health Policy Commission’s Office of Patient Protection for Appeals or Grievances not resolved to your satisfaction by CeltiCare.

**Rights and Responsibilities Policies:** Members have a right to make recommendations regarding the organization’s Member Rights and Responsibilities policies.

**Refusal of Treatment:** You may refuse treatment to the extent the law allows. You are responsible for your actions if treatment is refused or if the PCP’s instructions are not followed. You should discuss all concerns about treatment with your PCP. Your PCP can discuss different treatment plans with you, if there is more than one plan that may help you. You will make the final decision.

**Primary Care Provider (PCP):** You have the right to pick your PCP within the plan network. You also have the right to change your PCP or request information on CeltiCare providers close to your home or work.

**Identity:** You have the right to know the name and job title of people giving you care. You also have the right to know which provider is your PCP.

**Language:** You have the right to an interpreter when you do not speak or understand the language of the area.

**Second Opinions:** You have the right to a second opinion by a participating provider, at no cost to you, if you believe your provider is not authorizing the requested care, or if you want more information about your treatment.

**Advance Directives:** All CeltiCare Members have a right to make Advance Directives for healthcare decisions. CeltiCare Members also have the right to refuse to make Advance Directives. You should not be discriminated against for not having an Advance Directive.
Member Responsibilities

All Members are responsible for learning how the CeltiCare plan works by reading the Evidence of Coverage.

Giving Information: You should give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about your health to CeltiCare and your healthcare providers. You should make it known whether you clearly understand your care and what is expected of you. You need to ask questions of your provider until you understand the care you are receiving. You need to review and understand the information you receive about CeltiCare. You need to know the proper use of services covered by CeltiCare.

Your Provider’s Advice and Your Treatment Plan: You should follow the treatment plan suggested by providers of medical care. You should ask questions to make sure that you fully understand your health problems and treatment plan. You should work with your PCP to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.

Identification Card (ID card): It is important that you show your CeltiCare ID card before you receive care.

Emergency Room Use: You should use an Emergency Room only when you think you have a medical emergency. For all other care, you should call your PCP.

Appointments: You need to keep appointments. If you cannot keep an appointment, you must call to cancel or reschedule. You should schedule appointments during office hours whenever possible.

Primary Care Provider (PCP): You should know the name of your assigned PCP. You should establish a relationship with your provider. You may change your PCP verbally or in writing by contacting our Member Services Department at 1-877-687-1186 (TDD/TTY) 1-877-941-9234.

Treatment: You should treat all CeltiCare staff, providers, and other Members with respect and dignity. Any concerns that you have about your care should be given to CeltiCare in a useful manner.

Changes: You need to tell the Health Connector about any changes in your address, name, telephone number, or any changes in your family. Call the Health Connector at 1-877-MA-ENROLL (1-877-623-6765).

Other Medical Insurance: When you enroll in the CeltiCare, you need to give all
information about any other medical insurance coverage you have. If, at any time, you get other medical coverage besides your CeltiCare coverage, you must tell the Connector.

Costs: If you access care without following CeltiCare rules, you may be responsible for the charges. If applicable, you are responsible to pay your portion of the monthly premium and all copayments at the time of service.

Advance Directives
All CeltiCare adult Members have a right to make Advance Directives for healthcare decisions. This includes planning treatment before you need it. Advance Directives are forms you can complete to protect your rights for medical care. It can help your PCP and other providers understand your wishes about your health. Advance Directives will not take away your right to make your own decisions, and will work only when you are unable to speak for yourself.

Examples of Advance Directives include:

- Living Will
- Health Care Power of Attorney
- “Do Not Resuscitate” Orders

You should not be discriminated against for not having an Advance Directive. For more information regarding Advance Directives, as well as a form you can use to designate a Healthcare Proxy, please call CeltiCare Member Services at 1-877-687-1186 (TDD/TTY) 1-877-941-9234 or visit our website: www.CeltiCareHealthPlan.com.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

NOTICE OF PRIVACY PRACTICES

Privacy Notices
Effective: July 1, 2011

For help to translate or understand this, please call 1-877-687-1186. If you are hearing impaired, call our TDD/TTY line at 1-877-941-9234.

Si necesita ayuda para traducir o entender este texto, por favor llame al telefono. 1-877-687-1186. TDD/TTY 1-877-941-9234. Interpreter services are provided free of charge to you.

At CeltiCare your privacy is important to us. We will do all we can to protect your health records. By law, we must protect your health records and send you this notice.

Member Services Department: 1-877-687-1186 (TDD/TTY) 1-877-941-9234
Log on to: www.CeltiCareHealthPlan.com
Effective Date: January 1, 2014

CHP-HIMFY2014
This notice tells you how we use your health records. It describes when we can share your records with others. It explains your rights about the use of your health records. It also tells you how to exercise those rights and who can see your health records. This notice does not apply to information that does not identify you.

When we talk about your health records in this notice, it includes any information about all of your health services while you are a Member of CeltiCare. This includes providing healthcare to you, and also includes payment for your healthcare while you are our Member.

Please note: You will also receive a Privacy Notice from the Health Connector outlining their rules for your health records. Other health plans and healthcare providers may have other rules when using or sharing your health records. We ask that you obtain a copy of their Privacy Notices and read them carefully.

How We Use or Share Your Health Records
Here are ways we may use or share your health records:

- To help pay your medical bills given to us by healthcare providers
- To help your healthcare providers give you the proper care; for example, if you are in the hospital, we may give them your records sent to us by your provider
- To help manage your healthcare; for example, we might talk to your provider about a disease or wellness program that could help improve your health
- To help resolve any Appeals or Grievances filed by you or a healthcare provider with CeltiCare or the Commonwealth of Massachusetts
- To assist others who help us provide your health services; we will not share your records with these outside groups unless they agree to protect your records
- For public health or disaster relief efforts
- To remind you if you have a provider’s visit coming up
- To give you information about other healthcare treatments and programs, such as how to stop smoking or lose weight

State and federal laws may call for us to give your health records to others for the following reasons:

- To state and federal agencies that oversee us, such as the Health Connector or United States Department of Health and Human Services
- For public health actions. For example, the Food and Drug Administration may need to check or track medicines and medical device problems
- To public health groups if we believe there is a serious public health or safety threat
• To a health agency for certain activities; this might include audits, inspections, and licensure or enforcement actions
• To a court or administrative agency
• To law enforcement. For example, records may be used to identify or find someone who is a suspect, fugitive, material witness, or missing person
• To a government person about child abuse, neglect, or violence in your home
• To a coroner or medical examiner to identify a dead person, or help find a cause of death These may be needed by a Funeral Director to help them carry out their duties
• For organ transplant purposes
• For special government roles, such as military and veteran activities, national security and intelligence activities, and to help protect the President and others
• For job-related injuries due to your state’s Worker Compensation laws

If one of the above reasons does not apply, we must obtain your written approval to use or share your health records with others. If you change your mind, you may retract your written approval at any time.

If sharing your health information is not allowed by or limited by a state law, we will obey the law that protects your health information best.

**What Are Your Rights?**
The following are your rights with regards to your health records. If you would like to exercise any of the following rights, please contact us. We can be reached at 1-877-687-1186 (TDD/TTY) 1-877-941-9234.

• You have the right to ask us to give your records only to certain people or groups, and to say for what reasons. You also have the right to ask us to stop your records from being given to family members or others who are involved in your healthcare. Please note that while we will try to follow your wishes, the law does not make us do so.
• You have the right to ask to get confidential communications of your health records. For example, if you believe that you would be harmed if we send your records to your current mailing address, you can ask us to send your health records by other means. Other means might be fax or an alternate address.
• You have a right to request behavioral health records. This information can only be provided with the approval of the treating provider responsible for the condition to which the information relates, or another equally qualified behavioral health professional. Upon release of any medical or behavioral health record information to a medical professional designated by you, CeltiCare will notify you that the information was provided to the medical professional.
• You have the right to view and get a copy of all the records we keep about you in your designated record set. This consists of anything we use to make decisions about your
health. It includes enrollment, payment, claims processing, and medical management records.

You do not have the right to get certain types of health records. We may decide not to give you the following:

- Information contained in psychotherapy notes
- Information collected in reasonable anticipation of, or for use in, a court case or another legal proceeding
- Information subject to certain federal laws about biological products and clinical laboratories

In certain situations, we may not let you get a copy of your health records; you will be informed in writing. You may have the right to have our action reviewed.

You have the right to ask us to make changes to wrong or incomplete health records we keep about you. These changes are known as amendments. Any request for an amendment must be in writing. You need to give a reason for your change(s). We will get back to you in writing no later than 30 days after we receive your request. If your health information is not maintained on-site, we will respond no later than 60 days after we receive your request. If we need additional time, we may take up to another 30 days. We will inform you of any delays and the date when we will get back to you.

If we make your changes, we will let you know they were made. We will also give your changes to others who we know have your health records and to other persons you name. If we choose not to make your changes, we will let you know why in writing. You will have a right to submit a letter disagreeing with us. We have a right to answer your letter. You then have the right to ask that your original request for changes, our denial, and your second letter disagreeing with us be put with your health records for future disclosures.

You have the right to receive an accounting of disclosures of your health records to others for 6 years beginning on the first day or enrollment with CeltiCare. By law, we do not have to give you a list of the following:

- Health records given or used for treatment, payment, and healthcare operations purposes
- Health records given to you or others with your written approval
- Information that is incidental to a use or disclosure otherwise permitted
- Health records given to persons involved in your care or for other notification purposes
- Health records used for national security or intelligence purposes
- Health records given to prisons, police, FBI, and others who enforce laws or health oversight agencies
• Health records given or used as part of a limited data set for research, public health, or healthcare operations purposes

To receive an accounting of disclosures, your request must be in writing. We will act on your request within 60 days. If we need more time, we may take up to another 30 days. Your first list will be free. We will give you one free list every 12 months. If you ask for another list within 12 months, we may charge you a fee. We will tell you the fee in advance and give you a chance to take back your request.

**Using Your Rights**

*You have a right to receive a copy of this notice at any time. We reserve the right to change the terms of this notice.* Any changes in our privacy practices will apply to all the health records that we keep. If we make changes, we will send a new notice to you.

If you have any questions about this notice or how we use or share your health records, please call. We can be reached at 1-877-687-1186 (TDD/TTY) 1-877-941-9234, Monday through Friday from 8:00 a.m. to 5:00 p.m.

If you believe your privacy rights have been violated, you may write a letter of complaint to:

**Privacy Officer**  
CeltiCare Health Plan of Massachusetts, Inc.  
200 West Street, Suite 250  
Waltham, MA 02451  

Phone: 1-877-687-1186  
TDD/TTY: 1-877-941-9234  
Fax: 1-888-828-5698

You may also contact the Secretary of the United States Department of Health and Human Services:

**Office for Civil Rights - Region I**  
U.S. Department of Health & Human Services  
Government Center  
J.F. Kennedy Federal Building - Room 1875  
Boston, MA 02203  

Voice phone(617)565-1340  
FAX (617)565-3809  
TDD (617)565-1343

**WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.**

**Member Services Department:** 1-877-687-1186 (TDD/TTY) 1-877-941-9234  
**Log on to:** www.CeltiCareHealthPlan.com  
**Effective Date:** January 1, 2014  
**CHP-HIMFY2014**
AUTHORIZED REPRESENTATIVE FORM FOR APPEALS

You have the right to choose someone to represent you during your Appeal with CeltiCare. To designate a representative, please complete this form and return it to CeltiCare. You may revoke this designation at any time by submitting a request to us in writing. Please note, if we do not receive a signed Authorized Representative Form in the timeframe for resolving your Appeal, your appeal may be dismissed. If any such action is taken, you will be notified in writing.

1. I hereby give permission to ______________________________ to act as my Authorized Representative to CeltiCare and to share information listed below in Section II regarding my Appeal or Grievance with CeltiCare or its delegate.

2. CeltiCare may share the following information (check all that apply):

   □ Eligibility notices and information about eligibility for and access to my CeltiCare benefits
   □ Information about my medical treatment (including medical and psychiatric records). By giving my representative permission to share my information, I am specifically giving permission to share any information about drug and alcohol treatment that is included in such information.
   □ Other (specify):

3. CeltiCare may share information listed in Section II above with the person or organization who is serving as my Authorized Representative.

4. CeltiCare may share the information listed in Section II for the timely resolution of my Appeal.

5. This permission is good until: ______/_____/______________ Date

6. I understand that I may cancel this permission at any time by sending a letter to:

   CeltiCare Health Plan of Massachusetts, Inc.
   ATTN: Grievances and Appeals Coordinator
   200 West Street, Suite 250
   Waltham, MA 02451

I have had the opportunity to read and consider this Authorization and agree to its terms.

___/___/__________
Date Printed Name Signature

This form is also available at www.CeltiCareHealthPlan.com
AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Member Name: ___________________________ Member ID: ______

As described in our Privacy Notice, CeltiCare is required by law to obtain your authorization for any use or disclosure of your health records for purposes other than your treatment, the payment for health care services provided to you and health care operations of CeltiCare. In our Privacy Notice, we provided you information about how CeltiCare can use or disclose your health records. You have a right to review and receive a copy of our Privacy Notice before signing this Authorization.

I ___________________________, authorize the use and disclosure of my health information as described below:

1. This authorization applies to the following information:

2. Permission about Specific Health Information. Only if you choose to share any of the following information, please write your initials on the line:
   _____I specifically give permission, to share information in my record about HIV antibody and antigen testing, and HIV/AIDS diagnosis or HIV/AIDS treatment.
   _____I specifically give permission, to share information in my record about my genetic information.
   _____I specifically give permission to share information in my record about alcohol or drug treatment. If this information is shared, I understand that a specific notice required by 42 CFR, Part 2 shall be included prohibiting the re-disclosure of this confidential information.

3. I authorize the following persons (or class of persons) to receive my health information:

   Name: ______________________________________
   Title: _______________________________________
   Address: _____________________________________
   City/State/Zip: _________________________________
   Phone: _______________________________________

4. We are requesting this authorization in order to use or disclose your health information for the following purposes:

   ______________________________________________

   □ At the request of the Member.

5. This authorization expires: ____________________________ (Date or Event)
   *If no date or event is given, permission will last for one year from the date this is signed.

   This form is also available at www.CeltiCareHealthPlan.com
You may request to inspect or copy the information that CeltiCare intends to disclose. You may refuse to sign this Authorization. CeltiCare will not condition treatment, payment, enrollment or eligibility for benefits on your providing or refusing to provide this Authorization. Once release of this health information is made to the above-named person or persons, your health information may be subject to redisclosure by that person or persons. If you have authorized the disclosure of health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected.

You may revoke this authorization at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the address at the end of this form. You may deliver your revocation by any means you choose (e.g., personally or by mail), but it will be effective only when we actually receive it. Your revocation will not be effective to the extent that we or others have acted in reliance upon this Authorization.

If you are requesting information for yourself or for a third party, CeltiCare may assess appropriate and reasonable fees for the copying of such information. Such fees will comply with all state and federal laws.

**AUTHORIZATION**

I, ________________________________, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to CeltiCare. I understand that, by signing this form, I am confirming my authorization that CeltiCare may use and/or disclose to the persons and/or organizations named in this form the health information described in this form.

________________________________________  ____________________________
Signature of Member or Legal Representative    Date

________________________________________
Print Name

If signing on behalf of a CeltiCare health plan Member please describe your authority and provide related documentation:

_____________________________________________________________________

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

For CeltiCare Use Only

Name: ________________________________  Title: ________________________________

________________________________________  ____________________________
Signature:  Date:

This form is also available at [www.CeltiCareHealthPlan.com](http://www.CeltiCareHealthPlan.com)