Member Handbook

Effective January 1, 2024

WellSense Essential

Managed Care Organization (MCO)

wellsense.org

WellSense HEALTH PLAN

Multilanguage Interpreter Services

Important! This is about your WellSense Health Plan benefits. We can translate it for you free of charge. Please call **888-566-0010 (TTY: 711)** for translation help.

¡Importante! Esta información es sobre sus beneficios de WellSense Health Plan. Podemos traducirlo para usted de forma gratuita. Llame al **888-566-0012 (TTY: 711)** para obtener ayuda de traducción. (ESA)

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Quan trọng! Đây là thông tin về quyền lợi trong WellSense Health Plan của quý vị. Chúng tôi có thể dịch thông tin này miễn phí cho quý vị. Vui lòng gọi số **888-566-0010 (TTY: 711)** để được trợ giúp dịch thuật. (VIT)

Важно! Здесь содержится информация о преимуществах вашего медицинского страхового плана WellSense Health Plan. Мы можем перевести для вас этот документ бесплатно. За помощью в переводе позвоните по телефону **888-566-0010 (TTY: 711)**. (RUS)

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महत्वपूर्ण! यह आपके WellSense Health Plan लाभों के बारे में है। हम आपके लिए इसका निःशुल्क अनुवाद कर सकते हैं। कृपया अनुवाद संबंधित सहायता के लिए **888-566-0010 (TTY: 711)** पर फ़ोन करें। (HIN)

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ចំណុចសំខាន់! ព័ត៌មាននេះគឺ ស្តីអំពីអត្ថប្រយោជន៍នៃ WellSense Health Plan របស់អ្នក។ យើងអាចបកប្រែវាសម្រាប់អ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខ **888-566-0010 (TTY: 711)** សម្រាប់ជំនួយផ្នែកបកប្រែ។ (KHM)

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Ważne! To dotyczy Twoich świadczeń w ramach planu zdrowotnego WellSense Health Plan. Możemy nieodpłatnie przetłumaczyć dla Ciebie te informacje. Zadzwoń pod numer **888-566-0010 (TTY: 711)**, aby uzyskać pomoc w tłumaczeniu. (POL)

ສິ່ງສຳຄັນ! ນີ້ແມ່ນກ່ຽວກັບຜົນປະໂຫຍດຂອງແຜນປະກັນ WellSense Health Plan ຂອງທ່ານ. ພວກເຮົາສາມາດແປພາສາໃຫ້ທ່ານໄດ້ໂດຍບໍ່ເສຍຄ່າ. ກະລຸນາໂທ **888-566-0010 (TTY: 711)** ເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາ. (LAO)

Important! This material can be requested in an accessible format by calling 888-566-0010 (TTY: 711).

Notice About Nondiscrimination and Accessibility

WellSense Health Plan complies with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex, gender identity, sexual orientation, limited English proficiency, or moral or religious grounds (including limiting or not providing coverage for counseling or referral services). WellSense Health Plan provides:

- free aids and services to people with disabilities to communicate effectively with us, such as TTY, qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- free language services to people whose primary language is not English, such as qualified interpreters and information written in other language.

Please contact WellSense if you need any of the services listed above.

If you believe we have failed to provide these services or discriminated in another way on the basis of any of the identifiers listed above, you can file a grievance or request help to do so at:

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

You can also file a civil rights complaint with the U.S. DHHS, Office for Civil Rights by mail, by phone or online at:

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

Complaint Portal:
hhs.gov/ocr/office/file/index.html

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Civil Rights Coordinator, 529 Main Street, Suite 500 Charlestown, MA 02129
Phone: 888-566-0010 (TTY/TDD 711) **Fax:** 617-897-0805 **Hours:** Monday-Friday 8a.m. - 6p.m

You can file a grievance in person or by mail, fax, or e-mail MemberQuestions@wellsense.org. If you need help filing a grievance, WellSense Health Plan is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F, HHH Building , Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are also available at hhs.gov/ocr/office/file/index.html.

Table of Contents

Chapter 1: Getting started as an MCO Plan Member

Section 1.1 Welcome to our Managed Care Organization (MCO) Plan!

You are enrolled in the WellSense Health Plan Managed Care Organization (MCO) Plan. Our Plan is a Massachusetts licensed health maintenance organization in Massachusetts and a not-for-profit Medicaid managed care organization. We contract with Massachusetts Medicaid (called MassHealth) to provide you all your MassHealth benefits, and more. In this Handbook, WellSense often calls itself "we" or "us."

You are on our MCO Plan because you chose us or were assigned to us by MassHealth. While you are enrolled in our MCO Plan, you are our "Member." We will send you a MCO Plan Member ID Card.

Section 1.2 What is an MCO Plan?

A Managed Care Organization (MCO) Plan, such as WellSense Health Plan, is a type of health plan that arranges for health care through its own Provider Network. Our Provider Network includes Primary Care Providers (PCPs), Specialists, Behavioral Health Providers, pharmacies, and hospitals.

Your PCP and his or her team work with you and other Providers in the MCO Plan's Provider Network to help you get the right care at the right time and in the right place.

Your MCO Plan provides:

- All your MassHealth benefits (called "Covered Services")
- Some "extra" benefits

Covered Services and "extra" benefits are described in Chapter 5 (Covered Services) and in the back of this Handbook. See the document titled "Prior Authorization (PA) and Referral Requirements for Covered Services for WellSense Health Plan Managed Care Organization Plan (MCO Plan) Members," which is also referred to as the "Covered Services List").

As a Member of our MCO Plan:

- Please choose a PCP who is in our MCO Plan's Provider Network, or one will be assigned to you.
- Remember you can change your PCP at any time to another PCP within the MCO Plan Provider Network. See Section 3.1 and 3.2 for MCO Plan Provider Network and information on how to access the MCO Plan Provider Listing.
- You must receive all Covered Services from the MCO Plan's Network Providers. There are exceptions for certain situations described later in this Handbook.
- You may get the services of a Behavioral Health or Long-Term Services and Supports (LTSS) Community Partner. See Section7.4.
- Most Members will have a Plan Selection Period and a Fixed Enrollment Period every year. See Chapter 12.

Section 1.3 What makes you eligible to be an MCO Plan Member?

MassHealth, not us, decides whether you can get MassHealth benefits. If MassHealth approves your application, MassHealth allows you to enroll in certain types of MassHealth health plans. In this case, you chose, or have been assigned, to enroll in our MCO Plan. Therefore, you are now our Member.

Section 1.4 Can you change your MCO Plan?

There are special rules for when you can—and cannot—change your MCO Plan to another MassHealth health plan. Most Members enrolled in an MCO Plan may only change their health plan during a certain time. This 90-day time period, which occurs every year, is called their "Plan Selection Period." MassHealth will notify you when this period starts. During that time, you can change your health plan for any reason.

When your Plan Selection Period has ended, you cannot change your health plan except for certain reasons—with MassHealth approval. The period of time that you are not allowed to change your health plan is called the "Fixed Enrollment Period."

Certain Members are allowed to change their health plan at any time. See Chapter 12. It will tell you more about changing your MCO Plan and the reasons that you can change health plans.

To change health plans during either Period described above, or if you have questions about your health plan choices, you must call the MassHealth Customer Service Center. See Chapter 2 for contact details.

Section 1.5 Renewing your MassHealth Coverage

Each year you must renew your MassHealth benefits. In some cases, MassHealth can renew your coverage automatically. If they are unable to do so, MassHealth will send you a reminder letter to let you know. Here are the different ways you can renew:

Go to MAhealthconnector.org and sign in to your user account.

- If you do not have an account, use the web link provided in your MassHealth renewal letter to create an account. You can also call MassHealth Customer Service to get help creating your online account. (You will need an e-mail address.)
- If you have an account, but do not know your username and/or password, you can "reset" them on the website.
- If you do not remember creating an online account, you **do not** need to complete a new application. Go to MAhealthconnector.org. There you can try to reset your username and password. Or **call** MassHealth Customer Service at **800-841-2900/TTY 800-497-4648, Monday- Friday from 8 a.m. t0 5 p.m.** for help. Interpreter services are available.
- Once you have access to your account, review the information on your renewal application. This is the fastest and easiest way to renew your MassHealth coverage.

Use the form with your information that came with your MassHealth renewal letter.

It is already filled out with your household information.

- **Step 1:** If you need to make updates, follow the instructions on the form. Make sure that your handwriting is easy to read.
- **Step 2:** Sign and date the form. Then, mail **ALL PAGES** to Health Insurance Processing Center, P.O. Box 4405, Taunton, MA 02780 or fax to 857-323-8300.

Renew by Phone.

- Call MassHealth at **800-841-2900/TTY 800-497-4648, Monday- Friday from 8 a.m. to 5 p.m.** to renew by phone. Interpreter services are available.

Renew in Person.

- You can get free, in-person help from a trained, certified enrollment assister. To find one near you use The MassHealth Connector Enrollment Assister Search at: https://my.mahealthconnector.org/enrollment-assisters. Enrollment Assisters, such as **Navigators** and **Certified Application Counselors (CACs)**are trained and certified individuals at organizations in your area that can help you apply for coverage, shop for plans, answer your questions abut your eligibility, payments, plan details and health care reform rules and requirements. **Help from an Enrollment Assister is free for people of any income level.**

Section 1.6 What to expect from us

About this Member Handbook

This Handbook was created to explain how our MCO Plan works. It describes services covered by us or by MassHealth. It also lists services not covered by us or MassHealth. This Handbook also explains the cost to you ("Copayments") for any Covered Services, any extra benefits, and whom to call if you have questions. This Handbook is also available on our website at **wellsense.org**.

Some words in this Member Handbook have special meanings. These words are capitalized throughout the Handbook. Their meanings can be found in Chapter 16.

We must follow all of the rules in this Handbook. If you think we have done something that goes against these rules, you may make a Complaint (Grievance) or file an Appeal—depending on the situation. See Chapter 11.

Language Translation and information in other formats

We offer MCO Plan information in other formats. These are also called "alternative formats." These are for Members who have trouble with reading abilities or who need language help services. This means we can give you information in other ways. For example, we can give you your documents in braille, large type size, and different languages. We have staff that speaks non-English languages. We

offer free translation services in over 200 languages. If you need this Handbook or other written documents translated into another language, or need someone to read this or other printed information to you, please call our Member Services Department.

New Members—welcome call and information we will send you

When you first join the MCO Plan, you will get a packet of Member materials. This packet will have this Handbook and an MCO Plan Member ID Card. We will also call you to welcome you to the MCO Plan. During this call, we will explain MCO Plan rules, your benefits, and answer any questions. This is a good time for you to ask questions about what is and is not covered under your MCO Plan benefits. If we cannot reach you, please call our Member Services Department. We are here and happy to speak with you.

Help us understand your health needs—"Care Needs Screening"

Your new Member packet also has a special form. It is called a Care Needs Screening (CNS). The CNS helps us better understand your health needs and how to help you stay healthy. It has questions that help us learn your medical, Behavioral Health, and other health needs. It is important that you fill out the CNS and return it to us. Send it to us in the postage-paid envelope that is given to you. You can also fill out your CNS online. Just go to the Member section at **wellsense.org**. If you do not fill out your CNS, one of our Member Services staff may call you to ask if you willing to answer the questions over the phone. Filling out the CNS does not affect your ability to get coverage or your health benefits in any way. We will keep your health information (Protected Health Information, or "PHI") confidential (private) as required by law. (See Chapter 13.)

Additional Available Screenings and Assessments Screenings

In addition to the Care Needs Screening, you may also be asked to participate in a Health Related Social Needs Screening. These screenings will be used to identify social needs, including but not limited to:

- housing insecurity
- food insecurity
- economic stress
- lack of access to transportation
- experience of violence

Also included may be questions for

- members up to the age of 21, regarding school and education-related needs
- members between the age of 21 and 45, employment support and needs
- members age 45 and older, social isolation concerns

As a result of this screening, you may inquire into services or assistance related to these concerns.

Assessments

At a minimum, a comprehensive assessment will be provided to members with the following:

- special health care needs
- high or rising-risk Members enrolled in enhance care coordination
- BH CP or LTSS CP members

This assessment will include the member's:

- care needs
- functional needs
- accessibility needs
- goals
- other needs

These assessments and screenings will help determine what care the member needs in addition to any care coordination activities. These screenings and assessments may take place at a location of the member's choice. Included in these screening and assessments are:

- any services being provided by state agencies,
- health conditions,
- medications,
- ability to communicate concerns, symptoms, etc.,
- functional status and needs, including
    - LTSS needs,
    - ADL or IADL needs,
    - mental health and substance use if appropriate, and
    - for members under age 21, any educational supports and services, etc.

We will ensure that all members receive the Medically Necessary MCO covered services and appropriate follow-up care based on the needs identified in the above assessments and screenings, including care coordination.

Section 1.7 Your MCO Plan Member ID Card

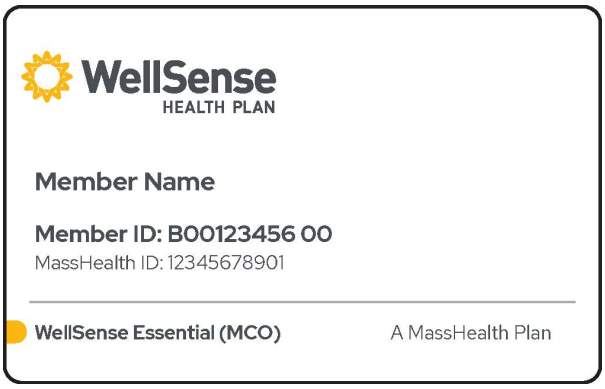
Your MCO Plan Member ID Card—Use it to get all Covered Services. This includes prescription drugs

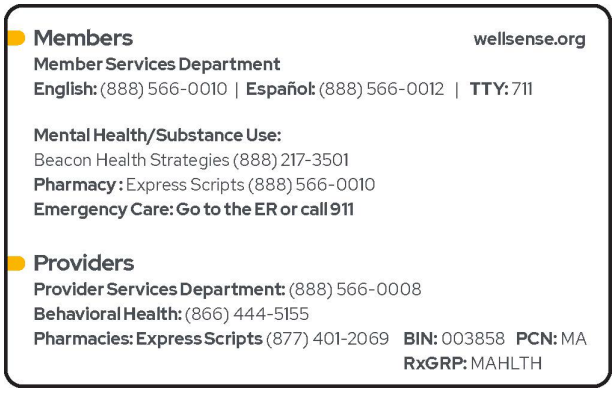
We will send you an MCO Plan Member ID Card. This card tells your Providers (including doctors and pharmacies) that you are covered by our MCO Plan. While you are a Member of our MCO Plan, you must use your MCO Plan Member ID Card whenever you get Covered Services. This includes covered drugs. However, even if you don't have your MCO Plan Member ID Card, a Provider should never

refuse to give you care. If a Provider refuses to treat you, please call our Member Services Department. We will speak with your Provider and confirm your health plan information.

- The front of your Member ID Card will tell you the name of your MCO Plan. Knowing the name of your MCO Plan is important. It will help you find the right information about your MCO Plan.
- The front of your Member ID Card will also tell you the name of your MCO Plan's Provider Network, which is "MassHealth MCO." Use that name when you go to our website to look up your MCO Plan's Provider Listing. This way you can be sure that you are looking up Providers in your MCO Plan.
- The back of your Member ID Card has important phone numbers for contacting us, getting Behavioral Health Care, and what to do if you need Emergency care.

Here is a sample MCO Plan Member ID Card. It shows you what yours will look like:





In addition to your MCO Plan Member ID Card, MassHealth will give you a MassHealth ID Card. Check both ID Cards to make sure the information is correct. If there is a mistake, or if you did not get both ID Cards, call our Member Services Department or the MassHealth Customer Service Center right away. You should always carry both cards to receive health care and pharmacy services. Do not let anyone else use your ID Cards—it is against the law.

Lost your ID Card?

If your MCO Plan Member ID Card is damaged, lost, or stolen, call our Member Services Department right away. We will send you a new one. Or, you may order a new one from our website at **wellsense.org**.

If your MassHealth ID Care is damaged, lost, or stolen, call MassHealth Customer Service Center to order a new MassHealth ID Card.

Section 1.8 Keep us up-to-date with your personal and other insurance information

How to help make sure that we have correct information about you

Your membership record with us has information we received from MassHealth. This includes your address and telephone number. Network Providers who care for you need to have correct information about you. They use your membership record to know what services and drugs are covered and any Copayments you must pay. Because of this, it is very important that you help us keep your information up-to-date.

Let our Member Services Department know about these changes

- Changes to your name, address, or phone number.
- Changes in any other health insurance coverage you have, such as:
  - Any employer's group health insurance plan that covers you.
  - Any Workers' Compensation you are getting because of a job-related illness or injury.
  - Any veteran's benefits or other government health plans you may have.
  - "Continuation coverage" that you have through COBRA (COBRA is a law requiring employers to let employees and their dependents keep their group health coverage for a time after they leave the group health plan.)
- If you have any claims from a car accident.
- If you are pregnant.
- If you have been admitted to a nursing home.
- If you receive care from an Out-of-Network Provider (such as a hospital) or Emergency room.
- If your guardian, or other responsible party (such as a caregiver) changes, or if you set up a Durable Power of Attorney. A "Durable Power of Attorney" is someone you choose to make health care decisions for you.

Let the MassHealth Customer Service Center know about these changes

- If you are pregnant, you may qualify for more benefits due to your pregnancy.
- If you wish to change your health plan during a Plan Selection Period.
- If you wish to change your health plan during a Fixed Enrollment Period for any of the reasons listed under the "Fixed Enrollment Period" in Chapter 12. This includes when you wish to change your PCP to a PCP who is not part of our MCO Plan.
- Changes in your income or other financial support.
- If you move out of Massachusetts. (Note: If you move out of Massachusetts, you will no longer be able to have MassHealth coverage.)

To contact the MassHealth Customer Service Center: call toll free at 800-841-2900 or 800-497-4648 (TDD/TTY), Monday through Friday, 8:00 a.m. to 5:00 p.m. ET.

Do we keep your Protected Health Information ("PHI") private?

Yes. Federal and state laws require that we keep your PHI private. We protect your PHI as required by these laws. (See Chapter 13.)

Section 1.9 Member Advisory Council

We want to hear from you. Your feedback is important to us. During the year, we have local and/or regional Member Advisory Council meetings. These allow us to hear from our Members. If you are interested in joining us, let us know. Call our Member Services Department.

Chapter 2: Important phone numbers and resources

Section 2.1 Member Services Department contact information

We are happy to help you. You may call our Member Services Department to get help with:

- Questions about your coverage
- Translating your Member materials
- Finding a Network Provider
- Filing a Complaint or Appeal
- Requesting an MCO Plan Member ID Card
- Getting paid back for Covered Services
- Any other questions

Method	Our Member Services Department—Contact Information
Call	888-566-0010 (English/other languages) 888-566-0012 (Spanish) Hours: Monday–Friday from 8:00 a.m. to 6:00 p.m. Calls to this number are free. Our Member Services Department has free interpreter services for non-English speakers.
TTY/TDD	For hearing impaired: 711 (TTY/TDD) 711 (Relay operator) This number requires special telephone equipment. It is only for people with hearing or speaking problems. Calls are free.
Fax	617-897-0884
Write	WellSense Attn: Member Services Department 529 Main Street, Suite 500 Charlestown, MA 02129 MemberQuestions@wellsense.org
Website	**wellsense.org**

Section 2.2 Contact information for other services

Type of Question	Whom to Call	Contact Information
Behavioral Health	Carelon Behavioral Health	Phone: • 888-217-3501 For hearing impaired: 711 Hours: 24 hours a day, 7 days a week. Behavioral Health Help Line: • 833-773-2445
Medical Services	Member Services Department	Phone: • 888-566-0010 (English or other languages) • 888-566-0012 (Spanish) For hearing impaired: 711 Hours: Monday–Friday 8 a.m.–6 p.m. Nurse Advice Line: • 800-973-6273
Pharmacy (general questions)	Express Scripts	Phone: For general pharmacy questions: • Call Express Scripts: 888-566-0010 For hearing impaired: 711 Hours: 24 hours a day, 7 days a week.

Type of Question	Whom to Call	Contact Information
Pharmacy (mail order questions)	Cornerstone Health Solutions	**To request a new mail order prescription** • Call Cornerstone Health Solution (Cornerstone) at 844-319-7588, 711 (TTY/TDD), available Monday through Friday 7 a.m. to 6 p.m. ET. • You may also complete the mail order pharmacy enrollment form and mail it in with your prescription(s) to us. You may also have your doctor submit your prescription electronically to us via fax. **To request a refill of your mail order prescription** • Call Cornerstone Health Solutions' mail order pharmacy at 781-805-8220, 711 (TTY/TDD), Monday through Friday 7 a.m. to 6 p.m. ET to request your refill. • Start an online refill request from Cornerstone Health Solutions' webpage • Start a mobile refill using Cornerstone Health Solutions' mobile app Cornerstone Health Solutions Mail Order Pharmacy: cornerstonehealthsolutions.org

Type of Question	Whom to Call	Contact Information
Care Management (CM) and Care Coordination	CM Department	Phone: • 866-853-5241 • 617-478-3762 Hours: Monday–Friday 8:30 a.m.–5 p.m.
Complaints (Grievances) and Appeals	Member Services Department or Appeals Department	Phone: • 888-566-0010 (English or other languages) • 888-566-0012 (Spanish) For hearing impaired: 711 Hours: Monday–Friday 8 a.m.–6 p.m. You may also call our Appeals Department: • 617-748-6338
Behavioral Health Complaints (Grievances) and Appeals	Carelon Behavioral Health	Phone: • 888-217-3501 For hearing impaired: 711 Hours: Monday–Thursday 8:30 a.m. to 6 p.m., Friday 8:30 a.m.–5 p.m.
Health care information from a nurse	Nurse Advice Line	Phone: • 800-973-6273 For hearing impaired: 711 (TTY/TDD) 711 (Relay operator) Hours: 24 hours a day, 7 days a week

Type of Question	Whom to Call	Contact Information
Dental services* **This benefit is covered directly by MassHealth*	DentaQuest Customer Services	Phone: • 800-207-5019 For hearing impaired: • 800-466-7566 Translation services: • 800-207-5019 Hours: Monday–Friday 8 a.m.–6 p.m.
Report suspected fraud	WellSense Compliance Hotline	Phone: • 888-411-4959 Hours: 24 hours a day, 7 days a week Fax: (866) 750-0947 E-mail: FraudandAbuse@bmchp-wellsense.org
MassHealth questions: • Enrolling or being eligible for coverage Benefits • Transportation help* • Vision benefit for eyeglasses* *This benefit is covered directly by MassHealth	MassHealth Customer Service Center	Phone: • 800-841-2900 For hearing impaired: 800-497-4648 Hours: Monday–Friday: 8 a.m.–5 p.m.

Type of Question	Whom to Call	Contact Information
Ombudsman • Get help from My Ombudsman staff person • Arrange for interpreter services in your preferred language and for the Deaf and Hard of Hearing to receive Ombudsman services • Request My Ombudsman informational materials in large print, braille, electronic format (PDF or Word doc) or in other languages.	Ombudsman staff	**Call:** 855-781-9898 (toll free) *For TTY users, use MassRelay at 711 to call the number above **E-mail:** info@myombudsman.org **Website:** myombudsman.org/ **Office:** 11 Dartmouth Street Suite 301 Malden, MA 02148 *Office is wheelchair accessible. Walk-in hours: Mondays 1 p.m.–4 p.m. and Thursdays 9 a.m.–12 p.m. Also by appointment.

Chapter 3: How to get care from Providers

Section 3.1 What is the MCO Plan Provider Network?

Your MCO Plan Provider Network has many different types of Providers that contract with us. All Network Providers are listed in our MCO Plan Provider Listing. You must get all your care from Network Providers except in certain situations stated in Section 3.9.

A Primary Care Provider (PCP) who is part of an Accountable Care Organization (ACO) Plan's Provider Network under MassHealth cannot also be PCP in our Provider Network. If you have any questions about whether a Provider, including a PCP, is part of our MCO Plan Provider Network, we recommend that you check our Provider Listing (see Section 3.2) or call the Member Services Department.

Section 3.2 Information in your MCO Plan Provider Listing

Your MCO Plan Provider Listing has a complete list of Network Providers in your MCO Plan. The list includes:

- Primary Care Providers (PCPs) and primary care sites
- Specialists
- Hospitals and other facilities
- Behavioral Health Providers
- Community Behavioral Health Center Providers, Providers such as physical therapists, laboratory providers, and radiology centers
- Hospital Emergency room and Urgent Care services
- Durable Medical Equipment suppliers

In our MCO Plan Provider Listing, you can find information about Providers, such as:

- Name
- Address
- Telephone number
- Specialty (like internal medicine or pediatrics)
- Languages spoken
- Handicap access
- Hours they are open
- Board certification status
- Hospital affiliation (if it applies)

You can get more information about any doctors, such as any malpractice, medical school, or training information. Contact the Massachusetts Board of Registration in Medicine. The number is 800-377-0550. Or go to mass.gov and click on "Physician Profiles."

How to find our MCO Plan Provider Listing

Our MCO Plan Provider Listing is on our website: **wellsense.org**. Click on the "Find a Provider" tab at the top of the home page. Then find the box that says "MassHealth MCO." This is the name of your MCO Plan's Network. The name of our MCO Plan's Network is also on the front of your MCO Plan Member ID Card.

The online Provider Listing is always the most current version. Call our Member Services Department if you need help finding a Network Provider in your area. You can also ask us to mail you a free printed Provider Listing of Network Providers in your area.

Why do you need to know which Providers are part of our MCO Plan Provider Network?

As a Member, you must use MCO Plan Network Providers to get all your Covered Services. There are some exceptions. See Section 3.9.

Section 3.3 Choosing a Primary Care Provider (PCP) to provide and oversee your care

Every Member must have a Primary Care Provider (PCP) who is in our MCO Plan Network. Your PCP will work with you to manage your health call needs. Always call your PCP first for health-related questions, except in an Emergency. Your PCP can tell you what to do.

There are different kinds of Providers who can be PCPs.

- Family practice doctors treat adults and children. They may also provide women's health services for pregnant individuals.
- Internal medicine doctors ("internists") treat adults over age 17 years.
- Pediatricians are doctors who treat children and young adults up to age 21 years.
- Nurse practitioners are registered nurses. They have extra training that allows them to offer primary care to children and adults.
- Physician assistants work on health care teams with doctors and other Providers to treat children and adults.
- Obstetricians/Gynecologists ("OB/GYNs") are doctors who treat pregnant individuals and other health needs. Only certain OB/GYNs are PCPs. They must be listed in your Provider Listing as a PCP. Check your Provider Listing at **wellsense.org** to see if an OB/GYN is listed as a PCP.

Each family member enrolled with us must have a PCP. You can choose a family practice doctor to be the PCP for all enrolled family Members if you wish.

What does a PCP do for you?

Your PCP will do many things for you:

- Provide and coordinate all your care.
- Treat you for your basic health needs and problems.
- Direct you to Specialists and other Providers in our MCO Plan Provider Network.

- Respond to your phone calls about your medical needs, even after business hours.
- Write prescriptions.
- Ask for Prior Authorizations (see Section 3.6), when needed.

Call your PCP for an initial appointment.

After you enroll in our MCO Plan, you may have a PCP assigned to you. If so, you should call your PCP to schedule a check-up or physical exam. Tell the office this is your first visit with the PCP, or that this is your first visit with the PCP using your MCO Plan coverage. If you have any problems making an appointment, call our Member Services Department. During your first visit with your PCP, you probably will get a physical exam. Your PCP will ask you questions about your health. The more your PCP knows about you and your family's health, the better he or she can manage your care. Adults should see their PCPs at least once a year for a checkup. Infants, children, and pregnant individuals should see their PCPs more often. See Chapter 5 about how often to see your Provider.

Call your PCP first when you're sick—unless you think it's an Emergency.

Your PCP will provide and coordinate your care, except in an Emergency. You should call your PCP's office if you feel sick. Your PCP or a covering Provider is on-call to help 24 hours a day, 7 days a week.

If you think you are having an Emergency, call 911 or go to the nearest hospital Emergency room. If it is a Behavioral Health Emergency, call 911, go to the nearest hospital Emergency room, or the nearest Community Behavioral Health Center (CBHC) in your area or nearest hospital Emergency room. A statewide list of CBHC's is in our Provider Listing, which you can see online at **wellsense.org**. This list is also in the "Statewide Community Behavioral Health Centers" section of your paper Provider Listing. If you want a paper copy, you may call our Member Services Department.

Need help getting to appointments?

Learn more about free transportation to scheduled health care appointments. See Section 5.2. Our Member Services Department can answer your questions. They can help make sure your needs are taken care of.

What to do if you have health questions after hours or if your PCP is not available

Our Nurse Advice Line can answer questions. This could possibly save you a trip to the Emergency room or Urgent Care center. It is available 24 hours a day, 7 days a week. Call 800-973-6273 to reach our Nurse Advice Line. See Section 5.5.

What to do if you have medical or behavioral health questions after hours

First you should call your PCP's or behavioral health provider's office and follow their instructions.. Your provider's office has after-hour coverage that is available 24 hours a day/7 days a week. You can also call our Nurse Advice Line or Behavioral Health Help Line for answers to questions. Both are available 24 hours a day, 7 days a week. Call 800-973-6273 to reach our Nurse Advice Line or 833-733-2445 to reach the Behavioral Health Help Line. See Section 5.5.

If you are unable to see your PCP, you can go to an Urgent Care Center. These are also called "Walk-In Care" or "Convenience Care" providers. They are able to provide care for injuries or illness that requires immediate attention, but are not serious enough to require an emergency department visit. If you need emergency behavioral health help, you can go to the nearest Community Behavioral Health Center or emergency room.

Section 3.4 How do you choose your PCP?

You will need to choose a PCP within 15 calendar days of joining your MCO Plan. In many cases you will be able to continue with the same PCP that you had before joining our MCO Plan. If you do not choose a PCP within that time, we will assign a PCP to you. Call our Member Services Department if you need help choosing a PCP. We have a long list of PCPs. We will help you choose one for you and each enrolled family Member. Even though you can pick any PCP in our MCO Plan Network, you should pick one who is near you. Be sure to write down your PCP's phone number. Keep it where you can find it.

Section 3.5 Changing your PCP

Changing your PCP to another PCP in our MCO Plan

We want you to be happy with your PCP. It is important to have an ongoing relationship with your PCP. This helps your PCP get to know you and understand how to keep you healthy. But, if you want to change your PCP, you can pick a new PCP within our MCO Plan Network at any time; just call our Member Services Department. You can find a new PCP in our online MCO Plan Provider Listing, or ask us to mail you a free paper copy of the Provider Listing. Our Member Services Department can also help you find a new PCP. See Sections 3.2 and 3.3. Once you choose a new PCP, you must let us know the PCP's name. You can do this in a few different ways: call our Member Services Department, complete a PCP Selection Form at your new PCP's office, or register with us at **wellsense.org** and change your PCP online.

Changing your PCP to another PCP who is not in our MCO Plan

You must call the MassHealth Customer Service Center to change your PCP to a PCP who is not in your MCO Plan. The toll free number is 800-841-2900 or 800-497-4648 (TDD/TTY). Call Monday through Friday, 8 a.m. to 5 p.m. In most cases you can change to a PCP outside of our MCO Plan only during certain times of the year:

- **During your Plan Selection Period:** Every year, you will have a Plan Selection Period for 90 days. During that time, you can choose a new MCO Plan or another MassHealth plan. If you want to change to a PCP who is not in our MCO Plan, you can do that during your Plan Selection Period. But, this will result in a change to your health plan. Your new health plan will be one of the following MassHealth health plans in which your new PCP participates:
  - A different MCO Plan. (Either another MCO offered by a different organization than WellSense Health Plan.)

  - An accountable care organization (ACO) plan. (Either one offered by WellSense Health Plan or a different organization.)
  - The Primary Care Clinician Plan. (This is offered directly by MassHealth.)
- **During your Fixed Enrollment Period:** The Fixed Enrollment Period is the 9 months during the year when you can change your MCO Plan only for certain reasons. During this time, you will need MassHealth approval if you want to change to a PCP who is not in your MCO. The reasons are in Chapter 12.

- **Members who can change their MCO Plan at any time:** If you are in any of the following categories, you can change your PCP to a new PCP in any MassHealth plan any time:
  - Children in the care or custody of the Department of Children and Families (DCF)
  - Youth in the care or custody of the Department of Youth Services (DYS)
  - Newborns and children younger than one year old

Section 3.6 How to get care from Specialists and other MCO Plan Network Providers

There may be times when you need to see a Specialist. A Specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of Specialists. Here are some examples.

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.

If you think you need to see a Specialist or other type of Provider, call your PCP first. If your PCP agrees, he or she will direct you to one who works with your PCP within our MCO Plan Provider Network. Your PCP works closely with certain MCO Plan Network Providers, including Specialists. These close working relationships mean your PCP can better coordinate your care so that it's the right care. For example, your PCP can often communicate with these other Network Providers through shared medical record systems. Shared records can help you avoid having the same medical test more than once or being prescribed drugs that do not interact well.

Your PCP will also help if you need hospital services or follow-up care. That's why it's important that you talk with your PCP about your specialty care needs.

Sometimes Prior Authorization is needed from us for visits to MCO Plan Network Specialists

Prior Authorization is our approval in advance for you to see certain Specialists. If we approve, we will cover (pay for) the visit to the Specialist. The chart below tells you when Prior Authorization is and is not needed.

Prior Authorization from us is required in the following cases:	Prior Authorization to see a Specialist is never required in the following cases:
Your PCP or Specialist must get Prior Authorization from us before you see a Specialist who is an Out-of-Network Provider. See Section 3.9 for more information.	• In an Emergency. • Urgent Care. • To go to any MCO Plan Provider Network obstetrician; gynecologist; certified nurse midwife or family practitioner for Routine health care. This includes gynecologic exams; Pap tests; pelvic exams; breast exams, and screening mammograms (x-rays of the breast). • To get Family Planning Services from any MCO Plan Network Provider or MassHealth-contracted Family Planning Services Provider.

Before you visit a Specialist, always check with your PCP. Ask if he or she has gotten Prior Authorization from us, if needed. You can find what hospitals your PCP and Specialists are connected with. Just look in the MCO Plan Provider Listing. It is on our website. You can also call our Member Services Department for help.

Section 3.7 Getting a Second Opinion

Members may get a Second Opinion from a qualified Network Provider. You may also see an Out-of-Network Provider if you get a Prior Authorization from us. You may ask for a Second Opinion about any health care services or treatments your Provider thinks you should have. Either way, we will pay for your Second Opinion visit. There is no cost to you.

Section 3.8 Getting care for your Behavioral Health needs

We work closely with another company called Carelon Behavioral Health (Carelon). They manage and coordinate Behavioral Health services for our Members. These are services for mental health and substance use disorder. Carelon also manages the Behavioral Health Providers in our MCO Plan's Provider Network. You can find a list of Behavioral Health Network Providers in our Provider Listing at **wellsense.org** or call Carelon's Member Services Department. They can send you a free printed Provider Listing of Behavioral Health Network Providers in your area. You can also ask family members, a community agency, or another Provider to suggest a Behavioral Health Network Provider.

Behavioral Health services are available by "self-referral." This means you can go to a Behavioral Health Network Provider when you think you need one. You do not have to first ask your PCP or other Provider. You do not need a Prior Authorization for a Behavioral Health Network Provider. Certain other Behavioral Health services must be Authorized in advance.

The Covered Services List shows the Behavioral Health services that require Prior Authorization. This list can be found in the back of this Handbook. Your Provider can arrange for Prior Authorization. You can call Carelon if you have any questions about Prior Authorization for Behavioral Health Covered Services. In a Behavioral Health Emergency, call 911; go to the nearest hospital Emergency room.

Section 3.9 Getting care from Out-of-Network Providers

Providers who do not have contracts with us are called "Out-of-Network Providers." You are not covered for services provided by an Out-of-Network Provider—except in any of the following cases:

- Emergency.
- Post-stabilization Services. (These are services that follow your Emergency room visit.) See Section 3.12.
- Urgent Care.
- Second Opinions—if we gave a Prior Authorization.
- Your PCP or other Provider has received Prior Authorization from us.
- For Family Planning Services; you may choose any doctor, clinic, community health center, hospital, pharmacy, or family planning office as long as they contract with MassHealth. See Section 4.1.
- If you need care that is a covered and is Medically Necessary and our Network Providers cannot provide this care, or cannot provide it within the timeframes in Section 3.11. In these cases, you may be able to get this care from an Out-of-Network Provider. We must approve this in advance through Prior Authorization.
- You have been Authorized to see an Out-of-Network Provider under our Continuity of Care policy described in Section 3.10.

You are not covered for medical care, including Emergency or Urgent Care, *outside of the United States or its territories*. You should still seek Emergency or Urgent Care when you are outside the country. But we and MassHealth will not cover it.

Section 3.10 Continuity of Care

This is the process to reduce disruptions in health care when a Member: changes health plans, or when a Network Provider leaves the Network. There are cases described below when we may cover, for a short time, health services from a Provider with whom you have an existing relationship. This is true even if that Provider is not in our MCO Plan Provider Network (Out-of-Network Provider).

New Members

If you are a new Member, here are some cases where we may be able to pay for your care with a Provider you were seeing before you became our Member:

- Pregnancy: You may be able to keep seeing your current OB/GYN through:

  - The delivery of your child, and
  - Follow-up care within the first weeks after delivery.
- Outpatient Services for up to 30 calendar days after your Effective Date of enrollment for:
  - Outpatient medical or Behavioral Health services (including substance use disorder care services) from a Provider whom you have been seeing. This includes a PCP.
  - Durable Medical Equipment and supplies (including Prosthetics and Orthotics), or outpatient therapies if another MassHealth health plan authorized these for you in the past.
- Inpatient Services: If you are an Inpatient on your Effective Date in the MCO Plan, for up to 30 calendar days after your Effective Date of enrollment, or for as long as Medically Necessary.
- Prescriptions: If you have an existing prescription as of your Effective Date of enrollment, you may be able to get coverage for refills for certain prescribed drugs.
- Applied Behavioral Analysis (ABA) Services: You may be covered for more visits to the Provider of ABA services. This could be for up to 90 calendar days after your Effective Date.
- Community Partner Programs: You may be covered up to 30 days after your Effective Date of enrollment.

Existing Members—if your Network Provider leaves our MCO Plan

Sometimes Network Providers may leave our Provider Network. This could happen for many reasons. For example, they move or retire. If your Network Provider leaves the Network for reasons not related to quality or Fraud, we will try hard to tell you in advance. That way you have time to pick a new one. We will also work with you to transfer your care to a new Network Provider. That new Provider can give you the Medically Necessary care you need.

If your Network Provider leaves the Network, we may be able to continue to cover some of your health care from this Provider. This might be done under our Continuity of Care policy. But only if any of the following cases apply to you:

- If the Provider is providing your pregnancy care, and you are in your second or third trimester of pregnancy, you may be able to keep seeing your Provider through delivery and the first six weeks after delivery.
- If your Provider, including your PCP, is actively treating a chronic or acute medical condition, you may be able to keep seeing your Provider through the current period of active treatment or for up to 90 calendar days (whichever period is less) after we tell you he or she is no longer part of our MCO Plan Provider Network.
- If you are receiving behavioral health services, and your provider leaves the MCO network, we will transition you to another provider minimizing any disruptions to treatment. While that transition is occurring, you may continue to see your current provider for Medically Necessary covered services.

How to ask us for Continuity of Care

If you are first joining the MCO Plan or are a current Member, you must call our Member Services Department and say that you want to get Continuity of Care. We will review your case. We may

Authorize continued coverage with your Provider. We will allow you to get continued treatment by an Out-of-Network Provider only if he or she agrees to our terms related to payment, quality, and other policies. You should make sure that the Provider has Prior Authorization from us before you see him or her. You may ask your PCP to arrange this. Or call our Member Services Department. You may also call us if you need help locating a new Network Provider.

If you choose to go to an Out-of-Network Provider (or a Network Provider who we did not Authorize you to see under Continuity of Care) and we did not approve coverage under one of the cases listed in Section 3.10, *you will be responsible for payment of the services you receive.*

Section 3.11 How long it should take to get care from Providers in our MCO Plan Provider Network

You don't want to have to wait too long for an appointment when you don't feel well or think you need to see a Provider. That's why we require all of our Network Providers to follow the appointment times below. You shouldn't need to wait any longer than what is listed. If you think any of these timeframes have not been met, you have the right to file an Internal Appeal. (See Chapter 11, Internal Appeals.)

Getting Medical Care

Type of Care	Description
Emergency care	An Emergency room or other Provider of Emergency services must give you care immediately, 24 hours a day, 7days a week. There is no limit on getting qualified Emergency care. This is the case whether or not the Provider is in our MCO Plan Network.
Urgent Care	A Network Provider must give you Urgent Care within 48 hours of your request for an appointment.
Primary care	Non-urgent, symptomatic care. (This means you are sick or have other symptoms that are not urgent.): A Network Provider must give you care within 10 calendar days of your request for an appointment.
	Routine, non-symptomatic care: (if you are not sick and do not have any symptoms): A Network Provider must give you care within 45 calendar days of your request for an appointment. Different times apply when a child's appointments are part of the EPSDT schedule. (EPSDT stands for Early and Periodic Screening, Diagnosis, and Treatment.) Your child's Provider can give you more information about EPSDT schedules. See Section 4.2 about EPSDT.
	Routine, first prenatal and first Family Planning visit: Within 10 working days of your request for an appointment.

Type of Care	Description
Specialty care	Non-urgent, symptomatic care. (This means you are sick or have other symptoms that are not urgent.) A Network Provider must give you care within 30 calendar days of your request for an appointment.
	Routine, non-symptomatic care. (This means you are not sick and do not have symptoms.) A Network Provider must give you care within 60 calendar days of your request for an appointment.

Getting Behavioral Health care

Type of Care	Description
Emergency Behavioral Health Services	A hospital Emergency room, a Community Behavioral Health Center (CBHC) Provider or other Provider of Emergency services must give you care immediately, 24 hours a day, 7 days a week.
Urgent Behavioral Health Services	A Network Provider must give you Urgent Care within 48 hours of your request for an appointment.
Other Behavioral Health Services	A Network Provider must give you care within 14 calendar days of your request for an appointment.
	For services described in an Inpatient or 24-hour diversionary services discharge plan, you must get care within these time frames: • For non-24-hour diversionary services: within 2 calendar days of discharge • For medication management: within 14 calendar days of discharge • For other outpatient services: within 7 calendar days of discharge • For Intensive Care Coordination services: within 24 hours of referral, including self-referral, offering a face-to-face interview with the family

Section 3.12 Emergency Services, Urgent Care and after-hours care

What is an "Emergency" and what should you do if you have one?

An Emergency is when you, or any other reasonable person with an average knowledge of health and medicine, believe that you have symptoms that require immediate medical attention. The medical or Behavioral Health symptoms may be an illness, injury, severe pain, or a medical or Behavioral Health condition that is quickly getting worse. Below are some examples of medical and Behavioral Health Emergencies. These are only the most common Emergencies. This list does not include all the health Emergencies someone may have.

Examples of medical Emergencies	• Convulsions, • Chest pain • Loss of consciousness • Heavy bleeding • Severe burns • Serious accidents • Poisoning • Throwing up continuously • Heart attack • Stroke • Heavy bleeding
Examples of Behavioral Health Emergencies	• Hallucinations • Wanting to harm yourself • Wanting to harm others

If you have a medical or Behavioral Health Emergency:

- **Get help as soon as possible.** Call 911 for help. Or go to the nearest Emergency room or hospital. You have a right to go to any hospital or other setting for Emergency Services. A statewide list of Emergency rooms is in our Provider Listing at **wellsense.org**. It is also in the "Statewide Emergency Care by Hospitals" section of your paper Provider Listing. You should seek immediate care when there is no time to call your Provider. Call for an ambulance if you need it. You do not need to get Prior Authorization or be directed by any Provider to seek Emergency care.
- **Coverage.** You are covered for Emergency care 24 hours a day, 7days a week. This is the case even if you travel away from home and need to see an Out-of-Network Provider. (Note: there is no coverage outside the United States or its territories.) You cannot be denied Emergency care based on your diagnosis (your illness or condition).
- **In a Behavioral Health Emergency.** Call 911Or go to the nearest Community Behavioral Health Center (CBHC) in your area or the nearest hospital Emergency room.. A statewide list of CBHC's is in our Provider Listing at **wellsense.org**. This list is also in the "Statewide Behavioral HealthCenters" section of your paper Provider Listing.
- **Call your PCP.** As soon as possible, but within 48 hours, you or someone else should call your PCP to tell him or her about your Emergency. This will help make sure you get the right follow-up care.

What is Covered if you have a medical or Behavioral Health Emergency?

We will cover Emergency services and Post-stabilization Care services from any Provider within the United States or its territories. We also cover Emergency-related ambulance services.

Note: We do not cover Emergency care (or Emergency ambulance services) outside of the United States or its territories. You should still seek Emergency care when you are outside the country. But the services you get will not be covered by MassHealth or us.

Care after the Emergency is treated

The Providers who treat your Emergency will decide when your condition is stable. This means that the Emergency is over and you are improved enough to be transferred or released from the hospital. This is called Post-stabilization Care. The treating Provider's decision is binding. This means we and anyone caring for you must follow the treating Provider's direction.

Post-stabilization Care services related to an Emergency are covered so that your condition remains stable. For example, if you are treated for a Behavioral Health Emergency at a Community Behavioral Health Center, you are also covered for the follow-up services you will need once your Emergency has been dealt with. This follow-up care might include outpatient visits or treatment at another facility.

We can work with your doctors to coordinate your Post-stabilization Care. If an Out-of-Network Provider gives you your Emergency or Post stabilization care, we will arrange for Network Providers to take over your care as soon as your medical condition and the situation allow.

What if it wasn't a medical or Behavioral Health Emergency?

Sometimes it can be hard to know if you have an Emergency. For example, you might go in for Emergency care thinking that your health is in serious danger. But the doctor may say that it was not an Emergency. If it was not an Emergency, as long as you thought your health was in serious danger, we will cover it. But after the doctor has said that it was not an Emergency, we will cover additional care only if you get that care in one of these two ways:

- You go to an MCO Plan Network Provider to get the additional care; or
- The additional care you get is considered "Urgent Care." Then you follow the rules for getting Urgent Care (see below).

What if you need Urgent Care – during or after regular office hours?

Urgent Care is care required to prevent a worsening of symptoms that a reasonable person would believe are not an Emergency but require medical attention.

- You should always try to call your PCP (or Behavioral Health Provider) when you think you need Urgent Care. This is the case even after regular office hours. You can call your PCP 24 hours a day, 7 days a week. If your PCP is not available, a covering Provider will call you back. Your PCP or Behavioral Health Provider can usually care for your Urgent Care needs. Your PCP and your Behavioral Health Provider must see you within 48 hours after you ask for an appointment for Urgent Care.
- If you think you can't wait to talk with your PCP, covering Provider or a Behavioral Health Provider, or if your condition gets worse before one of these Providers sees you, go to a Network Urgent Care center. Or go to the closest hospital Emergency room.
- You may also call our Nurse Advice Line 1-800-973-6273 at any time or the Behavioral Health

Help Line at 833-733-2445. See Section 5.5.

What if you are traveling away from home and need Urgent Care?

If you need Urgent Care while you travel from home for a short period of time, try to call your PCP and follow your PCP's advice. If you cannot wait, go to the nearest Urgent Care center, Minute Clinic, or hospital Emergency room. You or a family member should call your PCP (or your Behavioral Health Provider, if that applies) within 48 hours after getting Urgent Care. Your PCP will want to follow up with you about any more care you may need.

We will cover Medically Necessary Urgent Care services that you get when you travel from home, EXCEPT we will not cover:

- ANY Urgent Care services provided outside the United States or its territories. You should still seek Urgent Care when you are outside the U.S. But neither we nor MassHealth cover these services.
- Tests or treatment your Provider told you to get before you left the area.
- Routine Care or follow-up care that can wait until you come home. Examples are physical exams, flu shots, stitch removal, or counseling.
- Care that you knew you were going to need before you left the area, like elective surgery. (This means surgery you choose to get.)

To make sure you are covered, take care of your Routine health needs before traveling.

What you should do if you are billed for Emergency or Urgent Care

An Out-of-Network Provider may ask you to pay for Emergency or Urgent Care at the time you get the service. If you pay for this type of service that you got within the United States or its territories, you may ask us to pay you back. See Chapter 8 about how to ask us to pay you back. You may also call our Member Services Department for help with bills that you may get from a Provider.

Chapter 4: Using our MCO Plan to help manage your health

This Chapter gives you important information about pregnancy and Family Planning Services. It also includes information about preventive care and other services that help you manage your care and stay healthy.

Section 4.1 Pregnancy and Family Planning

Pregnancy (prenatal) care

The health care you get while you are pregnant (before your baby is born) is called "prenatal care." This type of care is very important. Your Provider will check with you often during your pregnancy. He or she will want to make sure your baby is growing like it should. This will include making sure you are eating the right foods and that there are no problems with your health. It also includes making sure that there are no problems with your growing baby. Even if you have had another baby, it is very important that you get prenatal care for every pregnancy.

Make an appointment with an obstetrician/gynecologist (OB/GYN)

You need to see an obstetrician (OB) as soon as you can after you become pregnant. An OB is a doctor who treats pregnant individuals and delivers babies. This type of doctor is usually also a gynecologist (GYN). That means that he or she is trained to know about diseases of the female reproductive system. This is the system in your body that allows you to have babies. The short name for this combined specialty is OB/GYN. If you think you are pregnant, you should:

- Tell your PCP that you are pregnant. Your PCP can give your OBGYN important health information about you. This will help make sure that you and your growing baby stay healthy.
- Ask your PCP to give you the name of an OB/GYN doctor. Or, call an OB/GYN doctor listed in our MCO Plan Provider Listing You do not need a Prior Authorization for these visits. This means you do not need to get approval before seeing an OB/GYN.
- You can see your OB/GYN as often as he or she wants to see you. We pay for all these visits, including childbirth in a hospital or a freestanding birthing center

Family Planning Services and supplies in Network or Out-of-Network

We cover Family Planning Services. These include medical services, counseling, birth control advice, pregnancy tests, sterilization services, and follow-up care. (Sterilization services are permanent medical procedures that stop you from getting pregnant in the future.) You can get Family Planning Services from your PCP. You can also get these services from any MCO Plan Network Provider or MassHealth-contracted Family Planning Services Provider. No Prior Authorization from us is required. Ask your PCP for names of Family Planning Services Providers. You can also call a Family Planning Services Provider directly (self-refer).

Section 4.2 Preventive Care—Staying Healthy

Staying healthy

The best health care happens before you get sick. It is called preventive care. We cover preventive care services that are rated A or B, as recommended by the U.S. Preventive Services Task Force. For children, we also cover preventive services recommended by the American Academy of Pediatrics Bright Futures Program. To help you stay healthy, we have a Guide to Wellness. This guide gives you the list of tests and shots you and your children should have. If you would like a copy of the guide, go to our website at **wellsense.org**. You can then select "Living Healthy" and "Wellness Center."

Preventive care for adults

Routine preventive care is important to stay healthy. We like all Members to visit their PCPs for preventive care. Examples of preventive care benefits that we cover for Members ages 21 and older include:

- Physical exams every one to three years.
  - Ages 18–21: once a year
  - Ages 22–49: every 1-3 years
  - Ages 50 and over: once a year
- Cholesterol screening beginning at age 18 or as recommended by your healthcare provider.
- Cholesterol screening every five years beginning at age 18 or as recommended by your Provider.
- Pelvic exams and Pap smears every three years starting at age 21 for individuals at average risk.
- Breast cancer screening (mammogram) every two years for ages 50-74; earlier or more frequently based on risk factors. These exams should start earlier if an immediate family member has a history of breast cancer. Colorectal cancer screening every 10 years starting at age 50. This screening could be earlier if an immediate family member has a history of colorectal cancer. In that case, screenings could be more often.
- Flu shot every year.
- Eye exams once every 24 months. These could be more often if certain medical conditions exist.

Preventive and well-child care for all children

Children who are under age 21 should go to their PCP for checkups even when they are not sick. At the checkup, your child's PCP will screen to see if there are any health problems. These screenings include:

- Health
- Vision
- Dental
- Hearing

- Behavioral Health (BH) - mental health and substance use disorders
- Growth progress
- Immunizations

At the checkups, the PCP can find small problems and treat them before they become big ones. We pay your child's PCP for these checkups.

Behavioral Health (BH) screenings can help you and your doctor or nurse see if you need help early with emotional or social problems. MassHealth requires that PCPs and nurses use specific tools to check a child's BH during well-child visits. These are short checklists that the parent or child (if they are old enough) fill out and talk about with the doctor or nurse. The checklist might be called the *Pediatric Symptom Checklist* or the *Parents' Evaluation of Developmental Status*. Or it can be another screening tool your PCP chooses.

Your Provider will talk about the checklists with you. The checklists will help you and your Provider know if your child needs help with emotional or social needs. If they do, they would go to see a BH Provider. For more information on how to get BH Covered Services, or to find a BH Provider, talk to your PCP or call Carelon Behavioral Health.

Below is the list of ages when your child needs a well-child check-ups and screenings:

- at 1 to 2 weeks
- at 4 months
- at 12 months
- at 1 month
- at 6 months
- at 15 months
- at 15 months
- at 9 months
- at 18 months
- at ages 2-20, children should visit their PCP according to the schedule advised by the American Academy of Pediatrics according to Bright Futures. Preventive Health Care schedule found at https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

Children should also visit their PCP any time you are worried about their medical, emotional, or BH needs, even when it isn't the time for a regular checkup.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children enrolled in MassHealth Standard or CommonHealth

EPSDT services are preventive care and treatment services PCPs provide on a specific schedule. The schedule is based on a child's age. The services include a complete assessment (screening), coordinating your services, helping in a crisis and in-home services.

If you or your child are under age 21 and enrolled in MassHealth Standard or CommonHealth, we will pay for all Medically Necessary services that are covered by federal Medicaid law. This includes services not specifically mentioned in your Covered Services List. We cover services that include doctor's visits and diagnostic services. We also cover treatment that corrects or improves physical and BH conditions. If the service is not on the Covered Services List, the Provider who gives the

service can ask us for Prior Authorization. Prior Authorization is the term we use for deciding if a service is Medically Necessary. We will pay for the service if Prior Authorization is given. If Prior Authorization is denied, you or your Authorized Representative has a right to Appeal. (See Chapter 11 about the Appeal process.) Talk to your child's PCP, BH Provider, or other Specialist for help getting EPSDT services.

Preventive Pediatric Healthcare Screening and Diagnosis (PPHSD) services for children enrolled in MassHealth Family Assistance Plan

If you or your child are under 21 years old and enrolled in MassHealth Family Assistance Plan, we will pay for all Medically Necessary services your PCP provides with a well-child checkup. The PCP will check for any health problems. The screenings include health, vision, dental, hearing, and BH. They also include screenings to see if your child is growing as they should and has had all necessary shots. At well-child checkups, PCPs can find and treat small problems before they become big ones. Children should see their PCPs any time there is a concern about their medical or BH, even if it is not time for a regular checkup. Children under age 21 are also allowed regular visits with a dentist.

Children's Behavioral Health Initiative (CBHI)

CBHI is a MassHealth program. Families and children with serious Behavioral Health needs get services they need. These services will help make sure that they do well at home, school and in the community. To decide which services your child needs, your child's BH Provider uses a standard tool to learn about your child's needs. MassHealth requires this tool. The tool is called the Child and Adolescent Needs and Strengths (CANS). This tool helps the BH Provider collect information. This information helps them decide what type of BH needs your child has. Your BH Provider also uses this tool to check if the treatment is helping your child. The provider will also use this tool to manage care if your child is in an Inpatient psychiatric hospital or community-based acute treatment setting.

We offer additional BH services to your child and family because of the CBHI. These include services such as Intensive Home or Community-Based Services for Youth. Check our MCO Plan Provider Listing for a list of BH Providers in your area. For more information, call Carelon Behavioral Health.

Dental care for children

MassHealth (not WellSense Health Plan) pays for preventive and basic dental services. These services keep your children's teeth and mouth healthy and prevent diseases. Your child's PCP will check your child's teeth at well-child checkups. When your child is three years old, his or her PCP will tell you to take your child to the dentist at least twice a year. They may ask you to go earlier if there are problems. When your child goes for routine dental exams, the dentist will do a full dental exam. The dentist will also clean your child's teeth and give them a fluoride treatment. It is important that your child gets the following dental care:

- A dental checkup every six months starting no later than age three.
- If your child's PCP or dentist finds problems with your child's teeth or oral health or gums, your child may need other dental treatments before age three.

Your child's dental health may be better when fluoride is put on his or her teeth. This can be done by a dentist or other Provider. It is best to have the fluoride put on when the child is very young. That means as soon as the front teeth begin to show. This usually happens at 6 months old. Fluoride is allowed for Members up to age 21 years old if they can't get to a dentist and the service is Medically Necessary.

Children younger than 21 years old can get all Medically Necessary services covered under Medicaid law. This includes dental treatments, such as:

- Preventive and basic services to prevent and control dental diseases. It also includes upkeep of teeth and gums. (These services are covered by MassHealth.)
- Oral surgery in an outpatient setting, such as Outpatient Hospital or same day surgical centers, and Emergency dental services. (These services are covered by us.)

Talk to your child's PCP or dentist if you need help getting these services. Please note:

- Children do not need Prior Authorization to see a MassHealth dentist.
- Children can visit a dentist before age three.

Early Intervention (EI) services for children with growth or developmental problems

Some children need extra help to grow and develop healthy. Network Providers who are EI Specialists can help them. EI Specialists work with children under three years old and their families. Some are social workers and nurses. And some are physical, occupational, and speech therapists.

They make sure your child gets needed extra support. Some of the services will take place in your home. Some will take place at EI centers. If you think your child has problems with growing or developing, talk to your child's PCP right away. You can also call your local EI program directly.

Children in the care or custody of the Department of Children and Families (DCF):

If you have children in the care or custody of DCF, a Network Provider must:

- Give your child a health care screening within 7 calendar days after you or the DCF worker asks for it.
- Give your child a full medical exam within 30 calendar days after you or the DCF worker asks for it. Sometimes it is sooner if the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) require it sooner.

Chapter 5: Covered Services (your benefits)

Section 5.1 Understanding your Covered Services (what is covered and what is not covered)

This Chapter explains what you need to know about using our MCO Plan to get your health care covered. Covered health care services and drugs are called "Covered Services." We cover and manage most Covered Services. However, some services are covered and managed directly by MassHealth. See Section 5.2. In either case, we coordinate all these services as of the date that you become a Member of the MCO plan. This date is your "Effective Date."

Covered Services List

For information on all your Covered Services, see the Covered Services List in the back of this Handbook. Your benefits are shown for your specific MCO Plan benefit plan. The type of benefit plans are:

- Standard (including Special Kids Special Care Program Members)
- CommonHealth
- Family Assistance Plan
- CarePlus

The Covered Services List has:

- The list of Covered Services.
- An explanation about whether the services are covered by us or by MassHealth.
- Copayments: amounts you have to pay for Covered Services.
- Benefit Limits.
- Services that require Prior Authorization from us. These services are marked with "Yes" in the Prior Authorization Required column of the Covered Services List.
- The services that are covered directly by MassHealth. The Covered Services List will tell you if your Provider will have to get a referral directly from MassHealth.

The Covered Services List is general information only. It does not list every service that is covered. MassHealth decides what all your benefits are. Your benefits may change over time. See our website for the most current information. Always check your Covered Services List to see what services are covered or not.

Excluded Services List

The Excluded and Limited Services List is also found in the back of this Handbook, after the Covered Services List. The Excluded and Limited Services List is a list of services that either have limits or are not covered by us or by MassHealth. *We and MassHealth don't cover any services outside of the United States and its territories. This includes Emergency and Urgent Care.*

Section 5.2 Services covered directly by MassHealth

MassHealth directly covers some services even though we may help coordinate them. The services directly covered by MassHealth are shown with an asterisk (*) on the Covered Services List. For more information on the services covered directly by them, please call:

- MassHealth Customer Service Center at 888-841-2900 (TTY/TDD 800-497-4648), Monday through Friday, 8:00 a.m. to 5:00 p.m. ET

Transportation assistance

Some Members may qualify for non-Emergency transportation to go to visits for Covered Services. MassHealth, not we, covers this benefit. However, we can help you to set up this transportation. You should contact us before your appointment so we can handle your request. In order to qualify for this benefit, you must make sure that:

- You do not have a family member or other person who can take you to your appointment.
- You do not have access to public transportation (buses or trains), or if you do, that there is a medical reason you cannot use it.
- Your appointment is for a Medically Necessary Covered Service.
- You will see a Network Provider or other MassHealth-contracted Provider.

Note: Non-Emergency transportation must be within 50 miles of the Massachusetts state border. For more information, please call our Member Services Department.

Section 5.3 "Extras" - free for our qualified Members

In addition to the Covered Services you get, qualified Members also get the following free extras:

- Infant/toddler safety car seats. If you're having a baby, call our Member Services Department. Ask to find out how to get your free car seat. You can get the car seat as early as 45 days before your due date.
- Bicycle helmets for kids. Kids who are Members of our MCO Plan can get a free bike helmet. Call our Member Services Department to find out how to get the helmet.
- Free dental kits every year for Members age four years and up.
- Payment towards:
  - A qualified gym membership fee.
  - Weight Watchers® Programs.
  - We will pay up to the amount stated on our website at **wellsense.org**.

For more information on whether you qualify for these extras, call our Member Services Department.

Section 5.4 Where to find the Covered Services List and Excluded and Limited Services List

See the Covered Services List. See the Excluded and Limited Services List. Both can be found at the back of this booklet.

Section 5.5 Nurse Advice Line and Behavioral Health Help Line for all our Members

You can get free health care information from a trained registered nurse or behavioral health provider. You can get this 24 hours a day, 7 days a week from our Nurse Advice Line for medical questions or Behavioral Health Help Line for mental health or substance use questions. Our Nurse Advice Line is 800-973-6273. The number for the Behavioral Health Help Line is 833-733-2445. Remember: these lines can help you. But the Line should not take the place of your Primary Care Provider (PCP) or Behavioral Health Provider.

Section 5.6 Rules for getting your health care covered by us

We will cover your health care if the following rules are met:

- You are enrolled in our MCO Plan at the time of the service.
- The care you get is listed in the Covered Services List. See the back of this Handbook.
- **The care you get is Medically Necessary.** "Medically Necessary" services are services, supplies, or drugs needed to prevent, diagnose, or treat of your medical condition. These services must meet accepted standards of medical practice. There must not be another similar medical service or place of service that is right for you or that is more appropriate or less costly.
- **The care you get is from an MCO Plan Network Provider.** In most cases, care you get must be from a Network Provider. The only time this is not true is when you get care from an Out of Network Provider as stated in Section 3.9.
- **Your Provider has received approval in advance from us. This is called Prior Authorization.** In certain situations, we must give your Provider approval before you can get a certain service or see certain Providers. See Sections 3.6 and 5.7.

If you have questions about Covered Services, or any of the rules for getting your care covered by us, call Member Services.

Section 5.7 Prior Authorization—getting approval from us for certain services

What is Prior Authorization?

For certain Covered Services, your Provider will need approval from us before we agree to cover the service for you. This approval is called **"Prior Authorization."** The rule for getting approval in advance helps us make sure that you get the right care. If you do not get this approval, we might not cover your service. The Covered Services List states whether Prior Authorization is required from us or from MassHealth.

When we make a decision to cover or not cover a service, we consider whether the service is Medically Necessary. We decide if a service is Medically Necessary based on clinical criteria. Clinical criteria are based on information from proven clinical research. Health care professionals who have the right clinical knowledge make our Prior Authorization decisions. You can request a copy of our clinical criteria: call our Member Services Department or go to our website at **wellsense.org.**

In general, Prior Authorization is required in the following cases:

- When the Covered Services List has "Yes" in the Prior Authorization Required column.
- When you are trying to get coverage for services with an Out-of-Network Provider. The only exception is for those services listed in Section 3.9 that do not require Prior Authorization. An example of this type of service is Family Planning.

We will send a letter to you, your Authorized Representative (if you have one) and the requesting Provider of any decision to deny a request for coverage. We will also send you a letter if we approve less than what was asked for. You have the right to file an Internal Appeal if you disagree with our decision - see Chapter 11.

Timeframes for Prior Authorization decisions

Prior Authorization decisions are made within the following timeframes:

- **Standard Authorization decisions:** Within 14 calendar days after we receive the request.
- **Expedited (fast) Authorization decisions:** Within 72 hours after we receive the request. Only a Provider or we can decide when an Authorization request may be expedited (processed fast). This decision is based on whether following the 14 day timeframe could seriously harm the Member's life or health, or ability to get, maintain or regain maximum function.

We can take 14 more calendar days to decide if you or your Provider requests it. The process of asking for more time is called an "extension." You can also get more time if:

- We have good reason to believe the extension is in your best interest;
- We need additional information that we think, if we receive it, will lead to approval of your request; and
- We think there is a good chance that we could receive more information if we waited for 14 calendar days.

If we decide that an extension of the timeframes is a good idea, we will send a letter to you and your Authorized Representative (if you have one). If you aren't happy with this decision, you may file a Complaint in writing, over the phone or in person. A Complaint is also called a "Grievance." Our Member Services Department staff can help you with this. Also, we will send a letter to you if we did not meet these timeframes. You have the right to file an Internal Appeal.

Chapter 6: Getting your prescription drugs

Section 6.1 MCO Plan Drug List

Our Drug List tells you:

- Which prescription drugs are covered by us.
- Which drugs are not covered by us.
- Which non-drug pharmacy products (such as diabetic test strips) are covered by us
- Whether the drug is part of any of our Pharmacy Programs. Pharmacy Programs put special rules on coverage of certain drugs.

We select the drugs on the Drug List with the help of doctors and pharmacists. The Drug List is sometimes called a "formulary."

Please note that sometimes a drug may appear more than once in our Drug List. This is because different Pharmacy Program rules or Copayments may apply based on factors such as the strength, amount, or form of the drug prescribed by your Provider. (For example: 10 mg versus 100 mg; one per day versus two per day; or tablet versus liquid).

The Drug List includes both brand name and generic drugs

A brand name drug is a drug made and sold by the drug company that originally developed the drug. A generic drug is a drug that is made and sold by other drug companies. A generic drug has the same active ingredients as the brand name drug. Generally, the generic drug works just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

Over-the-Counter (OTC) Drugs

We cover certain over-the-counter drugs as listed in the MassHealth Over-the-Counter Drug List. Some OTC drugs are less expensive than prescription drugs and work just as well. To be eligible for coverage, OTC drugs require a prescription from your Network Provider. To search the list of drugs covered by Masshealth, visit wellsense.org/masshealth-prescriptions.

Non-Drug Pharmacy Products

We cover certain non-drug pharmacy products as listed in MassHealth's ACO/MCO Unified Pharmacy Product List. To find out whether the non-drug item you are looking for is covered, visit wellsense.org/masshealth-prescriptions.

Drugs that we do not cover

There are certain drugs we do not cover. If you get drugs not covered by us, you must pay for them yourself. Here are some general rules about drugs that we do not cover:

- We do not cover drugs that MassHealth (Medicaid) does not cover.
- We do not cover drugs purchased outside the United States and its territories.
- We usually do not cover off-label use of drugs. "Off-label use" is any use of the drug other than those uses listed on a drug's label as approved by the Food and Drug Administration. Generally, coverage for "off-label use" is allowed only when certain reference books (such as the American Hospital Formulary Service Drug Information book) support the use. If the use is not supported by these reference books, then we do not cover it.
- Certain drugs are not covered through our pharmacy benefit but are covered under our MCO Plan's medical benefits. These drugs are usually given to you directly by your Provider rather than from a pharmacy.

If a drug is not covered, it will be marked as "excluded" in our online Drug List. You may also contact our Member Services Department for more information.

Section 6.2 Where to find our Drug List

The most up-to-date Drug List is on our website at wellsense.org. You can look up specific drugs and non-drug pharmacy products to see if they are covered, not covered (excluded), part of our Pharmacy Programs, and other information. If you would like a copy of the Drug List, call our Member Services Department and ask for the Pharmacy Department.

Section 6.3 Changes to the Drug List

The Drug List can change during the year

We make changes to the Drug List every other quarter or more frequently if necessary. The online Drug List is updated as changes are made. For example:

- We might add or remove drugs and non-drug pharmacy products from the Drug List for many reasons. New drugs may become available, including new generic drugs. We might replace a brand name drug with a new generic drug. Sometimes the government has given approval for a new use for an existing drug. Sometimes the government recalls a drug and we decide not to cover it. Or, we might remove a drug from the Drug List because it has been found to be ineffective.
- We might add a drug to, or remove a drug from one or more of our Pharmacy Programs. See Section 6.5 for more information about our Pharmacy Programs.

How will you find out if your drug's coverage has been changed?

If there is a change to coverage for a drug you take and that change could have a negative effect on you, we will send you a notice. In most cases, we will let you know at least 30 days ahead of time. Sometimes a drug is suddenly recalled because it has been found to be unsafe, or for other reasons. If this happens, we will immediately remove the drug from the list of covered drugs in the Drug List

and let you know of this change right away. Your Provider will also be notified and can work with you to find another drug for your condition.

If a brand name drug you are taking is replaced by a new generic drug, the pharmacy will automatically substitute the generic drug when you get your next refill. In most cases, we will cover the new generic drug and require Prior Authorization for the brand-name version. You can work with your Provider to switch to the generic or to a different drug that we cover. Or, you and your Provider can ask us to make an exception and continue to cover the brand name drug for you.

Section 6.4 Getting your prescriptions covered

Basic prescription drug coverage rules

We will cover your drugs as long as you follow these basic rules:

- You must have a Network Provider (a doctor or other qualified prescriber) write your prescription (except for Emergency or Urgent Care).
- You must use a Network pharmacy. Most drugs are available from Network retail pharmacies. Certain prescriptions can be filled through our Network mail-order pharmacy. Specialty drugs must come from our Network specialty pharmacy.
- Your drug must be listed on the Drug List as a covered drug. See Section 6.1.
- Certain drugs are subject to special rules through our Pharmacy Programs before we will cover them.
- Your drug must be used for a medically accepted indication. This means the use of the drug is either approved by the Food and Drug Administration or supported by certain reference books.
- If you are required to pay a Copayment (see the Covered Services list at the back of your handbook), you should pay it at the time you get your medication. (If you can't pay the Copayment, the Network pharmacy must still fill your prescription.)

Get a Prescription from your Network Provider

Your MCO Plan Network Provider needs to write a prescription for both prescription medications and over-the-counter (OTC) medications if you need them. The only exceptions are for Emergency or Urgent Care. See Section 3.12.

Fill your prescriptions at a Network pharmacy

In most cases, your prescriptions are covered only if they are filled at the MCO Plan's Network pharmacies. A Network pharmacy is a pharmacy that has a contract with us to provide your covered prescription drugs. You may go to any Network retail pharmacy. We contract with more than 1,000 retail pharmacies across Massachusetts—including major chain stores.

To find a Network pharmacy near you, go to our online Pharmacy Listing ("Find a Pharmacy") at **wellsense.org**. This lets you search for a Network pharmacy in your area. If you need help finding a Network pharmacy, call our Member Services Department.

To fill your prescription, show your MCO Plan Member ID Card at the Network pharmacy you choose. When you show this ID Card, the Network pharmacy will automatically bill us for our share of the cost of your covered prescription drug. You will need to pay the pharmacy your share of the cost (Copayment) when you pick up your prescription, if required. If you do not have your MCO Plan Member ID Card with you when you fill your prescription, ask the pharmacy to call us to get the necessary information.

What if the Network pharmacy you have been using leaves the Network?

If the pharmacy you have been using leaves the MCO Plan's Network, you will have to find a new Network pharmacy. You can get help from our Member Services Department or use our Pharmacy Listing ("Find a Pharmacy") on our website at **wellsense.org**.

When you may use an Out-of-Network pharmacy

If you travel outside the area and need to fill a prescription due to an Emergency or Urgent Care need, you may have to go to an Out-of-Network pharmacy. In such case, you will need to pay for the drug and then contact us to have us pay you back. See Chapter 8 for more information about how to ask us to pay you back.

Using our Network mail-order pharmacy service

You can get certain kinds of drugs from our Network mail-order pharmacy—Cornerstone Health Solution (Cornerstone). These drugs are called "maintenance drugs." Generally, maintenance drugs are drugs that are refilled regularly for conditions like diabetes and high blood pressure. Mail order allows Members to have a 90-day supply of maintenance drugs sent to their homes instead of having to get the prescription at a local retail Network pharmacy. To find out if your drug is available through mail order, go to our Drug List on **wellsense.org**. The drugs available through mail order are marked as "mail order" drugs in our Drug List.

How to sign up with the mail-order pharmacy:

To request a new mail order prescription

- Call Cornerstone Health Solution (Cornerstone) at 844-319-7588, 711 (TTY/TDD), available Monday through Friday 7 a.m. to 6 p.m. ET.
  You may also complete the mail order pharmacy enrollment form and mail it in with your prescription(s) to us. You may also have your doctor submit your prescription electronically to us via fax.

To request a refill of your mail order prescription

- Call Cornerstone Health Solutions mail order pharmacy at 781-805-8220, 711 (TTY/TDD), Monday through Friday 7 a.m. to 6 p.m. to request your refill.
- Email CornerstoneMailOrderPharmacy@bmc.org 24 hours a day, 7 days a week to request your refill.
- Start an online refill request from Cornerstone Health Solutions' webpage.
- Start a mobile refill using Cornerstone Health Solutions' mobile app.
- Complete the mail-order enrollment form that is available on the website at cornerstonehealthsolutions.org.

Once you are signed up, you can refill prescriptions by mail, phone, or online at cornerstonehealthsolutions.org. Your prescribing Provider may call Cornerstone Health Solution (Cornerstone) at 844-319-7588, 711 (TTY/TDD), or fax your prescription to them at 781-805-8221. Please make sure to let the mail order pharmacy know the best ways to contact you so they can confirm your order before shipping. Usually a mail order pharmacy order will get to you within 5–7

business days after your prescription order has been confirmed with you. If the mail order prescription is delayed, you should contact us to obtain a temporary supply of medication from a network pharmacy until the mail order can be delivered. If you have never used our mail order delivery to fill prescriptions, the pharmacy will contact you for setup. The pharmacy will also contact you when it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

It is important that you tell the pharmacy the best ways to contact you when you enroll in mail order services, including specifying your communication preferences and confirming your shipping address. If you have questions or problems with your mail order prescriptions, please contact Cornerstone Health Solutions by phone at 844 319-7588, 711(TTY/TDD).

Using our Network specialty pharmacy

Certain prescription drugs **must** be filled through our Network specialty pharmacy. These drugs include certain medications that are often used to treat chronic (ongoing) conditions that require special drug support services. Specialty pharmacies can provide extra help to Members and Providers. Go to our Drug List on the **wellsense.org** to see if your drug is a specialty drug and to determine which Network specialty pharmacies can fill your prescription.

Section 6.5 Your share of the cost—Prescription Drug Copayments

A prescription drug Copayment may be required for each prescription

A Copayment (sometimes called a "Copay") is a fixed amount you must pay each time you fill a prescription under our MCO Plan. Prescription drug Copayment amounts may change each year. You will receive a letter if there is a change to the Copayment amounts.

There are some Members who don't have to pay a Copayment—see below for where to go to see how copayments apply to you. Otherwise, you will need to pay a Copayment at the Network pharmacy for your prescription drugs. (Please note that our MCO Plan Members pay the same Copayments for prescription medications as individuals enrolled in other MassHealth health plans.)

For information about copayments, see the Covered Services List that is included as an insert in your printed handbook (at the back of your handbook). The Covered Services list can also be found on our website at **wellsense.org**. Once you are on the website- select I AM A / MEMBER/ GET CARE/ YOUR BENEFITS and you will see the member handbook and the Covered services list for your plan. If you have questions, please call our Member Services department at 888-566-0010 (English/other languages), 888-566-0012 (Spanish) 711 (hearing impaired), Monday–Friday from 8:00 a.m. to 6:00 p.m. Calls to this number are free.

Section 6.6 Our Pharmacy Programs—special rules for coverage of certain drugs

We have several Pharmacy Programs that apply special rules to certain prescription drugs before we will cover those drugs. These drugs must meet our clinical criteria in order to be covered.

The purpose of these Pharmacy Programs is to make sure you get medications that are safe and effective—meaning that the drugs work to help your medical condition. Our Pharmacy Programs are also designed to encourage you and your Provider to use lower-cost drug options whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug. This helps control overall drug costs, which keeps your drug coverage more affordable.

How to find out if a drug is part of a Pharmacy Program

To find out if a drug is part of any of our Pharmacy Programs, check the Drug List at **wellsense.org** or call our Member Services Department and ask for the Pharmacy Department.

Description of our Pharmacy Programs

This section describes the following Pharmacy Programs:

- Getting approval in advance from us ("Prior Authorization")
- Restricting brand name drugs when a generic version is available ("Mandatory Generic Substitution Program")
- Trying a different drug first ("Step Therapy Program")
- Quantity Limits on prescription drugs ("Quantity Limits Program")
- Drugs that are "New to Market"
- Other Pharmacy Programs

Getting approval in advance from us (Prior Authorization Program)

Your Provider needs to get approval in advance from us before we will cover certain drugs. This is called **"Prior Authorization."** When we receive a Prior Authorization request, a clinician will review it. If the medication is Medically Necessary, we will cover the medication. If we do not approve the request for Prior Authorization, we will not cover the drug. You can file an Appeal. See Chapter 11 for information about how to Appeal.

Restricting brand name drugs when a generic version is available (Mandatory Generic Substitution Program)

Generally, a generic drug works the same as a brand name drug and usually costs less. In most cases, when a generic version of a brand name drug is available, our Network pharmacies will provide you the generic version. We usually will not cover the brand name drug when a generic is available. If your Provider thinks the brand name drug is Medically Necessary, he or she may submit a request for Prior Authorization. A clinician will review the request. If the brand name drug is Medically Necessary, we will cover it. If we do not approve the request for Prior Authorization, we will not cover the brand name drug. You can file an Appeal. See Chapter 11 for information.

Trying a different drug first (Step Therapy Program)

This requirement encourages you to try less costly but just as effective drugs before we will cover another drug. For example, if Drug A and Drug B treat the same medical condition, we may require you to try Drug A first. If Drug A does not work for you, we will then cover Drug B. This requirement to try a different drug first is called "step therapy." If your Provider thinks it is Medically Necessary for you to use Drug B without first trying Drug A, he or she can request Prior Authorization. A clinician will review the request. If Drug B is Medically Necessary for you, we will cover it. If we do not approve the request for Prior Authorization, we will not cover Drug B. You can file an Appeal. See Chapter 11 for information.

Quantity Limits on a prescription drug (Quantity Limits Program)

For certain drugs, we limit the amount of drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day, we may limit coverage to no more than one pill per day. This Program ensures the safe and appropriate use of certain drugs. If your Provider thinks it is Medically Necessary for you to have more than the allowed amount of the drug, he or she can request Prior Authorization. A clinician will review the request. If it is Medically Necessary for you to have more than the allowed amount, we will cover it. If we do not approve the request for Prior Authorization, we will not cover the larger amount of the drug. You can file an Appeal. See Chapter 11 for information about how to Appeal.

New-to-Market medications

We review new drugs for safety and efficacy before we add them to our Drug List. (Efficacy means that the drug works.) If your Provider thinks that a new-to-market drug that is not on our Drug List is Medically Necessary for you, he or she can submit a Prior Authorization request to us. A clinician will review the request. If approved, we will cover the drug. If we do not approve the request for Prior Authorization, we will not cover the new-to-market drug. You can file an Appeal. See Chapter 11 for information about how to Appeal.

Other Pharmacy Programs

We have other Pharmacy Programs with special rules on drug coverage. These rules include:

- When you fill your prescription, you are limited to up to a 30-day supply of the drug each time you refill it. (Mail-order eligible drugs allow for 90-day supplies.)
- You have to use up about 75% (70% for ophthalmic medications) of your medication supply before you can refill the prescription.

What you can do if you or your Provider wants a drug that is not covered by us or a drug that is limited by the special rules of one of our Pharmacy Programs?

Start by talking with your Provider. Perhaps there is a different drug covered by us that might work just as well for you. You can call our Member Services Department to ask for the Drug List to see which covered drugs treat the same medical condition. This List can help your Provider find a covered drug that might work for you and he or she can prescribe that drug for you.

If your doctor thinks it is Medically Necessary for you to take a medication we do not cover, or is limited by the special rules of one of our Pharmacy Programs, he or she can submit a Prior Authorization request to us. A clinician will review this request. If the drug is Medically Necessary, we will cover the medication. If your Provider asked us for Prior Authorization but we denied the request, you can Appeal the decision. See Chapter 11 for information.

In certain cases, we will approve an emergency supply of a drug if you cannot wait for a Prior Authorization from us because waiting would be a risk to your health. Please have your pharmacy contact our Member Services Department to receive Authorization for this temporary supply.

Section 6.7 Programs to help Members use drugs safely

Drug Utilization Review Program

We conduct drug use reviews to help make sure Members are getting safe and appropriate care. These reviews are especially important for Members who have more than one Provider who prescribes their drugs. We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions written for drugs with ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking

If we see a possible problem in your use of medications, we will work with your Provider to correct the problem.

Prescription Drug Monitoring Program (PDMP)

This program uses claims data to identify Members who are at risk for using medications that could be abused. These drugs include Schedule II controlled substances (such as Oxycodone and Morphine) or other medications that are considered high risk due to overuse or inappropriate use. The goal of the PDMP is to help Providers be more aware of their patients' medication use, and to reduce the possibility of medication misuse. Based on reviewing a Member's medical history and medication use, we may take actions such as:

- Pharmacy Lock-In: This is a process that prevents a Member from getting controlled medications (such as hydrocodone or tramadol) at more than one pharmacy for one year. It also helps the Member's Providers and pharmacist to better understand the Member's medications and reduce risks. Any Member who is placed in a pharmacy lock-in will be notified in writing in advance, including Appeal rights.
- Communicating with the doctor who prescribed the medication.
- Referring the case for further evaluation of potential Fraud, Waste, and Abuse.

Chapter 7: Care Management

Section 7.1 Care Management Programs

We want our Members to get and stay healthy. Our Care Management (CM) Programs can help by giving you the information and support you need. Members who may benefit from our CM Program include those with:

- Medical needs
- Behavioral Health needs
- Health-related social needs
- Long-term services and supports (LTSS) needs
- High risk for being admitted to the hospital
- Special health care needs

The CM Programs involve the following:

- Members will have a Care Manager who leads the care team assigned to manage and coordinate the Member's care. The care team includes the Member's PCP and other specialists to help Members understand and manage their health.
- Members will have an assessment completed and a care plan created to help meet their health care goals. Members have a right to approve their care plan when there is a change.
- The care team will also help Members by finding benefits and help in the community. This include finding services to help Members with:
  - Free rides to scheduled health care appointments
  - Getting food stamps and housing
  - Helping pay for utilities
  - Finding support groups

These resource services are available to all Members. You don't have to be in the CM Program.

The plan has several CM programs including:

- Health Care Education
- Population Management
- Complex Care Management
- Transition of Care
- Social Care Management
- Behavioral Health

Our CM team works together for Members with both medical and BH needs. Care Management is just a phone call away.

Section 7.2 Medical Care Management Program

Our Medical CM Program includes the following programs so we can get the right level of care for you:

- **Health Care Education and Wellness**
  This program offers educational tools and resources to support wellness and prevention. The goal is to help you learn new and easy ways to manage illnesses and to stay healthy. Topics may include:
  - Childhood and adult immunizations
  - Nutritional tips
  - Home and safety reminders
  - Condition specific education through mailings, text messaging and on line materials

  You can find these resources on our website **wellsense.org**. Just select the Care Management tab on the Member page. Our online Wellness Center also has information on how to stay healthy.
- **Population Management**
  Our Care Managers take a "hands on" approach. We work with you and a team of health care Providers to take care of medical, behavioral, and social needs for specific conditions such as diabetes or asthma. This program includes an assessment of your condition or other conditions you may be at risk for. This program also helps to coordinate your care and determine any benefits and resources that may help you. These resources may include family and community resources. An Individualized Care Plan (ICP) is then developed and carried out for each member. The ICP will focus on:
  - Your psychological and social supports
  - Self-treatment goals
  - Care coordination, including Enhanced care coordination for certain conditions
  - Personal and home safety
  - Treatment plan

  By following this care plan, you will learn more about your condition and health while building skills to lead a healthy lifestyle.
- **Medical Complex Care Management**
  This program is intensive short-term CM for members have high-risk health conditions, multiple conditions, and/or special health care needs. This program includes all of the elements of population management and frequent check-ins from a Care Manager. These care management check-ins can be at home, in provider offices, or in the community, as needed. A care team includes your PCP, nurse care manager, community health worker, pharmacist, behavioral health, and other health care Providers. This team will help with your medical and social needs and determine how they can work with your family support and community resources/partners to take care of your health care needs. They can teach you

about managing your condition, arrange for your care, and coordinate services, resources, and equipment. The team works with you to set your health goals and helps you meet them.

- **Transition of Care:** This program is for members who have been discharged from a hospital or the emergency room. The Care Transitions Program provides available services and resources to make sure that discharge plans are put into place and that discharge instructions are understood. The Plan's non-clinical staff can also provide assistance with arranging transportation to and from your medical appointments. We may also help set up appointments with your primary care physicians (PCPs) and specialists, if necessary.
- **Social Care Management**: This program involves a Social Care Manager assessment of your and your family's social needs and determines whether you could benefit from services. They will serve as your advocate (supporter). Follow-up actions occur at both the individual and family levels and may include connecting you with community supports to address obstacles to you staying healthy.

Contact us. Our CM Program is free and voluntary. This means you choose whether to be in the Program. We can place you in the right level of CM based on your needs. You may be referred into our Programs by:

- Our review of claims or clinical information
- Your answers to the Care Needs Screening that you complete when you enroll with us. This form includes your health information and a summary of your current needs.
- A referral from our Nurse Advice Line
- A referral from a hospital or Provider
- Asking us to join the Program

If you think these CM programs could help you, please call us at 866-853-5241. You do not need a referral and may self-refer yourself to us to enroll in the Program. You can also call that number if you want to leave our CM Program. Please note: Your choice to be in the CM Program does not replace the care and services you get from your PCP and other health care Providers.

Section 7.3 Behavioral Health (BH) Care Management Program

The BH CM Program is for Members with certain BH conditions. Licensed BH clinicians are trained to help you with your BH needs. We can help you find a BH Provider near you and explain available treatment options. Some of the conditions that this Program is designed for include:

- Depression
- Anxiety
- Emotional distress significantly affecting your relationships, school, work, job performance, sleep, or eating patterns
- Bipolar disorder, mood disorders, psychotic disorders, or schizophrenia
- Substance use or misuse such as alcohol, pain medications, or illegal drugs

Care Coordination

BH Care Management offers coordination of services for members with BH needs that could benefit from BH services. The BH Care Manager evaluates the Member's needs and, taking into consideration the member's input and preferences, coordinates the appropriate BH services. Care Coordination services are available to children, adolescents, and adults.

Complex Behavioral Health Care Management

The Care Management Program also offers Complex BH Care Management for Members dealing with more persistent or severe behavioral or psychosocial conditions. BH Care Managers will speak up in support of your health needs. They will work with you and your Providers, and help make sure you have what you need to get better. This includes:

- Evaluating your health
- Planning your care
- Helping you plan for services you will need when you leave the hospital
- Getting any other resources for you

BH Complex Care Management is a voluntary service for adults. This means you choose whether to be in the Program. It is a short-term program to meet specific needs and get you to the best health possible. Licensed BH clinicians provide services by phone. These meetings include you and your Providers. With your permission, we will work with your PCP and other Providers and family members to better help you. BH Complex Care Management care plans are personally developed with you and your Behavioral Health Providers with clear goals and the resources you need.

Contact us. For more information about BH Care Management program:

- Call Carelon Behavioral Health at 888-217-3501 (24 hours a day/7 days a week)
- Or visit our website: **wellsense.org**

Community Support Program for People Experiencing Chronic Homelessness (CSPECH)

CSPECH is a program for homeless Members. It provides many services that can be delivered in your community. These services can be provided to both the Members and their families to help Members who have a long history of Behavioral Health (BH) needs and who are at risk. Services also are given to Members who are children or teenagers who are having BH issues that affect their ability to get along in the community.

Section 7.4 Working with Community Partners to coordinate your care

Community Partners are organizations that work with certain Members to help coordinate care and provide CM. There will be two types of Community Partners. One type specializes in Behavioral Health. The other type specializes in long-term services and supports (LTSS). Behavioral Health Community Partners work with certain Members who have very high needs for Behavioral Health

services. LTSS Community Partners work with Members who need help meeting their needs for basic activities of daily life and caring for themselves. These Community Partners may be able to help:

- Assess Members' needs.
- Plan the right treatments and services for Members.
- Change a Member's care from one type of care to another. An example is Inpatient care to outpatient care.
- Manage and check medication.
- Provide health and wellness information.
- Find other community and social services programs that can support Members.

If you want more information about Community Partners, or if you think you may qualify to get services from a Community Partner once they are available, you can do the following:

- For Behavioral Health Community Partners, call Carelon Behavioral Health at 888-217-3501.
- For LTSS Community Partners, call our Member Services Department at 888-566-0010. You do not need a referral in order to qualify for these services.

Chapter 8: Asking us to pay

We do not allow Network Providers to bill you for Covered Services—except for required Copayments. You should never get a bill from a Network Provider for Covered Services as long as you follow our MCO Plan's rules (See Section 5.6: Rules for getting your health care covered by us.) This is true even if we pay a Provider less than the Provider charges for a service or if we have a disagreement with a Provider about what we should pay the Provider. You only have to pay your Copayment amount, if any, when you get Covered Services.

However, there are times when you may be responsible for payment. For example:

- For care that is not an MCO Plan Covered Service or a MassHealth covered service
- **In cases when you signed a waiver.** Sometimes your doctor may ask you to sign a "waiver." Typically, a waiver says that you agree to pay for a service that your health plan does not cover. By signing a health insurance waiver, you agree that you will pay for the services if we do not pay for them. For questions about waivers, call our Member Services Department. We can help you figure this out.

What to do if you have already paid for something you think you shouldn't have

If you paid for any Covered Services with your own money, you can ask us to pay you back. (Paying you back is often called "reimbursing" you). Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. It is your right to be paid back whenever you paid more than your share of the cost of Covered Services (including drugs).

What if you get a bill from a Provider but have not paid it?

If you get a bill from a Provider for some or all of the cost of care you have received, we recommend that you first follow up with your Provider to make sure that they have your correct insurance information. If your Provider tells you that they have the correct information for you, please call us. We will help you determine whether the services should have been paid by us or if you are responsible for payment because the service you received is not a Covered Service.

Examples of when you may ask us to pay you back or pay a bill

Here are examples of when you may need to ask us to pay you back or pay a bill you received:

- If you paid for, or got a bill for, Emergency or Urgent Care from an Out-of-Network Provider
- If you pay the full cost for a prescription because you do not have your MCO Plan Member ID Card with you, the pharmacy cannot confirm your enrollment in our MCO Plan, and you need your medication right away

How and where to send us your request for reimbursement

If you get a bill or paid for a Covered Service, please send us your bill and proof of any payment you have made, such as a receipt. Print the name of the Member who received the care, and his or her MCO Plan Member ID Card number on the bill. **Always make a copy of the bill and receipts for your records.**

Type of Bill	Whom to Contact
Medical Services	Mail any bills for medical services to: Member Services Department Attention: Concierge Specialist WellSense Health Plan 529 Main Street, Suite 500 Charlestown, MA 02129
Behavioral Health Services	Mail any bills for Behavioral Health services to: Carelon Behavioral Health Attn: Claims PO Box 1866 Hicksville, NY 11802-1866
Prescription Medications	First, download the Member Self Pay Reimbursement Form that is on our website: **wellsense.org**. If you do not have a computer, call us at 888-566-0010 (English or other languages), 888-566-0012 (Spanish), and for hearing impaired 711, and we will mail you the form. Once you have completed the Reimbursement Form, mail the Form and your original paid pharmacy receipt(s) to: Express Scripts Attn: Commercial Claims P.O. Box 14711 Lexington, KY 40512-4711 You may also call Express Scripts at 888-566-0010 (English or other languages). 888-566-0012 (Spanish) and for hearing impaired: 711,); 24 hours a day, 7 days a week for questions about your submitted claims.

Please contact our Member Services Department if you have any questions.

What happens once you have submitted your reimbursement request?

Once we receive your request for payment, we will let you know if we need any more information. We will review your request and determine whether the bill should be paid by us.

If we decide that the service or drug is a Covered Service and you followed all the rules for getting the service or drug, we will pay you back. If you have already paid for the service or drug, we will mail our share of the cost to you. If you have not paid yet, we will send you a letter letting you know our decision and, if payment is approved, will mail the payment to the Provider.

Chapter 8: Asking us to pay

If we decide that the service or drug is not covered, or you did not follow all the rules for coverage, we will not pay for the service or drug. Instead, we will send you a letter letting you know our decision, the reasons for our decision and your right to appeal.

If you think we have made a mistake in turning down your request for payment or you do not agree with the amount we are paying, you can file an Appeal. If you file an Appeal, it means you are asking us to change the decision we made when we turned down your request for payment. See Chapter 11 for information about how to request an Appeal. You may also call our Member Services Department to get more information.

Chapter 9: How other insurance works with our MCO Plan

Section 9.1 Which plan pays first when you have other insurance (Coordination of Benefits)

Some members may have other health care coverage. If so, we work with your other insurance to coordinate your MCO Plan benefits. The way we work with the other insurance depends on your situation. This process is called "Coordination of Benefits."

As a Medicaid Plan, we are the payer of last resort. This means when you have other insurance (like health insurance from an employer), they always pay first. Your other insurance is called "primary insurance." We will always pay second. We are called "secondary insurance." This is the case unless the law states something different. If we don't cover certain services, you may be able to get them covered by your other insurance. If you have questions about other health insurance, call our Member Services Department.

You must follow all of your primary insurance rules when getting services. We may cover services or items not covered by your primary insurance. Also, we may cover your Copayments. It is important to use Providers that are in both your primary insurance network and our Provider Network for claims to be paid correctly.

If you have other health insurance, you should tell your Providers when you receive services. Your Providers will know how to file claims to your other insurance and to us. If you have questions, call our Member Services Department. You should also call us if you need to update your other insurance information.

Section 9.2 Motor vehicle accidents and/or work-related injury/illness

Motor Vehicle Accidents: If you are in an auto accident, you must use all of your auto insurance company's medical coverage first. This includes:

- Personal injury protection and/or
- Medical payment coverage

Then, we may pay for health care expenses related to your accident. You must send us any proof of payment or denial of payment letters from your auto insurance company. These will help us decide if we will pay the Claim from your Provider.

Work-related injury/illness: If you have a work-related injury or illness, the workers' compensation company will be the first party that must pay for your health expenses. You must send us any proof of payment or denial of payment letters from this company. This will help us decide if we will pay the Claim from your Provider.

Section 9.3 Right to recover money from a person who is responsible for your injury (Subrogation)

If another person injures you, we will go through a process called "Subrogation." This means that we may use your legal rights to recover money from:

- The person(s) who caused your injury; or
- An insurance company or other responsible party

If another person or party is or may be responsible to pay for services related to your injury, we will use your legal rights to recover the full amount of money we paid or will pay for the health care services for your injury. To carry out these rights, we may take legal action, with or without your consent, against any responsible party to get paid back the money we paid. Our subrogation rights apply even if the injured Member is under 18 years old.

If you receive bills for health care services related to the injury, you must send them to us before any settlement. If you do not send these to us, we may deny paying the Claim.

If another party pays you directly for any medical expenses that we paid for, we have the right to get back from you the full amount we paid.

Section 9.4 Member Cooperation

As a Member, you agree to cooperate with our Coordination of Benefits and Subrogation processes. This means you must:

- Immediately tell us if there is a potential for any possible Coordination of Benefits or Subrogation.
- Give us all information and documents we request.
- Complete and sign all documents we think are necessary to protect our rights.
- Give us notice before you settle any claim that relates to an injury for which someone else is responsible.
- Promptly assign or give us any money you have received from another responsible party for services we paid for.
- Not do anything that might interfere with or prevent us from carrying out our processes.

Note: Our Prior Authorization of any services does not mean that we are required to pay for those health care services.

Nothing in this *Member Handbook* can be interpreted to limit our right to use any legal remedy to enforce our rights described in this Chapter.

Chapter 10: Your Rights and Responsibilities

Section 10.1 Your rights

Our Members have the following rights:

- You have the right to get information from us about our MCO Plan, our Covered Services, Network Providers, and your rights and responsibilities.
- You have the right to get the Medically Necessary services in your Covered Services List.
- You have the right to get a notice about any major changes to our Provider Network. These include when a PCP, Specialist, hospital, or facility leaves our Network and you are affected.
- You have the right to be respected and have your dignity and right to privacy recognized.
- You have the right to be free from all restraint (being placed under control) or seclusion (being isolated) used as a means of force you, punish you or get back at you or for anyone else's convenience.
- You have the right to get a copy of your medical records. You have the right to ask that they be changed or corrected as allowed by law.
- You have the right to have an honest discussion about health care treatment options in a way that you understand. This is the case no matter the cost or benefit coverage.
- You have the right to take part in decisions regarding your health care. This includes refusing treatment.
- You have the right to exercise your rights without it affecting you in a bad way or in how we and our Network Providers treat you.
- You have the right to ask for a Second Opinion for suggested treatment and have us pay for the Second Opinion visit.
- You have the right to file a Complaint when you're not happy with us, your Providers, or the quality of care or services you get. See Chapter 11.
- You have the right to an Internal Appeal or External Board of Hearings Appeal to ask us to change our mind about an Adverse Action (denial) decisions that have been made. See Chapter 11.
- You have a right to leave Disenroll from the MCO Plan in some cases. See Chapter 12.
- You have the right to request written summary of our physician incentive plans.
- You have the right to be told whether we have moral or religious reasons that would keep us from covering counseling or a referral service. You may also get information about how you can get this service.
- You have the right to make suggestions about these Rights and Responsibilities.

Section 10.2 Your responsibilities

Below are some important things you need to do:

- Get to know your Covered Services and the rules you must follow to get Covered Services.
- Help your Providers care for you:
  - Clearly tell them about your health complaints, health history, and other health information.
  - Ask them questions. Your Providers will explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.
  - Learn as much as you can to about your health conditions and any recommended treatment. Consider the treatment before it is given.
  - Follow the treatment plans and instructions that you and your doctors agree to. Remember that refusing treatment recommended by your Provider might harm you.
  - Allow your PCP to get copies of all your health records. This will help your PCP better your care for you.
  - Make sure your Providers know all of the drugs you take. This includes over-the-counter drugs, vitamins, and supplements.
  - Work with your Provider to understand your health problems. Work out treatment plans and goals as much as possible.
- You must tell us if you have any other health insurance coverage or drug coverage in addition to this MCO Plan. Please call our Member Services Department to let us know.
- Tell your Providers you are enrolled in our MCO Plan. Show your MCO Plan Member ID Card and your MassHealth Medicaid ID Card when you get Covered Services.
- Keep your appointments. Be on time. Call in advance if you're going to be late or must cancel.
- Be considerate. Our Members should respect the rights of other patients. We also expect you to act in a way that helps your Provider offices run smoothly. Treat your Provider with respect.
- Pay what you owe. You are responsible to pay required Copayments. If you get medical services or drugs that are not covered by us or by other insurance you have, you must pay the full cost.
- Tell us right away if you move or change your phone number. Please call our Member Services Department.

Section 10.3 Your responsibility to report Fraud

You play an important role in protecting the Medicaid program from health care Fraud, Waste, and Abuse (FWA). Please help us detect FWA if it happens. The definition of Fraud, Waste, and Abuse is in Chapter 16. FWA can involve any type of individual or Provider, such as doctors and pharmacists. It can also involve medical equipment companies. Some examples of health care Fraud are:

- Billing for health care services never provided
- Giving false or misleading healthcare information
- Loaning your Member ID Cards to others so that they can get services or drugs that they are not supposed to have access to
- Selling medical supplies you get under our MCO Plan

You must notify WellSense Health Plan when you think that someone has purposely misused the MCO Plan or MassHealth benefits or services. You should report something you think is wrong or suspicious behavior related to health care benefits or services to us. Just let us know:

Method	Contact Information
Call	888-411-4959 (Anonymous Hotline), available 24 hours a day, 7 days a week
Fax	866-750-0947
E-mail	FraudandAbuse@wellsense.org
Write	WellSense Health Plan ATTN: Special Investigations Unit 529 Main Street, Suite 500 Charlestown, MA 02129

You do not need to let us know who you are when you contact us. But it is helpful for you to give us as much information as possible, such as:

- Name of person or Provider you think acted wrong
- Member's MCO Plan Member ID Card number
- Description of the suspected FWA
- Where the services (if any) were provided
- Date of service

Section 10.4 Mental health parity

Federal and state laws require that all Medicaid managed care plans provide coverage for Behavioral Health (BH) services. These include substance use disorders treatment services. The rules require that we cover BH services in the same way we provide coverage for physical health services. This is called "parity." For example, coverage for BH services cannot be more restrictive (limited) than coverage generally available for medical conditions. Parity applies to the following:

- Copayments and Copayment cap amounts
- Limits on services. For example, such as limits on how many Inpatient days or outpatient visits are covered
- Use of Utilization Management/Care Management tools
- How we decide:
  - Medical Necessity determinations
  - Prior Authorizations
  - Drug List tiers (if applicable)

In general, "parity" means that we must do all of the following:

- Provide the same level of benefits for any mental health and/or substance use disorder as we would for other physical problems you may have.
- Have similar Prior Authorization requirements and treatment limitations for BH benefits as we do for physical health benefits.
- Give you or your Provider the Medical Necessity criteria we used for Prior Authorization upon your or your Provider asks.
- Not place lifetime or annual dollar limits on BH benefits.
- Within a reasonable time, give you the reason for denying any Authorization for BH services.
- If we cover Out-of-Network medical and surgical benefits, we must cover Out-of-Network BH services under certain circumstances.

If you think we are not providing parity as explained above, you have the right to file a Complaint with us. For more information about Complaints, see Chapter 11.

You may also file a Complaint (Grievance) with MassHealth. Just call the MassHealth Customer Service Center at 800-841-2900 (TTY: 800-497-4648) Monday–Friday 8 a.m. to 5 p.m.

Section 10.5 Advance planning for your health care decisions

Sometimes people can't make health care decisions for themselves because they are very sick or injured. You have the right to say what you want to happen if you can't make health care decisions for yourself.

Advance Directives are legal documents that allow you to name someone in advance to make medical decisions for you, and to give directions about future medical care if you can't. Advance Directives are also called a health care proxy, health care agent, durable power of attorney for health care, or a living will. Advance Directives let you communicate your wishes about future medical care to family, friends, and Providers.

In Massachusetts, if you are at least 18 years old and of sound mind, you can make decisions for yourself. You may also choose someone as your health care "agent" or health care "proxy." This is a person you appoint to make decisions about your medical care if you can no longer speak for yourself. This includes decisions about life support. This person would carry out the wishes you put in your Advance Directive. You can change this person any time you wish.

You do not have to use an Advance Directive. But you can if you want to. It is your choice. Here is what to do.

Get the form. You can get a form from your doctor, a lawyer, a legal services agency, or a social worker. You can also get a Health Care Proxy Form from the State by going to mass.gov and entering "health care proxy form" into the search box.

Fill out the form and sign it. The form is a legal document. You should consider having a lawyer help you fill it out.

Keep a copy for your records. Give copies to people who need to know about it. You should give a copy of the form to your doctors. Your doctors will put the form in your medical records. This will let them have your written instructions about handling your care if you cannot tell them yourself. You may also want to give copies to family or close friends.

If you are going to be hospitalized and you have signed an Advance Directive, take a copy of it with you. The hospital will ask if you have signed an Advance Directive form and if you have it with you. If you have not signed one, the hospital may have forms available. They may ask if you want to sign one.

It is your choice whether you want to fill out an Advance Directive. This includes if you want to sign one if you are in the hospital. According to law, no one can deny you care or discriminate against you based on whether or not you signed an Advance Directive.

What if your instructions are not followed? If you signed an Advance Directive and you think that a Provider did not follow the instructions in it, you may file a complaint with Massachusetts Department of Public Health, Division of Health Care Quality's Complaint Unit by calling 800-462-5540.

Chapter 11: What to do if there is a problem or you have an Inquiry, Appeal, or Complaint (Grievance)

We want you to contact us if you have any concerns with your care or services. Our Member Services Department will help you with your concerns. You also have the right to voice concerns to MassHealth at any time. Call the MassHealth Customer Services Center.

Section 11.1 Inquiries

An Inquiry is any question that you may have about our or Carelon Behavioral Health's operations. We will resolve your Inquiries right away or, at the latest, within one business day of the day we receive your Inquiry. We will let you know about the outcome on the day your Inquiry is resolved. To make an Inquiry, call our Member Services Department, or Carelon Behavioral Health (for Behavioral Health questions).

An Inquiry is not for addressing your dissatisfaction with Carelon Behavioral Health or us. If you are dissatisfied, you have the right to file a Complaint (Grievance). See Section 11.15.

For other types of problems, you need to use our Internal Appeals process. See Sections 11.3–11.12 for the Appeals process.

Each process has a set of rules and deadlines that must be followed by you and by us. These are explained in this Chapter.

Section 11.2 What is an Authorized Representative?

An Authorized Representative is someone you have given permission, in writing, to act on your behalf with respect to an Internal Appeal, an External Appeal, or a Complaint (Grievance). **An Authorized Representative can act on your behalf for all the actions we describe in this Chapter.**

If your Authorized Representative is your family member:

- You can have him or her represent you in your Appeal or Complaint (Grievance).
- The family member can have a standing permission from you.
- This permission will end if you send us a letter telling us that you have cancelled it.

If the Member is deceased, an Authorized Representative can also include the legal representative of his or her estate.

If you pick an Authorized Representative who is not a family member:

- You must send us new written permission each time you want them to represent you.
- We must receive this written permission before our deadline for resolving your Internal Appeal or Complaint ends. We can help you write the letter. Or we can mail you a permission form for you to complete. For a copy of the form, call our Member Services Department, or Carelon Behavioral Health (for Behavioral Health).

Section 11.3 What is an Appeal?

An Appeal is something you may file if you disagree with an Adverse Action taken by us. Common Adverse Actions that can be the basis for an Appeal include:

- We denied or provided limited Authorization for a service requested by your Provider. This includes a decision that the requested service is not a Covered Service.
- We reduced, suspended, or stopped a Covered Service that we Authorized in the past.
- We denied, in whole or in part, payment for a Covered Service.
- We did not provide Covered Services in a timely manner within the times stated in Section 5.7.
- We did not make a Prior Authorization decision within the timeframe described in Section 5.
- We did not act within the Internal Appeal times stated in this Chapter 11 for reviewing and sending notice of a decision.

There are two levels of Appeal available:

- The First level: is a request you make **to us** to review an Adverse Action (denial) we have taken. It is called an "Internal Appeal."
- The Second level: is a request you make **to the Board of Hearings (BOH)** to review our Internal Appeal decision. It is called an "External Appeal" or a "Board of Hearings (BOH) Appeal."

Section 11.4 What is an Internal Appeal?

An Internal Appeal is one that you file with us or with Carelon Behavioral Health (for Behavioral Health concerns), if you disagree with an Adverse Action. There are two types of Internal Appeals:

- Standard Internal Appeal
- Expedited (fast) Internal Appeal

In most cases, you will receive a notice letting you know an Adverse Action has been taken. (However, you may file an Internal Appeal when an Adverse Action occurs, even if you did not receive a notice from us or Carelon Behavioral Health.) Our Adverse Action letter will tell you your Appeal rights. Health care professionals who have the right clinical expertise and were not involved in the original Adverse Action make Internal Appeal decisions.

You can file an Internal Appeal in writing, over the phone, or in person. Here's how to file an Internal Appeal:

Appeal Type	Contact Information
For Medical or Pharmacy Appeals	Mail or fax your written Appeal to: WellSense Health Plan 529 Main Street, Suite 500 Charlestown, MA 02129 Attention: Member Appeals. Fax: 617-897-0805
For Behavioral Health Appeals	Mail or fax your written Appeal to: Appeals Coordinator Carelon Behavioral Health 500 Unicorn Park Drive Suite 401, Woburn, MA 01801 Fax: 781-994-7636
To call and request a verbal appeal	**For Medical and Pharmacy Appeals:** call our Member Services Department at 888-566-0010; or the Appeals Department at 617-748-6338, Monday–Friday 8 am. to 6 p.m. **For Behavioral Health Appeals:** call Carelon Behavioral Health's Member Services Department at 888-217-3501, Monday–Thursday 8:30 a.m. to 6 p.m. and Friday 8:30 a.m. to 5 p.m.
To file an In-Person Appeal	Visit us or Carelon Behavioral Health at the office location listed in Chapter 11.

Sections 11.5 and 11.6 explain how you can file your Internal Appeal.

Section 11.5 How and when to file a Standard Internal Appeal

You must file your Standard Internal Appeal with us or Carelon Behavioral Health (for Behavioral Health services) within 60 calendar days of the date of our written notice of Adverse Action (denial) to you. If you ask for an Appeal over the phone or in person, it must be followed by a written and signed Appeal request (unless the request is for an Expedited (fast) Internal Appeal – see Section 11.6). You may name someone to file the Appeal for you. This includes naming your Provider or an Authorized Representative. To name someone, you must send us a letter stating whom you wish to name.

- The date you call us to request a verbal appeal of an Adverse Action will be the date of the

Appeal request. When we receive your Internal Appeal, a specialist will send you a letter stating that we have received your Appeal. Our staff will begin work on resolving your Appeal right away.

- You may lose your right to Appeal if you do not file your Internal Appeal within the 60-calendar-day timeframe.
- You may request that services or benefits you currently receive continue while you are waiting for the results of your Appeal. This is called "Continuing Services." To ask for this while you are waiting, you must specifically request Continuing Services and file your Internal Appeal with us within 10 calendar days from the date you receive our notice of Adverse Action. Your Provider cannot request Continuing Services for you.

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

We will resolve your Standard Internal Appeal within 30 calendar days from the day we receive it. This is the case unless the timeframe is extended. You, we, or Carelon Behavioral Health can extend the timeframe by up to 14 calendar days. We explain more about this in Section 11.7. We will notify you in writing of our decision.

Section 11.6 How and when to file an Expedited (fast) Internal Appeal

An Expedited Internal Appeal is when you ask that your Appeal be resolved more quickly than the time for resolving a Standard Internal Appeal. You can do this if you or your Provider feel that waiting for a standard resolution would put your health at serious risk. You or your Provider may request an Expedited (fast) Internal Appeal. To file for this, follow the instructions for filing a Standard Internal Appeal in Section 11.5 above. When you contact us, tell us that you would like an Expedited Internal Appeal.

We will never penalize a Provider who requests or supports a Member's Expedited Internal Appeal.

In most cases, we will agree to give you an Expedited Internal Appeal if your Provider requests it or supports it. However, we may not agree if the request is unrelated to your health condition. If your Provider is not involved in your request, then we have the right to decide if the Appeal will be processes as an Expedited Internal Appeal.

How quickly will you receive a decision on your Expedited (fast) Internal Appeal?

If we accept your request for an Expedited Internal Appeal, we will decide it as quickly as your health condition requires. But our decision will be no later than 72 hours after the date we receive your request—unless the timeframes are extended as stated in Section 11.7. We will notify you in writing of our decision. We will also try to contact you by phone to tell you about the decision. If you disagree with our decision, you can file an External Appeal with the Board of Hearings. See Section 11.13.

If your request does not qualify for an Expedited Internal Appeal, we will notify you in writing. We will then process your Internal Appeal as a Standard Internal Appeal within the standard 30-calendar-day timeframe stated in Section 11.5. You have the right to file a Complaint (Grievance) if you disagree

with our decision not to process your Internal Appeal as an Expedited Internal Appeal. See Section 11.15 about how to file a Complaint.

Section 11.7 Can Internal Appeal timeframes be extended?

You may ask to extend the timeframes for resolving Standard or Expedited Internal Appeals by up to 14 calendar days. We also may ask to extend the timeframes for resolving your Internal Appeal by 14 calendar days if we feel that it would benefit your Appeal. The reasons we may ask to extend the timeframes include:

- The additional time is in your best interest.
- We need more information that we believe will lead to approving your request.
- We think the more information we are looking for will be sent to us within 14 calendar days.

When we choose to extend a timeframe, we will send you a notice. If you disagree with the decision, you may file a Complaint. See Section 11.15 about filing a Complaint.

Section 11.8 When can we dismiss your Internal Appeal?

We may dismiss (decide not to consider) your Internal Appeal if:

- Someone else files an Internal Appeal for you and we do not receive your written permission for that person to serve as your Authorized Representative before the timeframe for resolving your Internal Appeal ends. Written permission is not required when your Provider serves as your Authorized Representative for an Expedited Internal Appeal; or
- You filed your Internal Appeal after the deadline in Sections 11.5 and 11.6 (60 calendar days after the notice of Adverse Action); or, if you did not receive our notice of Adverse Action (because, for example, you moved), you filed your Internal Appeal more than 60 days after learning on your own about our Adverse Action.

We will notify you of an Internal Appeal dismissal.

Section 11.9 Can you dispute when we dismiss an Internal Appeal?

If you believe that you asked for your Internal Appeal within 60 calendar days and you have proof of your request, you have the right to:

- Dispute our dismissal of your Appeal; and
- Request us to continue with your Appeal.

To do this, you must submit a letter to us or to Carelon Behavioral Health (for Behavioral Health concerns) within 10 calendar days of notice to dismissal. In the letter, you can ask us to reconsider the dismissal. We will review your request. We will then notify you of our decision.

Section 11.10 Continuing Services during your Internal Appeal Process

If your Internal Appeal involves a decision by us to change a service that we Authorized in the past, including a decision to reduce, suspend, or end a service, you can ask us to continue to cover the requested services during the Internal Appeal process. These services are called "Continuing Services." If you want to receive Continuing Services, you must:

- Submit your (Standard or Expedited) Internal Appeal request within 10 calendar days from the date of our Adverse Action letter. This is the letter we sent you explaining that we decided to change a service that we Authorized in the past; and
- State in your request that you want to get Continuing Services.

Section 11.11 Your rights during the Internal Appeal Process

We will provide you a reasonable chance to present evidence in person and in writing. This includes facts and law about your case. We will also allow you to see your files before and during the Internal Appeal process. We can also help you with interpreter or translation services during the Internal Appeal process. There is no cost to you.

What do you do if you disagree with our or Carelon Behavioral Health's decision on your Internal Appeal?

If you disagree with the decision, you may file an External Appeal with the Board of Hearings (BOH). See Section 11.13.

Section 11.12 What if we do not resolve your Internal Appeal within the required timeframes?

If we do not decide your Internal Appeal within the required timeframes, you can file an External Appeal with the BOH. See Section 11.13.

Section 11.13 How to file an External Appeal with the Board of Hearings (BOH)

You cannot request an External Appeal with the Board of Hearings without first going through our Internal Appeal process as described above. If you are unhappy with the results of your Internal Appeal, you have the right to request an External Appeal with the BOH. The BOH is within the state's Office of Medicaid. If you want the BOH to give you an expedited (fast) hearing, you should file a request for an External Appeal with the BOH within 20 calendar days of an Expedited Internal Appeal decision from us. Otherwise, you have 120 calendar days from our Internal Appeal decision to file for a standard hearing with the BOH. Please note that if you file between 21 and 120 calendar days from

the date of our Internal Appeal decision, the BOH will process your External Appeal within their standard timeframe.

The letter we send you telling you our Internal Appeal decision, will include the form (and other information) you will need to file your request for an External Appeal with the BOH—if you choose to file one.

After your BOH Appeal is filed, you will receive a free copy of your case file before the hearing. You may bring witnesses, present testimony and evidence, and question other witnesses at this hearing. Staff from the BOH will schedule hearings.

The following rules also apply:

- If the BOH reverses our decision to deny, reduce, limit, suspend, or end services that were not provided during the time of the Internal Appeal or External Appeal, we will approve the services as quickly as your health condition requires. In any event, we will approve the services no later than 72 hours from the date we receive BOH notice that it reversed our decision.
- If you receive "Continuing Services" while the BOH Appeal was happening, we will pay for those services.

Section 11.14 How to request Continuing Services during the External Appeal to the Board of Hearings (BOH)

If your BOH Appeal involves a decision by us or by Carelon Behavioral Health to change a service that we Authorized in the past, including a decision to reduce, suspend, or end a service, you can choose to continue getting the requested services during the BOH Appeal process. These services are called Continuing Services. If you want to get Continuing Services during the BOH Appeal process, you must file your BOH Appeal within 10 calendar days from the date of our letter to you that explained our decision on your Appeal. If you do not want to keep getting the requested services during your BOH Appeal, you must check Box A in Section III of the BOH Appeal form.

Whenever you Appeal our decision to deny, reduce, limit, suspend or end health care services, you have a right to Continuing Services while your BOH Appeal is happening.

If we continue your services during the BOH Appeal process, the services must be continued until one of the following occurs:

- You withdraw your BOH Appeal request, in writing;
- The BOH makes a decision that is not favorable to you; or
- The original approval of services expires (ends) or service limits are met.

Section 11.15 How to file a Complaint (Grievance) and what to expect from us

What is a Complaint (Grievance)?

We use the words "Complaint" and "Grievance" to mean the same thing. You can report a Complaint to us at any time if you are not happy with us or a Provider, for any reason. (Note: the Adverse Actions described in Section 11.2 are Appeals, not Complaints.) Here are some common types of Complaints:

- You are not satisfied with the quality of care or services you receive.
- You are not satisfied with the way you were treated by our staff or Network Providers.
- We extended the time to decide a Prior Authorization request or Internal Appeal and you disagree with this decision.
- We did not approve your request for an Expedited (fast) Internal Appeal, we processed it as a Standard Internal Appeal, and you do not agree with this decision.
- You believe our staff or Network Providers did not respect your rights.

How to file a Complaint (Grievance)

You may file a Complaint in writing, over the telephone, or in person. Here's how to do this:

To File a Complaint	Contact Information
In writing or by fax	**For all medical Complaints** WellSense Health Plan– MassHealth 529 Main Street, Suite 500 Charlestown, MA 02129 Attention: Member Grievances Fax: 617-897-0805 **For all Behavioral Health Complaints** Carelon Behavioral Health Appeals Department P.O. Box 1856 Hicksville, NY 11802 Fax: 781-994-7636
By phone	**For all medical Complaints** If you want to submit a Complaint (Grievance)

	over the telephone, you may call our Member Services Department at 888-566-0010. **For all Behavioral Health Complaints** Call Carelon Behavioral Health at 888-217-3501
In Person	**If you want to submit a medical Complaint in person, we are located at:** WellSense Health Plan 529 Main Street, Suite 500 Charlestown, MA 02129 **If you want to submit a Behavioral Health Complaint in person, Carelon is located at:** Carelon Behavioral Health Attn: Appeals and Grievance Department 500 Unicorn Park Drive, Suite 401 Woburn, MA 01801
Directly with MassHealth	Call MassHealth Customer Services Department at 800-841-2900 (TTY: 800-497-4648), Monday through Friday, from 8 a.m. to 5 p.m.

When can we dismiss your Complaint (Grievance)?

We may dismiss your Complaint if someone else files it for you and we did not receive permission for that person to be your Authorized Representative before our 30-calendar day timeframe for resolving your Complaint ends. If this happens, we will send you a letter saying that we will not consider your Complaint.

How quickly will we respond to your Complaint (Grievance)?

Once we or Carelon Behavioral Health receive your Complaint, we or Carelon Behavioral Health will send you a letter within one business day saying we received it. We or Carelon Behavioral Health will start to work right away to address your Complaint. We or Carelon Behavioral Health will send you a written response within 30 calendar days from the date we received your Complaint.

What do you do if you do not speak English?

We or Carelon Behavioral Health will help you with free interpreter or translation services during the Complaint process. If you have any questions about the Complaint process, please call our Member Services Department or Carelon Behavioral Health.

Chapter 12: Ending your MCO Plan membership

There are only certain times when your membership with our MCO Plan may end.

When you no longer qualify for MassHealth (Disenrollment for loss of eligibility)

If you are no longer eligible for MassHealth coverage, MassHealth will Disenroll (take you off) our MCO Plan. This means you will no longer be able to have coverage by the MCO Plan as of the date of your MassHealth Disenrollment. If you lose your MassHealth coverage, you must contact MassHealth if you want to start the re-enrollment process.

- If MassHealth re-enrolls you within 6 months following your Disenrollment date, they will place you in the same health plan you were disenrolled from.
- If MassHealth re-enrolls you after 6 months from your Disenrollment date, they will place you either in the health plan you were Disenrolled from or they will place you in a different MassHealth health plan.

When you decide you want to end your membership with our MCO Plan (voluntary Disenrollment)

You may choose to end your enrollment in our MCO Plan. This is called "voluntary Disenrollment." To Disenroll from our MCO Plan, call the MassHealth Customer Service Center. Voluntary Disenrollments usually begin one business day after we get the notification from MassHealth. There are different rules for voluntary Disenrollment during different times of the year:

- Voluntary Disenrollment during the "Plan Selection Period"

  Most Members have a 90-day period in which they can choose to change health plans for any reason. This is called the "Plan Selection Period." MassHealth will send you a letter. This letter will tell you when this period begins and ends.

  To Disenroll from the MCO Plan during this period, call the MassHealth Customer Service Center. We will continue to cover you until you are Disenrolled.
- Voluntary Disenrollment during the "Fixed Enrollment Period"

  When your "Plan Selection Period" has ended, you will not be able to change your health plan until the next Plan Selection Period unless any of the following reasons apply and MassHealth approves. This period is called the "Fixed Enrollment Period":
  - You move out of our MCO Plan's Service Area.
  - We do not, because of moral or religious reasons, cover the service you need.
  - You need related services to be performed at the same time; the related services are not all available within our Provider Network; and your PCP or another Provider determines that getting the services separately would cause you unnecessary risk.
  - You receive poor quality of care.
  - You are not able to access Covered Services.
  - You cannot get access to Providers experienced in dealing with your health care needs.

- We are no longer contracted with MassHealth in your Service Area.
- You clearly show to MassHealth that we have not provided access to Providers that meet your health care needs over time, even after you asked for assistance.
- You are homeless, MassHealth's records indicate that you are homeless, and we cannot meet your needs in your area.
- You are clearly able to show MassHealth that we violated an important provision of our contract with MassHealth.
- MassHealth imposes a sanction on us that allows Members to Disenroll from our MCO Plan without cause.
- You clearly show to MassHealth that we are not meeting your language, communication, or other accessibility preferences or needs.
- You clearly show MassHealth that your key Network Providers, including PCPs, Specialists, or Behavioral Health Providers, have left our MCO Plan Provider Network.

MassHealth might deny your request to transfer to another health plan during your Fixed Enrollment Period. In such case, you can ask for a fair hearing with the Board of Hearings. To request this hearing, contact MassHealth Customer Services Department.

- Voluntary Disenrollment at any time for certain Members

  The following MCO Plan Members do not have a Plan Selection Period or Fixed Enrollment Period. This means they can Disenroll from our MCO Plan at any time for any reason:

  - Children who are in the care or custody of the Department of Children and Families (DCF)
  - Youths who are in the care or custody of the Department of Youth Services (DYS)
  - Newborns and children who are younger than one year old

Disenrollment for cause

We are not allowed to ask a Member to leave our MCO Plan for any reason related to: a Member's health; use of medical services; lessened mental capacity; or disruptive or non-cooperative behavior due to special needs. However, there may be cases where we are allowed to ask MassHealth to let us Disenroll a Member for cause. MassHealth is the only one who can decide or approve our request. If you are Disenrolled for cause, MassHealth will send you:

- Written notice of Disenrollment; and
- Information on how to choose another MassHealth health plan

Getting Covered Services until your Disenrollment

Please remember that until your Disenrollment is effective:

- You must continue to get Covered Services through our MCO Plan.
- You must continue to use our Network pharmacies to get your prescriptions filled.

Chapter 13: Notice of Privacy Practices

This Notice describes how health information about you may be used and communicated, and how you can get this information. Please review this Notice of Privacy Practices carefully. If you have any questions, please call our Member Services Department. The Notice of Privacy Practices is effective September 23, 2013. This Notice describes how we may use and disclose your health information to carry out treatment, payment, or healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your health information. Protected Health Information ("PHI") is health information about you, including individually identifiable information, related to your physical or Behavioral Health condition used in providing health care to you or for payment for health care services.

By law, we are required to:

- Maintain the privacy and confidentiality of your Protected Health Information
- Give you this Notice of Privacy Practices
- Follow the practices in this Notice

We use physical, electronic, and procedural safeguards to protect your privacy. Even when disclosure of PHI is allowed, we only use and disclose PHI to the minimum amount necessary for the permitted purpose. Other than the situations mentioned in this Notice of Privacy Practices, we cannot use or share your Protected Health Information without your written permission, and you may cancel your permission any time by sending us a written notice. We reserve the right to change this Notice of Privacy Practices and to make the revised notice effective for any of your current or future Protected Health Information. You are entitled to a copy of the Notice of Privacy Practices currently in effect.

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

For Treatment: We may communicate PHI about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and need the information to provide you with medical care. For example, if you are being treated for a back injury, we may share information with your Primary Care Provider, the back specialist and the physical therapist so they can determine the proper care for you. We will also record the actions they took and the medical claims they made. Other examples of when we may disclose your PHI include:

- Quality improvement and cost containment, wellness programs, preventive health initiatives, early detection programs, safety initiatives, and disease management programs.
- To administer quality-based cost-effective care models, such as sharing information with medical providers about the services you receive elsewhere to assure effective and high-quality coordinated care.

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

For Healthcare Administration and Operations: We may use and disclose your PHI to support our normal business activities. For example, we may use your information for Care Management, customer service, coordination of care, or quality management.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services: We may contact you to provide appointment or refill reminders, or information about possible treatment options or alternatives and other health-related benefits, or services that may be of interest to you.

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

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

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

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

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

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

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

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

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

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

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

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

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

Personal Representative: If you have a personal representative, such as a legal guardian (or an executor or administrator of your estate after your death), we will treat that person as if that person is you with respect to disclosures of your PHI.

Public Health and Safety: We may communicate your PHI for public health activities. This includes disclosures to: (1) prevent or control disease, injury or disability; (2) report birth and deaths; (3) report child abuse or neglect; (4) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; (5) the appropriate government authority if we believe a person has been the victim of abuse, neglect, or domestic violence and the person agrees or we are required to by law to make that disclosure; or (6) when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

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

Workers' Compensation: We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

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

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

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

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

Your Rights Regarding Protected Health Information about You

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

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

Right to Get Notice of a Security Breach: We are required to notify you by first class mail of any breach of your Unsecured PHI as soon as possible, but no later than 60 days after we discover the breach. "Unsecured PHI" is PHI that has not been made unusable or unreadable. The notice will give you the following information:

- A short description of what happened, the date of the breach, and the date it was discovered;
- The steps you should take to protect yourself from potential harm from the breach;
- The steps we are taking to investigate the breach, mitigate loses, and protect against further breaches; and
- Contact information where you can ask questions and get additional information.

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

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

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

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

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

How to Exercise Your Rights

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

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

Your Written Authorization is Required for Other Uses and Disclosures

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

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

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

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

Privacy Officer
WellSense Health Plan
529 Main Street
Suite 500
Charlestown, MA 02129

Or, you may call this office at 617-748-6325, Monday-Friday, from 8 a.m. to 6 p.m.

You may also notify the Secretary of the Department of Health and Human Services (HHS). Send your complaint to:

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

You may also contact OCR's Voice Hotline Number at 800-368-1019 or send the information to their Internet address: hhs.gov/ocr. We will not take retaliatory action against you if you file a complaint about our privacy practices with OCR or us.

If you have any questions or would like a copy of this Notice of Privacy Practices, please contact our Member Services Department.

Method	Our Member Services Department—Contact Information
Call	888-566-0010 (English and other languages) 888-566-0012 (Spanish) Monday–Friday, 8 a.m. to 6 p.m. Calls to this number are free. Our Member Services Department has free interpreter services for non-English speakers.
TTY/TDD	For hearing impaired: 711 (TTY/TDD) 711 (Relay operator) This number requires special telephone equipment. It is only for people with hearing or speaking problems. Calls are free.
FAX	617-897-0884
Write	WellSense Health Plan 529 Main Street, Suite 500 Charlestown, MA 02129
Website	**wellsense.org**

Chapter 14: Notice about Nondiscrimination and Accessibility Requirements and Non Discrimination Statement

We comply with applicable federal civil rights laws and do not discriminate, exclude people, or treat them differently because of race, color national origin, age, disability, sex, gender, sexual orientation, gender identity, moral or religious grounds, or limited English proficiency.

We provide free aids and services to people with disabilities to help communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, please contact our Member Services Department. See Chapter 2 for contact information.

If you believe that we have failed to provide these services or discriminated in another way because of race, color, national origin, age, disability, sex, gender, sexual orientation, gender identity, moral or religious grounds, or limited English proficiency, you can file a Complaint with:

WellSense Health Plan
Civil Rights Coordinator
529 Main Street, Suite 500
Charlestown, MA 02129

Phone: 888-566-0010 (TTY/TDD 711)

Fax: 617-897-0805

E-mail:MemberQuestions@wellsense.org

You can file a Complaint (Grievance) in person or by mail, fax, or e-mail. If you need help filing a Complaint (Grievance), our Member Services Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. To do this electronically through the Office for Civil Rights Complaint Portal, go to https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf Or to file by mail or phone:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

800-368-1019, 800-537-7697 (TDD)

Complaint forms are also available at hhs.gov/ocr/office/file/index.html.

Chapter 15: Other important MCO Plan information

Section 15.1 Structure and Operations of WellSense Health Plan

Here is some information about us:

- "WellSense Health Plan" is the trade name of the legal entity Boston Medical Center Health Plan, Inc.
- We are a Massachusetts non-profit tax-exempt 501(c 3) corporation.
- We are licensed by the Massachusetts Division of Insurance as a health maintenance organization (HMO).
- We are a Medicaid managed care organization.
- Our corporate office is located in Charlestown, MA.
- We are part of a family of companies that includes Boston Medical Center.
- We have a Board of Trustees. It oversees us.
- We contract with some other companies. They help us with our MCO Plan. For example:
  - Carelon Behavioral Health helps with Behavioral Health services; and
  - Express Scripts helps with pharmacy services.
- We contract with MassHealth.
- We offer other health coverage programs in addition to MassHealth:
  - We offer a Senior Care Options plan and Qualified Health Plans.
  - In New Hampshire, we offer a Medicaid plan.

For more information about us, please call our Member Services Department.

Section 15.2 Quality Improvement Program

The goal of WellSense's quality program is to ensure our Members have access to high-quality health care, health information, and service. WellSense works to help Members improve their physical and behavioral health well-being.

Examples of quality program activities include measurement and tracking of Plan performance on health care measures, as well as the development and distribution of clinical standards and guidelines in areas such as preventive care, member satisfaction; and appointment access.

Section 15.3 Clinical Practice Guidelines

We have Clinical Practice Guidelines (CPGs). CPGs are tools that recommend the best care for medical conditions and preventive health. CPGs are used by our Network Providers. Providers use them to make sure Members get the right care in the right way. For example to recommend tests and screenings to manage your health. We get the CPGs from professional health organizations, or we

work with others to develop CPGs. We share the CPGs with our whole Provider Network. You may ask for a copy of our current CPGs. To do so, call the Member Services Department.

Section 15.4 Utilization Management (UM)

UM is the process we use to make sure the care you get is "Medically Necessary." This is care you need when and where you need it. Our UM includes:

- Pre-service review
- Urgent or ongoing review
- Post-service review

UM looks at the clinical needs, appropriateness, and efficiency of:

- Services and supplies
- Equipment and drugs
- Procedures and settings

We make decisions based on criteria from scientific and medical research. The criteria are developed with input from Providers. This process and the criteria support the correct use of services. This helps us give our Members the best health outcomes. We do not reward any decision-maker for denying coverage of a service. We do not offer them money to discourage them from approving coverage. UM decisions are based on whether the care is appropriate and the existence of coverage.

For more information about the UM, call our Member Services Department. After hours, please leave a message or send a fax. All messages will be read the next business day. Member Services can also connect you to our clinical staff to discuss UM.

Section 15.5 Review of new technology

We review new clinical technologies and new uses for current technologies. We do this to decide if they are safe and effective. Then we decide if we will cover it.

These technologies may include:

- A medical treatment or surgical procedure
- Medical device, test, drug, or a biologic

Our review includes:

- Getting advice from experts who know about the technology or medical condition
- Evaluating reliable medical research
- Reviewing reports from public agencies
- Reviewing standards of care from national medical groups and other reliable sources

This information is then presented to our internal committees. These include doctors and other Providers (such as pharmacists). These committees make final decisions about whether we will cover the new technology or a new use of a current technology.

Section 15.6 Physician incentive plans

We can give you a written summary of our physician incentive plans. Please call our Member Services Department.

Chapter 16: Definitions of important words

Adverse Action: The following actions (or inactions) by Carelon or us:

- Denying or providing limited Authorization for a service requested by your Provider
- Reducing, suspending or ending coverage for a Covered Service we previously Authorized
- Denying, in whole or in part, payment for a service
- Not providing Covered Services in a timely way
- Failing to make an Authorization decision within the times in Section 5.7
- Not acting within the timeframes described in Chapter 11
- The involuntary transfer of a member to a different PCP except as listed in this document

Advance Directive: A legal document that allows you to:

- Name someone in advance to make medical decisions for you; and
- Write guidelines about your future medical care.

This document applies if you are not able to make those decisions for yourself.

Appeal: An Appeal is something you may do if you do not agree with an Adverse Action by us. For example, you may Appeal if we make a decision not to cover a service you think should be covered. See Chapter 11.

Authorize, or Authorization: See "Prior Authorization."

Authorized Representative: A person you name in writing to act for you as it relates to Appeals and Complaints.

Carelon Behavioral Health ("Carelon"): The company we contract with to manage Behavioral Health services and Provider Network for Members.

Behavioral Health Help Line: Telephone, text, chat, website, etc. that provides Behavioral Health information, resources, and referrals, including 24/7 referral and access to the appropriate provider

Behavioral Health Services: Mental health and substance use disorder services.

Behavioral Health Supports for Individuals with Justice Involvement (BH-JI): BH-JI supports that help Members with justice involvement, including those members who are currently incarcerated or detained in a correctional facility, released from a correctional institution within one year, or who are under the supervision of the Massachusetts Probation Service or the Massachusetts Parole Board, in accessing health care services, and primarily behavioral health services.

Chapter 16: Definitions of important words

Behavioral Health Urgent Care: Same-day or next-day appointments for evaluation or assessment for new clients and urgent appointments for existing clients; psychopharmacology appointments and Medication Assisted Treatment (MAT) now known as Medication for Opioid Use Disorder (MOUD); and additional availability outside of weekday hours between 9am and 5pm, by certain Mental Health Centers (MHC).

Benefit Limit: Day, visit, or dollar limits that may apply to certain Covered Services. If the amount of the benefits you receive reaches a Benefit Limit for a Covered Service, no more benefits will be provided for that Covered Service for the rest of the Benefit Year (or other stated time period). See the Covered Services List for Benefit Limits.

Benefit Year: The time period during which a Benefit Limit applies. For 2023, the Benefit Year begins on April 1, 2023 and ends on December 31, 2023. Thereafter Benefit Years will begin on January 1 and end on December 31.

Board of Hearings (BOH): The Board of Hearings in the Massachusetts Office of Medicaid.

Board of Hearings (BOH) Appeal: See "External Appeal."

Care Coordinator: A provider-based clinician or other trained individual who is employed or contracted by the Plan or a Member's PCP. They will provide care coordination activities, which include referrals and sharing of useful patient information; obtaining accurate information about services other than those provided by the PCP; participating in the Enrollee's Comprehensive Assessment, if any; and supporting safe transitions in care for Enrollees moving between settings in accordance with the Plan's Transitional Care Management program. The Care Coordinator may serve on one or more care teams, coordinates and facilitates meetings, and other activities of those Care Teams.

Care Management: A program that provides Members with extra support to help reach their health care goals. See Chapter 7.

Care Manager/Clinical Care Manager: an individual employed by the Plan or the Member's PCP to provide clinical care management including monitoring, follow-up, care coordination, and clinical management of high- and rising-risk Members.

Care Needs Screening (CNS): A form that Members fill out about their health. This helps us provide the right care to Members.

Care Plan: The plan of care developed by the Member and others involved in the Member's care or Care Management, including Person-Centered Treatment Plans developed by BH Community Partners (CPs) and LTSS CPs**.**

Chapter 16: Definitions of important words

Care Team: A multidisciplinary team responsible for coordinating certain aspects of a member's care.

Care Team Point of Contact: A member of a BH CP or LTSS CP Member's care team responsible for ongoing communication with the care team. The Care Team Point of Contact may be the Member's PCP or PCP Designee, or the Plan's staff member that has face-to-face contact with the PCP or the care team.

Child and Adolescent Needs and Strengths (CANS) Tool: A tool that provides a standardized way to organize information gathered during Behavioral Health Clinical Assessments and during the Discharge Planning process from Inpatient Mental Health Services and Community Based Acute Treatment Services. A Massachusetts version of the CANS Tool has been developed and is intended to be used as a treatment decision support tool for Behavioral Health Providers serving Enrollees under the age of 21.

Children's Behavioral Health Initiative (CBHI): A program whose goals are to strengthen, expand and integrate Behavioral Health Services for Members under the age of 21 into a comprehensive system of community-based, culturally competent care.

Children's Behavioral Health Initiative Services or CBHI Services: Any of the following services: Intensive Care Coordination (ICC), Family Support and Training, In-Home Behavioral Services (including Behavior Management Therapy and Behavior Management Monitoring) and Therapeutic Mentoring Services, In-Home Therapy Services (including Therapeutic Clinical Intervention and Ongoing Therapeutic Training and Support) and Youth Mobile Crisis Intervention.

CBHI Services Medical Necessity Criteria: The criteria used to determine the amount, duration or scope of services to ensure the provision of CBHI Services that are Medically Necessary.

Children in the Care or Custody of the Commonwealth: Children who are Members and who are in the care or protective custody of the Department of Children and Families (DCF), or in the custody of the Department of Youth Services (DYS).

Chronic Homelessness: A definition established by the U.S. Department of Housing and Urban Development (HUD) of a disabled individual who has been continuously homeless on the streets or in an emergency shelter or safe haven for 12 months or longer, or has had four or more episodes of homelessness (on the streets, or in an emergency shelter, or safe haven) over a three-year period meeting certain criteria. To meet the disabled part of the definition, the individual must have a diagnosable substance use disorder, serious and persistent mental illness, developmental disability, post-traumatic stress disorder, cognitive impairment resulting from a brain injury, or chronic physical illness, or disability, including the co-occurrence of two or more of those conditions.

Claim: A bill from a Provider for services that have been provided to a Member.

Clinical Advice and Support Line: A phone line that provides Members with information to support access to and coordination of appropriate care

Community Behavioral Health Center (CBHC): A comprehensive community behavioral health center offering crisis, urgent, and routine substance use disorder and mental health services, care coordination, peer supports, and screening and coordination with primary care. A CBHC will provide access to same-day and next-day services and expanded service hours including evenings and weekends. A CBHC must provide services to adults and youth, including infants and young children, and their families. CBHCs include an Adult Mobile Crisis Intervention (AMCI), Youth Mobile Crisis Intervention (YMCI), Adult Community Crisis Stabilization (Adult CCS) and Youth Community Crisis Stabilization (YCCS).

Community Partner: A community organization that works with Members and us. It helps plan care and coordinates services for Members. These Members have very high needs for Behavioral Health services or for long-term services and supports (LTSS). There are two types of Community Partners: one specializes in Behavioral Health; and the other specializes in LTSS.

Community Service Agency (CSA): A community-based Behavioral Health provider organization who facilitates access to all Behavioral Health services for children and families when a child is referred for Intensive Care Coordination. Services provided are Intensive Care Coordination and Family Support and Training Services.

Co-Morbid Disorders: The diagnosis of both a physical disorder and a behavioral health disorder, or two different physical health disorders.

Complaint (Grievance): A Complaint is a statement of dissatisfaction by a Member about any action or inaction by us or Network Providers. The formal name for a Complaint is a Grievance. Examples include Complaints about:

- Quality of care or services
- Rudeness by a Provider or staff
- Failure to respect a Member's rights

Complaints do not include Adverse Actions.

Comprehensive Assessment: A person-centered assessment of an Enrollee's care needs, functional needs, accessibility needs, goals, etc.

Continuing Services: The process of continuing to receive coverage during an Internal Appeal or BOH Appeal for Covered Services we (or Carelon Behavioral Health) previously Authorized.

Chapter 16: Definitions of important words

Continuity of Care: A process to help ensure that Members do not have interruptions in health care services. This may apply when a Member switches health plans or when there are Provider changes. See Section 3.10.

Co-Occurring Disorders (or Dual Diagnoses): Medical conditions involving both a mental health disorder and a substance use disorder at the same time.

Copayment: A set amount you have to pay as your share of the cost for a Covered Service. An example is a Drug Copayment. For example, you might have to pay a $1 or $3.65 Copayment for a drug.

Covered Services: The general term for all of the health care services, supplies, equipment and drugs covered by us and MassHealth. These are described in:

- The Covered Services List in the back of this Handbook; and
- Chapter 5.

Covered Services List: This is the list of Covered Services covered by us and MassHealth. The list is at the back of the Handbook and is titled "Prior Authorization (PA) and Referral Requirements for Covered Services for WellSense Health Plan Managed Care Organization Plan (MCO Plan) Members."

Crisis Prevention Plan: A plan that helps get Member/family-focused clinical care during a psychiatric crisis, using what has been learned from past treatment. This Plan includes a checklist of the triggers that may lead to or escalate a psychiatric crisis. The plan also includes the Member's preferences related to the involvement of the Member and his/her family or other supports, which could include behavioral health providers, community social service agencies, and community supports. This type of plan may also be referred to as a Wellness Recovery Action Plan (WRAP) for adults with Serious and Persistent Mental Illness (SPMI), and a Risk Management Safety Plan for children with Serious Emotional Disturbance (SED) and their families.

Cultural and Linguistic Competence: Competence, understanding, and awareness with respect to Culturally and Linguistically Appropriate Services

Culturally and Linguistically Appropriate Services: Health care services that are respectful of and responsive to cultural and linguistic needs, and that are characterized by cultural and linguistic competence, as described in the Culturally and Linguistically Appropriate Services (CLAS) standards set forth by the Office of Minority Health of the U.S. Department of Health and Human Services.

Discharge Planning: The evaluation of an Member's medical and Behavioral Health care needs and coordination of any other support services in order to arrange for safe and appropriate care and

living situation after discharge from one care setting (e.g., acute hospital, inpatient behavioral health facility) to another care setting (e.g., rehabilitation hospital, group home), including referral to and coordination of appropriate services.

Disease Management: The Plan's disease or condition specific benefits related to ongoing services and assistance for specific disease and/or conditions. Services include specific interventions and education/outreach targeted to Members with, or at risk for, these conditions. These conditions include but are not limited to Special Health Care Needs, Members with Serious and Persistent Mental Illness, AIDS, Severe Physical Disabilities, and Pregnancy.

Disenroll or Disenrollment: The process of ending your membership in our MCO Plan. Disenrollment may be:

- Voluntary (your own choice); or
- Involuntary (not your own choice)

See Chapter 12.

Drug List: A list of drugs covered and not covered by us. It includes brand name and generic drugs. Sometimes a Drug List is called a "formulary."

Dually Eligible: Individuals determined eligible for both Medicaid and Medicare.

Durable Medical Equipment: Certain equipment that is ordered by your doctor for medical reasons. Examples are walkers or wheelchairs.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT): The delivery of health care services to MassHealth Standard and CommonHealth Members under the age of 21, subject to an EPSDT Periodicity Schedule.

Early Intensive Behavioral Intervention (EIBI): Provided to children under three years of age who have a diagnosis of autism spectrum disorder (ASD) and meet clinical eligibility criteria. Such services shall be provided only by DPH-approved, Early Intensive Behavioral Intervention Service Providers

Early Intervention Services: A comprehensive program for children between the ages of birth and three years who have developmental delays or are at risk of delays through the influence of certain biological or environmental factors. Early Intervention Services include a set of integrated community-based developmental services which use a family centered approach.

Effective Date: The date on which a person:

- Becomes a Member of our MCO Plan; and
- Is eligible for Covered Services.

Chapter 16: Definitions of important words

Emergency: A condition:

- Which is either physical or mental; and
- With such serious symptoms, including severe pain, that anyone with an average knowledge of health could reasonably expect is so serious that if it does not get immediate medical attention, it may result in serious danger to your health.

This danger could include:

- Serious harm to bodily functions
- Serious dysfunction of any body organ or part; or
- In the case of a pregnant individual who is in active labor—if there is not enough time to safely transfer the individual to another hospital before delivery, or if the transfer may pose a threat to theirhealth or safety or to that of their unborn child.

Emergency Services Program (ESP) Providers: Treatment centers that provide Behavioral Health Emergency services 24 hours a day, 7 days a week.

Excluded Services: Health care services and supplies we do not cover.

Excluded and Limited Services List: This list of health care services and supplies that have a benefit limit or are not covered by MassHealth or us. This list appears at the back of this handbook and it titled "Excluded and Limited Services List."

Expedited (fast) Internal Appeal: A 72-hour Appeal process. It is a faster process than a Standard Internal Appeal.

Express Scripts: The company we contract with to manage our drug benefits. It also manages a Network of pharmacies. See Chapter 6.

External Appeal (or a "Board of Hearings (BOH) Appeal"): An Appeal you make to the BOH in the Office of Medicaid.

Family Planning Services: Services to prevent getting pregnant. They include:

- Birth control counseling
- Family planning education
- Exam and treatment
- Lab tests
- Medically approved birth control methods
- Pharmacy supplies and devices
- Sterilization, including tubal ligation and vasectomy

Abortion is not a Family Planning Service.

Family Resource Centers (FRCs) of Massachusetts: A statewide network that provides services to strengthen families and keep them connected to resources within their own community. There are FRCs in every county in the state. The FRCs help family's access housing and employment supports as well as health and behavioral health services. They also provide school supports, assistance with childcare and transportation, and provide equipment, clothing, food, and other assistance to families.

Final Internal Appeal Decision: The Contractor's final review of an expedited or standard Internal Appeal.

Fixed Enrollment Period: A nine-month period every year when MassHealth does not permit Members to change health plans unless certain reasons apply. See Chapter 12.

Formulary: Please see "Drug List."

Fraud, Waste and Abuse:

- **Fraud:** Intentional deception by a person who knows that the deception could result in some unauthorized benefit. An example is if a Member lends their ID Card to others to get health services.
- **Waste:** Extra costs that happen when health care services are overused; or when bills are not done correctly. Unlike Fraud, Waste is usually caused by mistake rather than intentional wrongful actions.
- **Abuse:** Provider actions that:
  - Are not consistent with sound fiscal, business, or medical practices; and
  - Result in an unnecessary cost to MassHealth, or in payment for services that are not Medically Necessary; or that do not to meet recognized health care standards.

It also includes Member actions that result in unnecessary cost to MassHealth.

Grievance: A Grievance is a formal name for a "Complaint." See "Complaint."

Health Equity: The opportunity for everyone to reach their full health potential. Regardless of their social position (e.g., socioeconomic status) or socially assigned circumstance (e.g., race, gender identity/gender expression, ethnicity, disability status, religion, sexual orientation, geography, disability, language etc.).

Health Related Social Needs (HRSN): The immediate daily needs that come from the lack of resources caused by the social determinants of health, such as a lack of access to stable housing, an environment free of life-threatening toxins, healthy food, utilities including heating and internet access, transportation, physical and mental health care, safety from violence, education and employment, and social connection.

Hospice: A package of services for terminally ill patients.

Examples include:

- Nursing
- Medical social services
- Physician services
- Counseling
- Drugs
- Durable medical equipment and medical supplies

Incarcerated: Individuals or members who are incarcerated includes (1) Individuals in County Correctional Facilities and Department of Corrections (DOC) facilities (including pre-arraignment individuals, pre-trial detainees, sentenced individuals, and civilly-committed individuals); and (2) Detained and committed youth in hardware-secure facilities in the Department of Youth Services (DYS) juvenile justice system.

Inpatient: A hospital stay when you have been formally admitted to the hospital for skilled medical services.

Inquiry: Any verbal or written question a Member has about our or Carelon Behavioral Health's operations. It does not include a Complaint (Grievance).

Internal Appeal: A verbal or written request for us or for Carelon Behavioral Health to review an Adverse Action. These can be Standard or Expedited (fast) Internal Appeals.

Long-Term Services and Supports (LTSS): A wide number of services and supports to help certain Members with activities of daily living and improve the quality of their lives. Examples include help with bathing; dressing and other basic activities of daily life; and self-care. LTSS may also include help with laundry, shopping, and transportation. LTSS are provided mostly in homes and communities. They can also be provided in facilities such as nursing facilities.

LTSS CP: Long-Term Services and Supports Community Partner.

MassHealth: The state's Medicaid and Children's Health Insurance Program. MassHealth provides affordable health care coverage for eligible residents that meet certain criteria. MassHealth's mission is to improve the health outcomes of our diverse members and their families by providing access to integrated health care services that support health, well-being, independence, and quality of life. The name of the Medicaid program in Massachusetts. We cover MassHealth members under the Standard (including Special Kids Special Care Program Members), CommonHealth, Family Assistance, and CarePlus programs.

Chapter 16: Definitions of important words

MassHealth Managed Care: The provision of Primary Care, Behavioral Health, and other services through an ACO, MCO, or the PCC Plan for all managed care eligible Members under age 65, based on state and federal requirements.

MCO Plan: A type of health plan offered by us that arranges for care through our Provider Network to provide you with quality health care. See Section 1.2.

MCO Plan Member ID Card: The card we send that names a person as a Member of our MCO Plan. The card includes your name, ID number and the name of the MCO Network ("MassHealth MCO"). The MCO Plan Member ID Card is not the same as the ID Card Members will receive from MassHealth.

Medically Necessary (or Medical Necessity): Services, supplies, or drugs that:

- Are needed to prevent, diagnose, or treat your medical condition;
- Meet recognized accepted standards of medical practice; and
- For which there is no comparable medical service or setting available or suitable for the Member that is more conservative or less costly,

Medication for Opioid Use Disorder (MOUD): The use of FDA approved medications for the treatment of substance use disorders; formerly known as Medication Assisted Treatment (MAT).

Member: A person who is enrolled in our MCO Plan by MassHealth.

Member ID Card: See "MCO Plan Member ID Card."

Member Services Department: A department within WellSense Health Plan. Our staff can answer your questions about our MCO Plan. For example:

- Your membership
- Covered Services
- Network Providers
- Complaints (Grievances) and Appeals

See Chapter 2.

Network: See "Provider Network."

Network Provider: A Provider who has a contract with us to provide Covered Services to Members in our MCO Plan.

Non-MCO Covered Services: Those services that are coordinated by the Plan, but are provided by MassHealth.

Chapter 16: Definitions of important words

Ombudsman: An independent organization, which has been contracted by MassHealth to help address issues you or your authorized representative have with the MCO, such as problems enrolling or getting services.

Opioid Treatment Programs (OTP): Substance Abuse and Mental Health Services Administration (SAMHSA)-certified programs, usually including a facility, staff, administration, patients, and services, that provide assessment and treatment, using approved medications, of individuals who are addicted to opioids.

Out-of-Network Provider: A Provider who does not have a contract with us to provide Covered Services to MCO Plan Members. See Section 3.9.

Peer Supports: Activities to support recovery and rehabilitation provided by other users of behavioral health services.

Pharmacy Programs: Programs that apply special rules to certain drugs before we will cover those drugs.

Plan Selection Period: A 90-day period every year when MassHealth allows you to change health plans for any reason. See Chapter 12.

Population Management (also Population Health): Population management is an approach to health that aims to improve the health of the entire population and to reduce inconsistent care among population groups.

Post-Stabilization Care: Care received right after Emergency care. This care is given to maintain the Member's stabilized condition. In certain cases, it is to improve or resolve the condition.

Primary Care Provider (PCP): A Provider you pick, or to whom we assign you. Your PCP provides and coordinates all your health care. See Section 3.3.

Prior Authorization: Approval we (or another company we contract with, for example, Carelon Behavioral Health) give in advance to your Provider. This approval allows coverage for certain services.

Protected Health Information (PHI): PHI is health information about you, or about your health care or payment for your health care.

Provider: A healthcare professional or facility licensed under state law. Providers include:

- Doctors

- Hospitals, skilled nursing facilities
- Labs
- Pharmacies
- Nurse practitioners, registered nurses
- Social workers, licensed mental health counselors, clinical specialists in psychiatric and mental health nursing and licensed alcohol and drug counselor

We only cover services of a Provider if those services are within the scope of the Provider's license.

Provider Listing: An online search tool on our website, or a printed booklet, listing MCO Plan Network Providers.

Provider Network: The combined group of Providers who contract with us to provide Covered Services to Members in the MCO Plan. This includes, but is not limited to, physical, behavioral, pharmacy, and ancillary service providers.

Region: A geographic area, specified by EOHHS and comprised of plan Service Areas.

Routine Care: Care that is not Emergency or Urgent Care. Examples are: physical exams, preventive care, and well child care visits.

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

Serious Emotional Disturbance (SED): A behavioral health condition that meets the definition in the Individuals with Disabilities Education Act (IDEA), *or* the definition set forth in regulations governing the Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States

Serious and Persistent Mental Illness (SPMI): A mental illness that includes a substantial disorder of thought, mood, perception, which grossly impairs judgment, behavior, capacity to recognize reality or the ability to meet the ordinary demands of life; and is the primary cause of functional impairment that substantially interferes with or limits the performance of one or more major life activities, and is expected to do so in the succeeding year; and meets diagnostic criteria specified with the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision) American Psychiatric Association, Washington, DC (2000), which indicates that the individual has a serious, long term mental illness that is not based on symptoms primarily caused by: (a) developmental disorders usually first diagnosed in infancy, childhood or adolescence, such as mental retardation or pervasive developmental disorders; or (b) cognitive disorders, including delirium, dementia or amnesia; or (c) mental disorders due to general medical condition not elsewhere classified; or (d) substance-related disorders.

Chapter 16: Definitions of important words

Service Area: A group of cities and towns in Massachusetts where we accept Members for enrollment in our MCO Plan. You must live in your MCO Plan's Service Area.

Significant BH Needs: Substance use disorder, SED, SPMI and other BH conditions as specified by EOHHS.

Social Service Organization: A community-based organization that provides services or goods in the area of Health Related Social Needs.

Special Health Care Needs including but not limited to, :

- complex or chronic medical needs requiring specialized health care services, including persons with multiple chronic conditions, co-morbidities, and/or co-existing functional impairments, and including persons with physical, mental/substance use, and/or developmental disabilities, such as persons with cognitive, intellectual, mobility, psychiatric, and/or sensory disabilities described below;
    - Cognitive Disability – a condition that leads to disturbances in brain functions, such as memory, orientation, awareness, perception, reasoning, and judgment. Many conditions can cause cognitive disabilities, including but not limited to Alzheimer's disease, bipolar disorder, Parkinson disease, traumatic injury, stroke, depression, alcoholism, and chronic fatigue syndrome.
    - Intellectual Disability – is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior that affect many everyday social and practical skills.
    - Mobility Disability - an impairment or condition that limits or makes difficult the major life activity of moving a person's body or a portion of his or her body. "Mobility disability" includes, but is not limited to, orthopedic and neuro-motor disabilities and any other impairment or condition that limits an individual's ability to walk, maneuver around objects, ascend or descend steps or slopes, and/or operate controls. An individual with a mobility disability may use a wheelchair or other assistive device for mobility or may be semi-ambulatory.
    - Psychiatric Disability – a mental disorder that is a health condition characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.

Examples include, but are not limited to, depression, bipolar disorder, anxiety disorder, schizophrenia, and addiction.

- Sensory Disability - any condition that substantially affects hearing, speech, or vision.

- children/adolescents who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type and amount beyond that required by children generally;
- high risk for admission/readmission to a 24-hour level of care within the next six months;
- high risk of institutionalization;
- diagnosed with a Serious Emotional Disturbance, a Serious and Persistent Mental Illness, or a substance use disorder, or otherwise have significant BH needs;
- Chronically Homeless;
- high risk of inpatient admission or Emergency Department visits, including certain Enrollees transitioning care across acute hospital, chronic disease and rehabilitation hospital or nursing facility setting; or

Receive care from other state agency programs, including but not limited to programs through Department of Mental Health (DMH), Department of Developmental Services (DDS), Department of Children and Families (DCF), and Department of Youth Services (DYS).

Specialist: A doctor who provides health care for a specific disease or part of the body. Examples include cardiologists (heart doctors) and obstetricians (for pregnant individuals).

Standard Internal Appeal: An Internal Appeal that is decided by us within a standard timeframe. An Expedited (fast) Internal Appeal is a faster process.

Transitional Care Management: The evaluation of an Member's medical care needs and coordination of any other support services in order to arrange for safe and appropriate care after discharge from one level of care to another level of care, including referral to appropriate services.

Urgent Care: Care required quickly to prevent a worsening of health due to symptoms that a reasonable person would believe are not an Emergency but require prompt medical attention. Urgent Care does not include preventive, elective, or Routine

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WellSense Health Plan ("We" or "Us")" A Massachusetts non-profit Medicaid managed care organization. We offer an MCO Plan. Our official legal name is Boston Medical Center Health Plan, Inc. In this Handbook, WellSense Health Plan is also called "we" or "us."