

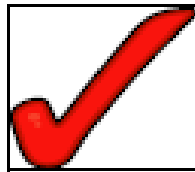


EVIDENCE OF COVERAGE
COMMONWEALTH CHOICE

GOLD
SILVER HIGH
SILVER MEDIUM
SILVER LOW
BRONZE HIGH
BRONZE MEDIUM
BRONZE LOW

PROVIDER NETWORK: "CELTICARE DIRECT"

This health plan **meets Minimum Creditable Coverage standards** and **will satisfy** the individual mandate that you have health insurance. Please see page 7 for additional information.



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

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

Effective: April 1, 2010

Member Services Department 1-866-895-1786 (TDD/TTY) 1-866-614-1949
Log on to www.celticarehealthplan.com



Other Formats Available

The information included in this booklet is about your CeltiCare Health Plan of Massachusetts, Inc. (CeltiCare) benefits. If you need information in a different language, please call Member Services so we can help you at 1-866-895-1786.

Spanish: La información incluida en este folleto es acerca de sus beneficios del Plan de Salud Celticare de Massachusetts (CeltiCare). Si necesita obtener la información en un idioma diferente, llame al Departamento de Servicios para Miembros al 1-866-895-1786 para que podamos ayudarle.

Russian: Информация, содержащаяся в этом буклете, касается ваших льгот по программе медицинского страхования для жителей штата Массачусетс CeltiCare. Если вам требуется информация на другом языке, обратитесь, пожалуйста, за помощью в справочную службу для участников программы по телефону 1-866-895-1786.

Cambodian: ព័ត៌មានភ្ជាប់ក្នុងកូនសៀវភៅនេះ គឺជា ព័ត៌មានកំរៃសុខភាពសេរីថែរ (CeltiCare) នៃ ម៉ាសាឈូសិត។ បើសិនជាលោកអ្នកត្រូវការព័ត៌មាន ជាភាសាផ្សេង សូមអញ្ជើញទាក់ទង សួររស្មីកម្មសមាជិក តាមលេខទូរស័ព្ទ # 1-866-895-1786 ។

Chinese- Traditional: 「本手冊中的資訊有關您的CeltiCare Health Plan of Massachusetts, Inc. (CeltiCare)醫療計畫福利。如果您需要此資訊的其他語言版本，請致電會員服務部，以便我們為您提供協助，電話號碼是1-866-895-1786。」

Chinese- Simplified: “本手册中的信息有关您的CeltiCare Health Plan of Massachusetts, Inc. (CeltiCare) 医疗计划福利。如果您需要此信息的其他语言版本，请致电会员服务部，以便我们为您提供协助，电话号码是1-866-895-1786。”

Haitian Creole: Enfòmasyon ki nan tiliv sa a, se sou avantaj nan CeltiCare Health Plan nan Eta Massachusetts, Inc. (CeltiCare). Si w bezwen enfòmasyon nan yon lòt lang, rele Sèvis pou Manm yo nan 1-866-895-1786, pou nou kapab ede w.

Laotian: "ຂໍ້ມູນທີ່ປະກອບປຶ້ມນີ້ແມ່ນກ່ຽວກັບຜົນປະໂຫຍດແຜນການປະກັນສຸກຂະໜາຍຢູ່ລັດ Massachusetts ຂອງທ່ານ (CeltiCare). ຫາກວ່າທ່ານຕ້ອງການຂໍ້ມູນເປັນພາສາອື່ນ, ຂໍໃຫ້ໂທລະສັບໄປຫາຝ່າຍບໍລິການສະມາຊິກຕາມໝາຍເລກ 1-866-895-1786 ເພື່ອພວກເຮົາຈະຊ່ວຍທ່ານໄດ້."

Portuguese- European: A informação incluída neste folheto diz respeito aos benefícios do seu Plano de Saúde CeltiCare de Massachusetts, Inc. (CeltiCare). Se necessitar de informações numa outra língua, por favor ligue para os Serviços ao Associado através do número 1-866-895-1786 para que o(a) possamos ajudar.

Member Services Department 1-866-895-1786 (TDD/TTY) 1-866-614-1949
Log on to www.celticarehealthplan.com



EVIDENCE OF COVERAGE

Portuguese- Brazilian: As informações contidas neste folheto referem-se aos benefícios do seu Plano de Saúde CeltiCare de Massachusetts, Inc. (CeltiCare). Se precisar de informações em outro idioma, telefone para o Atendimento aos Clientes para que possamos ajudá-lo. O número é 1-866-895-1786.

Vietnamese: Thông tin trong tập sách này nói về các quyền lợi của quý vị trong chương trình CeltiCare Health Plan of Massachusetts, Inc. (CeltiCare). Nếu quý vị cần thông tin bằng ngôn ngữ khác, xin gọi ban Dịch Vụ Hội Viên để được giúp đỡ tại số 1-866-895-1786.

French: L'information contenue dans ce livret concerne les avantages de votre assurance maladie CeltiCare du Massachusetts, Inc. (CeltiCare). Si vous souhaitez ces informations dans une autre langue, veuillez appeler le Service pour les membres au 1-866-895-1786.

Polish: Informacje zawarte w niniejszej broszurze dotyczą świadczeń w ramach planu opieki zdrowotnej CeltiCare Health Plan of Massachusetts, Inc. (CeltiCare). W razie potrzeby otrzymania informacji w innym języku, udzielimy pomocy po skontaktowaniu się z Działem Usług Członkowskich (Member Services) pod numerem 1-866-895-1786.

Greek: Οι πληροφορίες που παρέχονται στο παρόν φυλλάδιο αφορούν στις παροχές σας του Προγράμματος Υγείας CeltiCare της Μασαχουσέτης (CeltiCare). Αν χρειάζεστε πληροφορίες σε μια διαφορετική γλώσσα, παρακαλούμε καλέστε τις Υπηρεσίες Μελών στο τηλέφωνο 1-866-895-1786 για να μπορέσουμε να σας βοηθήσουμε.

Italian: Le informazioni contenute in questo opuscolo riguardano i benefici del suo piano sanitario "CeltiCare Health Plan of Massachusetts, Inc. (CeltiCare)". Se desidera informazioni in una lingua diversa, la preghiamo di chiamare Member Services al numero 1-866-895-1786 per ricevere l'assistenza richiesta.

Arabic: CeltiCare Health Plan of المعلومات المشمولة في هذه الكراسة تتعلق بمنافع برنامج تأمينك الصحي
(CeltiCare) Massachusetts. إذا احتجت لمعلومات بلغة أخرى، رجاء الاتصال بمكتب خدمات العملاء
لكي نستطيع مساعدتك على الرقم 1-866-895-1786.

Member Services Department 1-866-895-1786 (TDD/TTY) 1-866-614-1949
Log on to www.celticarehealthplan.com



Table of Contents

Other Formats Available 2

Table of Contents 4

WELCOME 7

Welcome to CeltiCare 7

Minimum Creditable Coverage Standards 7

Your Evidence of Coverage 8

Your Provider Directory 8

CeltiCare Website 8

Member and Community Advisory Council 9

Quality Improvement (QI) 9

How to Contact Us 10

Other Important Phone Numbers 10

Interpreter Services 10

Your Member ID card 11

HOW YOUR PLAN WORKS 12

Service Areas Covered 12

Member Services 12

NurseWise® 12

Membership and Eligibility Information 13

Involuntary and Voluntary Rates for members 13

Major Life Changes 13

Newborn, Foster and Adoptive Children Coverage 14

Domestic Partner Coverage 15

Lock-In Coverage 15

Termination of Coverage 15

Contributory Plan Termination of Employer Group for Non-Payment of Premium 16

Continuation of Coverage 16

 Qualifying Event 17

 Extension 17

Continuation of Spousal Coverage 17

Annual Deductible 19

Annual Out of Pocket Expense 19

Copayments 19

Premiums 19

BENEFITS 20

Covered Services 20

Medically Necessary Services 20

SPECIFIC PLAN BENEFIT DESCRIPTIONS 21

Gold 21

Silver High 23

Silver Medium 25

Member Services Department 1-866-895-1786 (TDD/TTY) 1-866-614-1949
 Log on to www.celticarehealthplan.com



Silver Low 27

Bronze High 29

Bronze Medium 31

Bronze Low..... 33

COVERED SERVICES DESCRIPTION 36

BEHAVIORAL HEALTH SERVICES..... 46

Mental Health and Substance Abuse Services 46

VISION SERVICES 49

Routine Vision..... 49

Non-Routine Vision 49

EXCLUDED BENEFITS 50

Services NOT Covered 50

HOW TO OBTAIN HEALTHCARE 55

Primary Care Provider (PCP)..... 55

Physician Profiling Information 55

Choosing Your PCP..... 55

Making an Appointment with Your PCP 56

After Hours Appointments with Your PCP 56

Changing Your PCP 57

What to Do if Your Provider Leaves the CeltiCare Network 57

Continuity and Transition of Care - New Members..... 57

HEALTH MANAGEMENT 59

CentAccount Healthy Rewards Program 59

Balance Program..... 59

Family Planning Services 60

When You Are Pregnant..... 61

Pregnancy & Maternity Services 61

Start Smart for Your Baby® 61

Case Management 62

Asthma and Diabetes Disease Management 63

UTILIZATION MANAGEMENT..... 64

Review Criteria 64

Experimental, Investigational and Clinical Trial Services..... 64

Prior Authorization for Services 64

Utilization Review 65

Second Medical Opinion..... 67

How to Get Medical Care When You Are Out of the Service Region (Area)..... 67

Referrals 68

Self-Referrals..... 69

Urgent Care-After Hours..... 70

Emergency Care 71

Emergency Transportation Services 72

Post Stabilization Services 72

PHARMACY 73

Member Services Department 1-866-895-1786 (TDD/TTY) 1-866-614-1949
 Log on to www.celticarehealthplan.com



Pharmacy Program 73
Preferred Drug List..... 73
Prior Authorizations 73
Exclusions 74
Step Therapy 74
Quantity Limits..... 74
Generic Drugs 75
Newly Approved Products..... 75
Specialty Pharmacy Provider..... 75
Filling a Prescription..... 76
Mail Order Program..... 76
MEMBER SATISFACTION 77
Internal Inquiry Process..... 77
Internal Grievance Process 77
How to File a Grievance 78
Internal Appeal Process..... 79
Standard/Non-expedited Internal Appeal..... 79
Expedited Internal Appeal 82
External Review..... 83
Waste, Abuse and Fraud (WAF) Program..... 86
Authority and Responsibility 86
What to do if you get a bill..... 87
Other Insurance 87
Accidental Injury or Illness (Subrogation)..... 87
Member Rights 88
Member Responsibilities 90
Advance Directives..... 91
Protecting Your Privacy..... 92
NOTICE OF PRIVACY PRACTICES 92
Privacy Notice..... 92
Using Your Rights..... 96
Important Definitions 97

Member Services Department 1-866-895-1786 (TDD/TTY) 1-866-614-1949
Log on to www.celticarehealthplan.com



WELCOME

Welcome to CeltiCare

Thank you for making CeltiCare Health Plan of Massachusetts, Inc. (CeltiCare) your choice for healthcare. This Evidence of Coverage describes your healthcare benefits and is designed to make it easy for you to make the most of CeltiCare benefits and services. CeltiCare is a new health plan that combines the strength of a national company with partnerships with local hospitals and physicians to provide the highest of quality of care. We have partnered with The Commonwealth Choice Health Insurance Program (Commonwealth Choice) to provide new health care solutions you can afford.

The Commonwealth Health Insurance Connector Authority (Connector) oversees the Commonwealth Choice program. You may also visit our website at www.celticarehealthplan.com for more information and services.

Minimum Creditable Coverage Standards

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information, call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan **meets Minimum Creditable Coverage standards** that are effective January 1, 2010 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you **will satisfy** the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE January 1, 2010. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

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

Your Evidence of Coverage

The Evidence of Coverage is a detailed guide to CeltiCare. It is our contract with you. The Evidence of Coverage explains your rights, benefits and responsibilities as a member of our health plan. Please read this book carefully. This booklet tells you how to access healthcare services. It also gives you information on your CeltiCare benefits and services such as:

- What is covered by CeltiCare and what isn't covered
- How to get the care you need or your prescriptions filled
- What you will have to pay for your healthcare or prescriptions
- What to do if you are unhappy about your plan or coverage
- Eligibility requirements
- The geographic service area of CeltiCare
- Materials you will receive from CeltiCare
- Paying your Commonwealth Choice premiums

Call Member Services at 1-866-895-1786 to receive a copy of the EOC at no charge.

Your Provider Directory

A listing of CeltiCare doctors is available online at www.celticarehealthplan.com. CeltiCare has plan physicians, hospitals and other healthcare providers who have agreed to provide you with your healthcare services. You may find any of our plan providers by completing the 'Find a Doctor' function on our website and selecting the "Commonwealth Choice/CeltiCare Direct" Network. There you will have the ability to narrow your search by provider specialty, zip code, gender, whether or not they are currently accepting new patients, and languages spoken.

At any time, you can request a copy of the Provider Directory at no charge by calling Member Services at 1-866-895-1786. CeltiCare can also help you pick a primary care provider (PCP). We can make your choice of PCP effective on the next business day.

Call the PCP's office if you want to make an appointment. If you need help, call Member Services at 1-866-895-1786. We will help you make the appointment.

CeltiCare Website

CeltiCare's website helps you get the answers. Our website has resources and features that make it easy to get quality care. CeltiCare's website can be accessed at www.celticarehealthplan.com.

It also gives you information on your CeltiCare benefits and services such as:

- Evidence of Coverage
- Current news and events
- Member self-service features
- Online form submission
- CeltiCare programs and services

Member Services Department 1-866-895-1786 (TDD/TTY) 1-866-614-1949
Log on to www.celticarehealthplan.com

Member and Community Advisory Council

You can help CeltiCare with the way our health plan works. We have a Member Advisory Council that gives members like you a chance to share your thoughts and ideas with CeltiCare. At the meetings you have a chance to talk about the way services are delivered. The council meets every three months. We ask doctors and providers, members, a community representative, advocates and members of CeltiCare staff to join in the meeting. This gives you a chance to discuss your concerns with a variety of people. You also have a chance to give us feedback, and let us know how we are doing. You may ask questions or share any concerns that you have about the delivery of services. Call Member Services at 1-866-895-1786 if you would like to be on the team.

Quality Improvement (QI)

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

- Conducting a thorough check on physicians when they become part of the CeltiCare provider network.
- Monitoring member access to all types of healthcare services.
- Providing programs and educational items about general healthcare and specific diseases.
- Sending reminders to members to get annual tests such as a physical exam, cervical cancer screening, breast cancer screening and immunizations.
- Investigating any member concerns regarding care received. For example, if you have a concern about the care you received from your doctor or service provided by CeltiCare, please contact us at 1-866-895-1786.

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



How to Contact Us

CeltiCare

1380 Soldiers Field Road, Suite 300
Brighton, Massachusetts 02135

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

Member Services	1-866-895-1786
TDD/TTY line	1-866-614-1949
Fax	1-866-614-1953
Massachusetts Relay Services	1-800-439-0183
Substance Abuse/Mental Health	1-866-896-5053
NurseWise®	1-866-895-1786, option 7

Other Important Phone Numbers

Vision	1-866-895-1786
Emergency	Call 911

Interpreter Services

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

To arrange for interpretation services, call Member Services at 1-866-895-1786 (TDD/TTY 1-866-614-1949).

Member Services Department 1-866-895-1786 (TDD/TTY) 1-866-614-1949
Log on to www.celticarehealthplan.com



Your Member ID card

When you enroll in CeltiCare, you will receive a member ID card within 5 business days of CeltiCare's receipt of your enrollment with the Connector Authority's Commonwealth Choice program. This card is proof that you are enrolled in a CeltiCare plan. You need to keep this card with you at all times. Please show this card every time you go for any service under the CeltiCare program. The CeltiCare ID card will show your name, member ID#, the phone number for Behavioral Health services, and co-payments required at the time of service. If you do not get your CeltiCare ID card within a few weeks after you join our plan, please call Member Services at 1-866-895-1786. We will send you another card.

Member ID Card- Sample

Front

- Name
- Member ID#
- Plan Name
- Co-pays

				Rx: US Script BIN:008019
Member Name: Jane Doe		Member ID#: XXXXXXXXXX		
PCP Name: John Doe		PCP Number: XXX-XXX-XXXX		
Co-pays				
PCP/Spec: \$X/\$X		ER:\$X	INPX: \$X	
Vision: \$X		RX:\$X/\$X/\$X		
<p>If you have an emergency, call 911 or go to the nearest emergency room. If you are not sure whether you need to go to the emergency room, call your PCP or CeltiCare as soon as possible.</p>				
Commonwealth Choice Plan:				

Back

- Important Member & Provider Phone Numbers
- Medical & Behavioral claims address
- Website address

MEMBERS: Member Services line 1-866-895-1786 TDD/TTY 1-866-614-1949 24/7 NurseWise 1-866-895-1786 , option 7 Vision: 1-866-895-1786	
For information on reproductive and family planning services, call 1-866-895-1786.	
PROVIDERS: IVR Eligibility inquiry - Prior Auth 1-866-895-1786 US Script Help Desk 1-866-810-1903 Cenpatico Behavioral Health 1-866-896-5053	
Medical claims: CeltiCare Attn: CLAIMS PO Box 3080 Farmington, MO 63640-3824	Behavioral Health claims: Cenpatico Behavioral Health Attn: CLAIMS PO Box 7200 Farmington, MO 63640-3813
Provider/claims information via the web: www.celticarehealthplan.com.	

Member Services Department 1-866-895-1786 (TDD/TTY) 1-866-614-1949
 Log on to www.celticarehealthplan.com

HOW YOUR PLAN WORKS

Service Areas Covered

CeltiCare is a health plan for individual and small employer groups and group plans available through Commonwealth Choice in Massachusetts. This means you are covered for benefits as long as you reside in the CeltiCare service area and use our provider network. CeltiCare's service area includes Suffolk County and portions of Norfolk and Middlesex County.

You can find more information regarding CeltiCare's Service area and participating providers on our website at www.celticarehealthplan.com. You can also contact the Commonwealth Choice Customer Service Center at 1-877-MA-ENROLL or 1-877-623-6765, Monday through Friday from 8:30 am to 5:00 pm. For persons with total or partial hearing loss, please call TTY 1-888-213-8163 or visit www.mahealthconnector.org.

Member Services

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

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

Please call 1-866-895-1786 (TDD/TTY 1-866-614-1949). We are open Monday through Friday from 8:00 a.m. to 5:00 p.m. EST.

NurseWise®

NurseWise is a free health information phone line. NurseWise is ready to answer your health questions 24 hours a day – every day of the year. NurseWise is staffed with registered nurses. These nurses have spent lots of time caring for people. They are ready and eager to help you. The services listed below are available by contacting NurseWise, CeltiCare's 24-hour nurse hotline at 1-866-895-1786, **option 7**.

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

Member Services Department 1-866-895-1786 (TDD/TTY) 1-866-614-1949
Log on to www.celticarehealthplan.com



Sometimes you may not be sure if you need to go to the emergency room. Call NurseWise. They can help you decide where to go for care.

Membership and Eligibility Information

All eligible individuals, eligible small business or groups that meet the Connector eligibility requirements are entitled to be enrolled through the Connector for CeltiCare Choice products. Your enrollment with CeltiCare is good for as long as you continue to meet eligibility requirements. You and/or your employer must also pay your required premiums to the Connector Authority.

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

To inquire about Commonwealth Choice eligibility, enrollment options and **Specific Plan Benefits** please contact the Connector.

Commonwealth Health Insurance Connector Authority

PO Box 120089

Boston, MA 02112-9914

Telephone: 1-877-MA-ENROLL (1-877-623-6765)

TTY: 1-888-213-8163

www.mahealthconnector.org

8:30 a.m. to 5:00 p.m. Monday through Friday

Involuntary and Voluntary Rates for members

CeltiCare must notify you on an annual basis of the voluntary and involuntary member disenrollment rate. Voluntary disenrollment occurs when a subscriber elects to end benefit coverage. Involuntary disenrollment occurs when the Health Connector or CeltiCare terminates subscriber or employer coverage due to actions outlined on page 15 under termination of coverage. Please contact CeltiCare Member Services at 1-866-895-1786 for more information.

Major Life Changes

If you have had a major change in your life, please contact CeltiCare Member Services at 1-866-895-1786. Some examples of major life changes are:

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

Member Services Department 1-866-895-1786 (TDD/TTY) 1-866-614-1949

Log on to www.celticarehealthplan.com

Life changes might affect your eligibility with CeltiCare. Call the Commonwealth Choice Customer Service if you move to a new county in Massachusetts or if you move out of the state.

A subscriber may change his/her health plan enrollment or coverage type (i.e. Individual to Family) outside of his/her renewal period, only under these specific circumstances:

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

A Qualifying Event must be reported to the Connector within 30 days of the event. Changes to health plan enrollment or coverage type will be effective as of the qualifying event date.

Newborn, Foster and Adoptive Children Coverage

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

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

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

For questions related to enrolling your newborn, please contact the Commonwealth Choice Customer Service Center. Call at 1-877-MA-ENROLL or 1-877-623-6765, Monday through Friday from 8:30 am to 5:00 pm. For persons with total or partial hearing loss, please call TTY 1-888-213-8163 or visit www.mahealthconnector.org.

Domestic Partner Coverage

CeltiCare offers Domestic Partner Coverage for Individual Plans. Coverage is only available through group plans if offered by your employer. Contact CeltiCare customer service for more information regarding Domestic Partner coverage.

Lock-In Coverage

Once coverage is effective, a subscriber may not change health plans until his/her annual renewal date. On his/her annual renewal date, a subscriber may select another health plan for any reason. If an employer voluntarily cancels coverage, the employer may be able to reapply and enroll at a later date.

Exceptions:

If a subscriber voluntarily cancels coverage and all premiums are paid in full, he/she may be able to reapply and enroll at a later date. However, the subscriber must pay the new rate and a new 12 month period will begin at the time of enrollment.

If you have questions, please contact the Commonwealth Choice Customer Service Center at 1-877-MA-ENROLL or 1-877-623-6765, Monday through Friday from 8:30 am to 5:00 pm. For persons with total or partial hearing loss, please call TTY 1-888-213-8163 or visit www.mahealthconnector.org.

Termination of Coverage

You could be terminated from coverage with CeltiCare if:

- You or your employer have not paid the required premium.
- You commit an act of physical or verbal abuse, or other uncooperative or disruptive behavior, unrelated to your physical or mental condition, that poses a threat to any provider, any member, or the plan or plan employee.
- You commit an act of misrepresentation or fraud related to obtaining health care services, coverage, or payment for health care services.

- You fail to comply in a material manner with the plan rules. For employers, includes failure to meet requirements regarding employer contributions to group premiums.
- You fail to provide to CeltiCare or the Connector the information necessary to show continuing eligibility or to enable the plan to provide coverage to you under the terms of this EOC.
- In the case of a group, the group is not actively engaged in business.
- You or your employer chooses to end coverage by notifying the Connector.
- You choose to relocate out of the service area.

If you have questions about canceling your Individual or Small Business or Group plan, please contact the Commonwealth Choice Customer Service Center at 1-877-MA-ENROLL or 1-877-623-6765, Monday through Friday from 8:30 am to 5:00 pm. For persons with total or partial hearing loss, please call TTY 1-888-213-8163 or visit www.mahealthconnector.org.

Contributory Plan Termination of Employer Group for Non-Payment of Premium

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

If you have questions about your participation in your Employer Group plan, contact the Commonwealth Choice Customer Service Center at 1-877-MA-ENROLL or 1-877-623-6765, Monday through Friday from 8:30 am to 5:00 pm. For persons with total or partial hearing loss, please call TTY 1-888-213-8163 or visit www.mahealthconnector.org.

THE FOLLOWING CONTINUATION OF COVERAGE PROVISIONS ONLY APPLY TO ENROLLEES THROUGH EMPLOYER/EMPLOYEE CONTRIBUTION BASED PRODUCTS.

Continuation of Coverage

If an employee, spouse and/or dependent (qualified beneficiaries) has a qualifying event that would result in a loss of coverage under the group health plan, coverage may be continued for the employee and/or qualified beneficiaries. To be eligible for continuation of coverage, the employer group must already be providing coverage through a CeltiCare Health Plan and the employee and/or qualified beneficiaries must live within the plan service area.

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Qualifying Event

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

- Subscriber’s employment ends (other than for reasons of gross misconduct) or work hours are reduced;
- The death of the subscriber;
- Divorce or legal separation;
- Subscriber becomes eligible for benefits under Title XVIII of the Social Security Act;
- A dependent child ceases to be eligible under the terms of the health benefit plan;
- For plans that extend coverage to retirees, the loss of coverage due to bankruptcy of the employer from whom the subscriber retired.

Continuation under this provision ends the earliest of:

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

Extension of Continuation of Coverage

Continuation of coverage may be extended in the following instances:

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

Continuation of Spousal Coverage

A subscriber’s divorced or legally separated spouse shall remain eligible and coverage will continue under the health benefit plan so long as the subscriber’s participation in



the health plan continues. Eligibility will end the earlier of the remarriage of either the subscriber or spouse, or such time as provided in the judgment of divorce or separation.

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

Continuation After Death or Layoff

If a subscriber loses coverage due to an involuntary layoff or death, the coverage under the health plan shall be continued for such member, spouse and dependents for a period of thirty-nine weeks from the date the subscriber becomes ineligible for coverage or until the subscriber and dependents become eligible for another group health plan, whichever comes first. The subscriber, spouse or dependent will be responsible for payment of the entire premium due.

If a subscriber loses coverage due to a plant closing or partial closing, coverage will continue for a period of 90 days from the date the subscriber becomes ineligible for coverage or until the subscriber and dependents become eligible for another group health plan, whichever comes first. The subscriber, spouse or dependent will be responsible for payment of the entire premium due.



PAYMENT INFORMATION

Annual Deductible

An annual dollar amount that must be paid by you for certain covered services before CeltiCare becomes obligated to pay for covered services. **See the Specific Plan Benefit Descriptions Section for any deductible applicable to your Health Plan.**

Annual Out of Pocket Expense

The annual dollar amount that you will pay for covered services under a CeltiCare Health Plan, not including premiums. Except for applicable Prescription Drug deductibles and co-payments, all other deductibles and co-payments will count toward the annual out of pocket expense. **See the Specific Plan Benefit Descriptions Section for the annual out of pocket expense applicable to your Health Plan.**

Copayments

The amount you must pay for a covered service. You may have to pay a co-payment to the provider for certain covered services at the time you receive the service. **See the Specific Plan Benefit Descriptions Section for co-payments applicable to your Health Plan.**

Note: Providers may refuse to provide covered services if a member fails or refuses to pay required copayments.

Timing of Out of Pocket Expense

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

Premiums

You, and/or your employer, are required to pay a monthly premium directly to the Connector. Do not send premium payments to CeltiCare. Please follow the directions provided to you by the Health Connector for paying your premiums.

For questions regarding payment of your premiums, please call the Commonwealth Choice Customer Service Center at 1-877-MA-ENROLL or 1-877-623-6765, Monday through Friday from 8:30 a.m. to 5:00 p.m. For people with partial or total hearing loss, please call TTY 1-888-213-8163.



BENEFITS

Covered Services

This section describes your CeltiCare covered benefits, co-payments, deductibles coinsurance and benefit limitations. With CeltiCare, you are entitled to receive medically necessary services and benefits listed in this section. You are responsible for co-payments, if required. You must pay co-payments at the time of service. You are responsible for any non-covered services, deductibles or coinsurance. Additionally, some covered services may require prior authorization by CeltiCare before services are provided. Check with your primary care provider, the ordering provider, or CeltiCare Member Services to see if the service requires authorization. You must contact them to see if authorization has been obtained prior to the provision of services. Refer to the **Prior Authorization** section in this booklet. Please refer to your **Specific Plan Benefits** for a full description of your covered benefits.

Medically Necessary Services

Covered services are only covered if they are medically necessary. Services that are medically necessary are those that:

- Are the most appropriate available supply or level of service for you considering potential benefits and harm
- Are known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes
- For services and interventions not in widespread use is based on scientific evidence and the least intensive and most cost-effective available

If you have any questions, call CeltiCare Member Services at 1-866-895-1786 (TDD/TTY) 1-866-614-1949. We can give you more information about any of the covered services described in the following sections.



SPECIFIC PLAN BENEFIT DESCRIPTIONS

Gold

Annual Out-of-Pocket Expenses per benefit year	Maximum amount
Per person	Unlimited
Family total	Unlimited
Annual Deductible	Maximum amount
Per person	None
Family total	None

Covered Benefit	Co-Payment
Outpatient Medical Care	
Community Health Center Visits (Primary Care and Specialist) *No Copayment for adult routine physical, annual GYN exam and well-child care	\$20/\$30
Office Visits (PCP/Specialists) *No Copayment for adult routine physical, annual GYN exam and well-child care.	\$20/\$30
Outpatient Surgery (Hospital and Ambulatory Surgery Centers)	\$150 per surgery
Diagnostic X-rays/Labs	\$25/\$25
Diagnostic CT/MRI/MRA/PET scan	\$100/\$100/\$100/\$100
Nuclear Cardiac Imaging	\$100
Inpatient Medical and Maternity Care	\$150 per admission
Prescription Drugs	
Medication via Pharmacy (1 month supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* \$15 •Preferred \$30 •Non-preferred \$50
Medication via Mail Order (90 day supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* \$30 •Preferred \$60 •Non-preferred \$150
Emergency Care (waived if admitted)	\$75
Mental Health (biological based)	-
Office visits	\$20
Inpatient Admission	\$150 per Admission
Mental Health (non-biological based)	-
Office visits	\$20
Inpatient Admission	\$150 per admission
Substance Abuse	
Outpatient Office Visits and rehabilitation	\$20
Outpatient detoxification	\$20

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EVIDENCE OF COVERAGE

Inpatient Admission (rehabilitation)	\$150 per admission
Inpatient Admission (detoxification)	\$150 per admission
Rehabilitation Services	
Cardiac Rehabilitation	\$25
Home Health Care	\$0
Inpatient Rehabilitation Services	
Skilled Nursing Facility (Up to 100 days per benefit year)	\$150 per admission
Inpatient Rehabilitation or Chronic Disease Hospital (Up to 60 days per benefit year)	\$150 per admission
Short-term outpatient rehabilitation (Physical and Occupational Therapy limited to a combined 60 visits per benefit year; Speech Therapy no limits other than medical necessity)	\$25
Other Benefits	
Ambulance (Emergency covered. Non-emergent covered only when prior authorized.)	\$0
Durable Medical Equipment, Supplies, Prosthetics, Orthotics, Oxygen & Respiratory Therapy Equipment. <ul style="list-style-type: none"> • Combined limit of \$1,000 per benefit year • No limit for DME provided during Home Health Service. • No limit on Diabetic Supplies. 	\$0
Hospice	\$0
Routine foot care (for diabetics)	\$0
Vision (exam and glasses every 12 months)	\$30
Wellness (Family Planning, Nutritional Counseling, Prenatal, Nurse Midwife)	\$0

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Silver High

Annual Out-of-Pocket Expenses per benefit year	Maximum amount
Per Person	\$2,000
Family total	\$4,000
Annual Deductible	Maximum amount
Per person	None
Family total	None

Covered Benefit	Co-Payment
Outpatient Medical Care	
Community Health Center Visits (Primary Care and Specialist) *No Copayment for adult routine physical, annual GYN exam and well-child care.	\$25/\$25
Office Visits (PCP/Specialists) *No Copayment for adult routine physical, annual GYN exam and well-child care.	\$25/\$25
Outpatient Surgery (Hospital and Ambulatory Surgery Centers)	\$500 per surgery
Diagnostic X-rays/Labs	\$0/\$0
Diagnostic CT/MRI/MRA/PET scan	\$75/\$75/\$75/\$75
Nuclear Cardiac Imaging	\$75
Inpatient Medical and Maternity Care	\$500 per admission
Prescription Drugs	
Medication via Pharmacy (1 month supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* \$15 •Preferred - 50% co-insurance •Non-preferred - 50% co-insurance
Medication via Mail Order (90 day supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* \$30 •Preferred 50% co-insurance •Non-preferred 50% co-insurance
Emergency Care (waived if admitted)	\$100
Mental Health (biological based)	-
Office visits	\$25
Inpatient Admission	\$500 per admission
Mental Health (non-biological based)	-
Office visits	\$25
Inpatient Admission	\$500 per admission
Substance Abuse	
Outpatient Office Visits and rehabilitation	\$25

Member Services Department 1-866-895-1786 (TDD/TTY) 1-866-614-1949
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EVIDENCE OF COVERAGE

Outpatient detoxification	\$25
Inpatient Admission (rehabilitation)	\$500 per admission
Inpatient Admission (detoxification)	\$500 per admission
Rehabilitation Services	
Cardiac Rehabilitation	\$25
Home Health Care	\$0
Inpatient Rehabilitation Services	
Skilled Nursing Facility (Up to 100 days per benefit year)	\$500 per admission
Inpatient Rehabilitation or Chronic Disease Hospital (Up to 60 days per benefit year)	\$500 per admission
Short-term outpatient rehabilitation (Physical and Occupational Therapy limited to a combined 60 visits per benefit year; Speech Therapy no limits other than medical necessity)	\$25
Other Benefits	
Ambulance (Emergency covered. Non-emergent covered only when prior authorized.)	\$0
Durable Medical Equipment, Supplies, Prosthetics, Orthotics, Oxygen & Respiratory Therapy Equipment. <ul style="list-style-type: none"> • Combined limit of \$1,000 per benefit year • No limit for DME provided during Home Health Service. • No limit on Diabetic Supplies. 	\$0
Hospice	\$0
Routine foot care (for diabetics)	\$0
Vision (exam and glasses every 12 months)	\$25
Wellness (Family Planning, Nutritional Counseling, Prenatal, Nurse Midwife)	\$0

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EVIDENCE OF COVERAGE

Silver Medium

Annual Out-of-Pocket Expenses per benefit year	Maximum amount
Per Person	\$2,000
Family total	\$4,000
Annual Deductible	Maximum amount
Per person	\$500
Family total	\$1000

Covered Benefit	Co-Payment
Outpatient Medical Care	
Community Health Center Visits (Primary Care and Specialist) *No Copayment for adult routine physical, annual GYN exam and well-child care.	\$20/\$20
Office Visits (PCP/Specialists) *No Copayment for adult routine physical, annual GYN exam and well-child care.	\$20/\$20
Outpatient Surgery (Hospital and Ambulatory Surgery Centers)	Deductible, then \$0
Diagnostic X-rays/Labs	Deductible, then \$0
Diagnostic CT/MRI/MRA/PET scan	Deductible, then \$0
Nuclear Cardiac Imaging	Deductible, then \$0
Inpatient Medical and Maternity Care	Deductible, then \$0
Prescription Drugs	
Medication via Pharmacy (1 month supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* \$15 •Preferred \$35 •Non-preferred \$60
Medication via Mail Order (90 day supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* \$30 •Preferred \$70 •Non-preferred \$120
Emergency Care (waived if admitted)	\$100
Mental Health (biological based)	-
Office visits	\$20
Inpatient Admission	Deductible, then \$0
Mental Health (non-biological based)	-
Office visits	\$20
Inpatient Admission	Deductible, then \$0
Substance Abuse	
Outpatient Office Visits and rehabilitation	\$20
Outpatient detoxification	\$20
Inpatient Admission (rehabilitation)	Deductible, then \$0
Inpatient Admission (detoxification)	Deductible, then \$0

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EVIDENCE OF COVERAGE

Rehabilitation Services	
Cardiac Rehabilitation	Deductible, then \$0
Home Health Care	\$0
Inpatient Rehabilitation Services	
Skilled Nursing Facility (Up to 100 days per benefit year)	Deductible, then \$0
Inpatient Rehabilitation or Chronic Disease Hospital (Up to 60 days per benefit year)	Deductible, then \$0
Short-term outpatient rehabilitation (Physical and Occupational Therapy limited to a combined 60 visits per benefit year; Speech Therapy no limits other than medical necessity)	Deductible, then \$20
Other Benefits	
Ambulance (Emergency covered. Non-emergent covered only when prior authorized.)	Deductible, then \$0
Durable Medical Equipment, Supplies, Prosthetics, Orthotics, Oxygen & Respiratory Therapy Equipment. <ul style="list-style-type: none"> • Combined limit of \$1,000 per benefit year • No limit for DME provided during Home Health Service • No limit on Diabetic Supplies. 	Deductible, then \$0 (\$15 for Diabetic Supplies
Hospice	\$0
Routine foot care (for diabetics)	\$0
Vision (exam and glasses every 12 months)	\$20
Wellness (Family Planning, Nutritional Counseling, Prenatal, Nurse Midwife)	\$0

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EVIDENCE OF COVERAGE

Silver Low

Annual Out-of-Pocket Expenses per benefit year	Maximum amount
Per Person	\$2,000
Family total	\$4,000
Annual Deductible	Maximum amount
Per person	\$1,000
Family total	\$2,000

Covered Benefit	Co-Payment
Outpatient Medical Care	
Community Health Center Visits (Primary Care and Specialist) *No Copayment for adult routine physical, annual GYN exam and well-child care.	\$20/\$20
Office Visits (PCP/Specialists) *No Copayment for adult routine physical, annual GYN exam and well-child care.	\$20/\$20
Outpatient Surgery (Hospital and Ambulatory Surgery Centers)	Deductible, then \$0
Diagnostic X-rays/Labs	Deductible, then \$0
Diagnostic CT/MRI/MRA/PET scan	Deductible, then \$0
Nuclear Cardiac Imaging	Deductible, then \$0
Inpatient Medical and Maternity Care	Deductible, then \$0
Prescription Drugs	
Medication via Pharmacy (1 month supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* \$15 •Preferred \$30 •Non-preferred \$50
Medication via Mail Order (90 day supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* \$30 •Preferred \$60 •Non-preferred \$150
Emergency Care (waived if admitted)	Deductible, then \$100
Mental Health (biological based)	-
Office visits	\$20
Inpatient Admission	Deductible, then \$0
Mental Health (non-biological based)	-
Office visits	\$20
Inpatient Admission	Deductible, then \$0
Substance Abuse	
Outpatient Office Visits and rehabilitation	\$20
Outpatient detoxification	\$20
Inpatient Admission (rehabilitation)	Deductible, then \$0
Inpatient Admission (detoxification)	Deductible, then \$0

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EVIDENCE OF COVERAGE

Rehabilitation Services	
Cardiac Rehabilitation	Deductible, then \$0
Home Health Care	\$0
Inpatient Rehabilitation Services	
Skilled Nursing Facility (Up to 100 days per benefit year)	Deductible, then \$0
Inpatient Rehabilitation or Chronic Disease Hospital (Up to 60 days per benefit year)	Deductible, then \$0
Short-term outpatient rehabilitation (Physical and Occupational Therapy limited to a combined 60 visits per benefit year; Speech Therapy no limits other than medical necessity)	Deductible, then \$20
Other Benefits	
Ambulance (Emergency covered. Non-emergent covered only when prior authorized.)	Deductible, then \$0
Durable Medical Equipment, Supplies, Prosthetics, Orthotics, Oxygen & Respiratory Therapy Equipment. <ul style="list-style-type: none"> • Combined limit of \$1,000 per benefit year. • No limit for DME provided during Home Health Service. • No limit on Diabetic Supplies. 	Deductible, then \$0 \$15 for Diabetic Supplies
Hospice	\$0
Routine foot care (for diabetics)	\$0
Vision (exam and glasses every 12 months)	\$20
Wellness (Family Planning, Nutritional Counseling, Prenatal, Nurse Midwife)	\$0

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Bronze High

Annual Out-of-Pocket Expenses per benefit year	Maximum amount
Per Person	\$5,000
Family total	\$10,000
Annual Deductible	Maximum amount
Per person	\$250
Family total	\$500
Prescription Drug (For Retail and Mail Order Preferred and Non-preferred)	\$250 per individual, \$500 per family

Covered Benefit	Co-Payment
Outpatient Medical Care	
Community Health Center Visits (Primary Care and Specialist) *No Copayment for adult routine physical, annual GYN exam and well-child care.	\$25/\$40
Office Visits (PCP/Specialists) *No Copayment for adult routine physical, annual GYN exam and well-child care.	\$25/\$40
Outpatient Surgery (Hospital and Ambulatory Surgery Centers)	Deductible, then 35% coinsurance
Diagnostic X-rays/Labs	Deductible, then 35% co-insurance
Diagnostic CT/MRI/MRA/PET scan	Deductible, then 35% co-insurance
Nuclear Cardiac Imaging	Deductible, then 35% co-insurance
Inpatient Medical and Maternity Care	Deductible, then 35% co-insurance
Prescription Drugs	
Medication via Retail Pharmacy (1 month supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* \$15 •Preferred – RX deductible, then 50% co-insurance •Non-preferred - RX deductible, then 50% co-insurance
Medication via Mail Order (90 day supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* \$30 •Preferred - RX deductible, then 50% co-insurance •Non-preferred- RX deductible, then 50% co-insurance

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EVIDENCE OF COVERAGE

Emergency Care (waived if admitted)	\$150
Mental Health (biological based)	-
Office visits	\$25
Inpatient Admission	Deductible, then 35% coinsurance
Mental Health (non-biological based)	-
Office visits	\$25
Inpatient Admission	Deductible, then 35% coinsurance
Substance Abuse	
Outpatient Office Visits and rehabilitation	\$25
Outpatient detoxification	\$25
Inpatient Admission (rehabilitation)	Deductible, then 35% coinsurance
Inpatient Admission (detoxification)	Deductible, then 35% coinsurance
Rehabilitation Services	
Cardiac Rehabilitation	Deductible, then 35% coinsurance
Home Health Care	\$0
Inpatient Rehabilitation Services	
Skilled Nursing Facility (Up to 100 days per benefit year)	Deductible, then 35% coinsurance
Inpatient Rehabilitation or Chronic Disease Hospital (Up to 60 days per benefit year)	Deductible, then 35% coinsurance
Short-term outpatient rehabilitation (Physical and Occupational Therapy limited to a combined 60 visits per benefit year; Speech Therapy no limits other than medical necessity)	Deductible, then 35% coinsurance
Other Benefits	
Ambulance (Emergency covered. Non-emergent covered only when prior authorized.)	Deductible, then 35% co-insurance
Durable Medical Equipment, Supplies, Prosthetics, Orthotics, Oxygen & Respiratory Therapy Equipment. <ul style="list-style-type: none"> • Combined limit of \$1,000 per benefit year. • No limit for DME provided during Home Health Service. • No limit for Diabetic Supplies. 	Deductible, then 35% coinsurance \$15 for Diabetic Supplies
Hospice	\$0
Routine foot care (for diabetics)	\$0
Vision (exam and glasses every 12 months)	\$15
Wellness (Family Planning, Nutritional Counseling, Prenatal, Nurse Midwife)	\$0

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Bronze Medium

Annual Out-of-Pocket Expenses per benefit year	Maximum amount
Per Person	\$5,000
Family total	\$10,000
Annual Deductible	Maximum amount
Per person	\$2,000
Family total	\$4,000
Prescription Drug (For Retail and Mail Order Preferred and Non-preferred)	\$250 per individual, \$500 per family

Covered Benefit	Co-Payment
Outpatient Medical Care	
Community Health Center Visits (Primary Care and Specialist) *No Copayment for adult routine physical, annual GYN exam and well-child care.	\$30/\$45
Office Visits (PCP/Specialists) *No Copayment for adult routine physical, annual GYN exam and well-child care.	\$30/\$45
Outpatient Surgery (Hospital and Ambulatory Surgery Centers)	Deductible, then \$250 per surgery
Diagnostic X-rays/Labs	Deductible, then \$0
Diagnostic CT/MRI/MRA/PET scan	Deductible, then \$0
Nuclear Cardiac Imaging	Deductible, then \$0
Inpatient Medical and Maternity Care	Deductible, then \$500 per admission
Prescription Drugs	
Medication via Pharmacy (1 month supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* \$10 •Preferred-RX deductible, then \$30 •Non-preferred-RX deductible, then \$50
Medication via Mail Order (90 day supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* \$20 •Preferred RX deductible, then \$60 •Non-preferred RX deductible, then \$90
Emergency Care (waived if admitted)	Deductible, then \$150

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EVIDENCE OF COVERAGE

Mental Health (biological based)	-
Office visits	\$30
Inpatient Admission	Deductible, then \$500 per admission
Mental Health (non-biological based)	-
Office visits	\$30
Inpatient Admission	Deductible, then \$500 per admission
Substance Abuse	
Outpatient Office Visits and rehabilitation	\$30
Outpatient detoxification	\$30
Inpatient Admission (rehabilitation)	Deductible, then \$500 per admission
Inpatient Admission (detoxification)	Deductible, then \$500 per admission
Rehabilitation Services	
Cardiac Rehabilitation	Deductible, then \$30
Home Health Care	\$0
Inpatient Rehabilitation Services	
Skilled Nursing Facility (Up to 100 days per benefit year)	Deductible, then \$500 per admission
Inpatient Rehabilitation or Chronic Disease Hospital (Up to 60 days per benefit year)	Deductible, then \$500 per admission
Short-term outpatient rehabilitation (Physical and Occupational Therapy limited to a combined 60 visits per benefit year; Speech Therapy no limits other than medical necessity)	Deductible, then \$30
Other Benefits	
Ambulance (Emergency covered. Non-emergent covered only when prior authorized.)	Deductible, then \$0
Durable Medical Equipment, Supplies, Prosthetics, Orthotics, Oxygen & Respiratory Therapy Equipment. <ul style="list-style-type: none"> • Combined limit of \$1,000 per benefit year. • No limit for DME provided during Home Health Service. • No limit on Diabetic Supplies 	Deductible, then \$0 \$10 for Diabetic Supplies
Hospice	\$0
Routine foot care (for diabetics)	\$0
Vision (exam and glasses every 12 months)	\$30
Wellness (Family Planning, Nutritional Counseling, Prenatal, Nurse Midwife)	\$0

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Bronze Low

Annual Out-of-Pocket Expenses per benefit year	Maximum amount
Per Person	\$5,000
Family total	\$10,000
Annual Deductible	Maximum amount
Per person	\$2,000
Family total	\$4,000

Covered Benefit	Co-Payment
Outpatient Medical Care	
Community Health Center Visits (Primary Care and Specialist) *No Copayment for adult routine physical, annual GYN exam and well-child care.	Deductible then \$25/ Deductible then \$25
Office Visits (PCP/Specialists) *No Copayment for adult routine physical, annual GYN exam and well-child care.	Deductible then \$25/ Deductible then \$25
Outpatient Surgery (Hospital and Ambulatory Surgery Centers)	Deductible, then 20% coinsurance
Diagnostic X-rays/Labs	Deductible, then 20% coinsurance
Diagnostic CT/MRI/MRA/PET scan	Deductible, then 20% coinsurance
Nuclear Cardiac Imaging	Deductible, then 20% coinsurance
Inpatient Medical and Maternity Care	Deductible, then 20% coinsurance
Prescription Drugs	
Medication via Pharmacy (1 month supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* Deductible, then \$15 •Preferred- Deductible, then 50% coinsurance •Non-preferred- Deductible, then 50% coinsurance
Medication via Mail Order (90 day supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	<ul style="list-style-type: none"> •Generic* Deductible, then \$30 •Preferred Deductible, then 50% coinsurance

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EVIDENCE OF COVERAGE

	•Non-preferred Deductible, then 50% coinsurance
Emergency Care (waived if admitted)	Deductible, then \$100
Mental Health (biological based)	-
Office visits	Deductible, then \$25
Inpatient Admission	Deductible, then 20% coinsurance
Mental Health (non-biological based)	-
Office visits	Deductible, then \$25
Inpatient Admission	Deductible, then 20% coinsurance
Substance Abuse	
Outpatient Office Visits and rehabilitation	Deductible, then \$25
Outpatient detoxification	Deductible, then \$25
Inpatient Admission (rehabilitation)	Deductible, then 20% coinsurance
Inpatient Admission (detoxification)	Deductible, then 20% coinsurance
Rehabilitation Services	
Cardiac Rehabilitation	Deductible, then 20% coinsurance
Home Health Care	\$0
Inpatient Rehabilitation Services	
Skilled Nursing Facility (Up to 100 days per benefit year)	Deductible, then 20% coinsurance
Inpatient Rehabilitation or Chronic Disease Hospital (Up to 60 days per benefit year)	Deductible, then 20% coinsurance
Short-term outpatient rehabilitation (Physical and Occupational Therapy limited to a combined 60 visits per benefit year; Speech Therapy no limits other than medical necessity)	Deductible, then 20% coinsurance
Other Benefits	
Ambulance (Emergency covered. Non-emergent covered only when prior authorized.)	Deductible, then 20% coinsurance
Durable Medical Equipment, Supplies, Prosthetics, Orthotics, Oxygen & Respiratory Therapy Equipment. <ul style="list-style-type: none"> • Combined limit of \$1,000 per benefit year. • No limit for DME provided during Home Health Service. • No limit on Diabetic Supplies. 	Deductible, then 20% coinsurance Deductible, then \$15 for Diabetic Supplies
Hospice	\$0
Routine foot care (for diabetics)	\$0

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EVIDENCE OF COVERAGE

Vision (exam and glasses every 12 months)	\$25
Wellness (Family Planning, Nutritional Counseling, Prenatal, Nurse Midwife)	\$0

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COVERED SERVICES DESCRIPTION

CeltiCare provides coverage for a broad range of medically necessary medical and behavioral health services to meet your healthcare needs. For a service to be covered and eligible for reimbursement, the service must be described in this section, prescribed by your treating provider or Primary Care Provider, and authorized by CeltiCare when prior authorization is required.

Please refer to the CeltiCare **Specific Plan Benefit Descriptions** and the **Excluded Benefits** sections of this manual for applicable co-payments, deductible, and exclusions. Certain services require your provider to obtain authorization prior to the rendering or delivery of the service. These include but are not limited to services or visits to a non-participating provider, certain surgical procedures, and inpatient admissions. If you would like to obtain or verify the status of a service needing authorization you may contact CeltiCare Member Services at 1-866-895-1786. Additional information regarding authorizations can be found in the **Prior Authorization for Services** section of this manual.

MEDICAL SERVICES

Abortion: The voluntary termination of pregnancy (abortion) is covered, only as permitted under Massachusetts law (i.e. within a certain period of time following conception for defined circumstances), without authorization when performed by a CeltiCare participating reproductive health facility or provider. Abortion services by a non-participating provider require authorization from CeltiCare. **Please contact your physician or CeltiCare Member Services at 1-866-895-1786 for assistance. Our bilingual staff is available 24/7 to assist you in finding a provider of these services. You may also search our online www.celticarehealthplan.com provider directory for a listing of providers that perform these services. We can arrange for transportation if timing is critical.** Your co-payment, deductible or coinsurance will be based on the location of the services (i.e. Specialist office, Clinic, Outpatient Surgery, Inpatient). Refer to the **Specific Benefit Plan Descriptions** for applicable co-payment, deductible or coinsurance information.

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

Non-emergency ambulance transportation to transport you from one facility to another facility may be covered (with applicable co-pays, deductible or coinsurance) if medically necessary and authorized by CeltiCare. Transportation is not covered to or from medical appointments, via ambulance, taxi, chair lift or public transportation.

Cancer Clinical Trials: Coverage is provided for patient care services furnished pursuant to qualified clinical trial to the same extent as they would be covered and reimbursed if the patient did not receive care in a qualified clinical trial.

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

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

Diabetic Service and Supplies: Medically Necessary services and supplies used in the treatment of diabetes are covered when prescribed by and obtained by a participating provider and/or when necessary with appropriate authorization from CeltiCare. Covered services and supplies include but are not limited to exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self management equipment and supplies such as urine and/or ketone strips, blood glucose monitor including supplies (glucose strips) for the device, and syringes or needles; orthotics and diabetic shoes, educational health and nutritional counseling for self management, eye examinations, and prescription medication. Please refer to the **Pharmacy** section of this manual for information on prescription drugs, including insulin pens, insulin and oral medications and other diabetic supplies. Please refer to the DME section for additional information. Your provider may need to obtain authorization from CeltiCare for certain DME items, diagnostic testing, and services by a nonparticipating provider.

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

If you are planning on traveling temporarily out of the area, CeltiCare will cover up to 30 days for out of service area dialysis. Services must be authorized in advance by your provider.

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

Durable Medical Equipment (DME) and Supplies: CeltiCare covers DME and supplies (including oxygen and respiratory equipment and supplies) that is needed to fulfill a medical purpose, is not useful in the absence of illness or injury, is appropriate for home use, and appropriate authorization has been obtained by CeltiCare for the rental, purchase, replacement and/or repair (less any applicable co-payments, deductibles or coinsurance). There is no limit for DME provided during a Home Health Visit or for Insulin Pumps or Insulin Pump Supplies. Coverage is limited to the least costly DME adequate to allow engagement in activities of daily living. If CeltiCare determines a less costly DME exists to meet the needs, the member may be responsible for costs above and beyond the amount for the less costly device. Certain DME requires prior authorization from CeltiCare by your provider.

The following Diabetic Supplies are considered DME equipment and supplies and are subject to the applicable co-payments, deductibles or coinsurance as noted in the Specific Benefit Plan for DME: voice synthesizers, glucose monitors, visual magnifying aids, insulin pumps, insulin pump supplies. There is no benefit limit for these Diabetic Supplies.

Early Intervention Services: CeltiCare covers all medically necessary care related to early intervention services including occupational, physical and speech therapy, nursing care and psychological counseling, delivered by certified early intervention specialists, for dependents from birth until their third birthday.

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

Enteral formulas and Low Protein Foods: Non-prescription enteral formula or special medical formulas or low protein food products (low protein is limited to \$5000 per benefit year) are covered when ordered by your physician, and

- Medically necessary to treat
 - Malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction; or
 - Inherited diseases of amino acids and organic acids
 - Phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic academia, or methylmalonic academia
- Or;

- Medically necessary to protect the unborn fetuses of pregnant women with phenylketonuria.

Extended Care Facility - Skilled Nursing, Rehabilitation, and Chronic Disease Facilities:

Care in an extended facility is covered when medically necessary for up to the day limits outlined in the **Specific Benefit Plan** (less any applicable co-payments, deductible or coinsurance). The extended care facility is required to obtain authorization from CeltiCare prior to the admission.

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

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

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

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

The following services **are not** considered Family Planning related services:

- Abortion
- Reversal of voluntary sterilization
- Infertility Services- any services, supplies or drugs related to the diagnosis or treatment of infertility

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- Services or fees related to using a surrogate to achieve pregnancy.
- Birth control devices, agents or preparations that by law do not require a prescription (except when given to you by a network provider during an office visit)

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

- A physician certifies:
 - service(s) are medically necessary
 - you are homebound and not able leave your residence or leaving your residence to receive care and/or services requires substantial effort
 - services are part of your individual plan of care with defined medical goals
- Prior authorization is obtained from CeltiCare by your provider

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

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

Home health services provided in a hospital, nursing facility, intermediate care facility for the mentally retarded, or any other institutional facility providing medical, nursing, rehabilitative, or related care are not covered by CeltiCare.

Homemaker, respite, heavy cleaning or household repairs are not covered home healthcare services.

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

Hospice: Hospice is care designed to provide palliative and supportive care to a member with a terminal illness (and related conditions) and their family. A terminal illness is a condition in which the member has a medical prognosis of a life expectancy of six months or less.

Services covered under hospice are coordinated by a specialized multidisciplinary team and include skilled nursing, medical social services, physician services, counseling services, bereavement counseling, nutritional counseling, spiritual counseling, physical

therapy, occupational therapy, speech therapy, home maker, home health aide, drugs, durable medical equipment and supplies, and short term inpatient care.

To receive coverage for hospice, the following is required:

- A determination by your physician you have a terminal illness and you have a life expectancy of six months or less
- Prior authorization obtained from CeltiCare by your provider

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

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

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

Infertility Treatment: Coverage is provided for the diagnosis or treatment of infertility, including, but not limited to diagnostic procedures or testing; oral and injectable drug therapy (CeltiCare does not impose exclusions, limitations or other restrictions on coverage for infertility-related drugs that are different from those imposed on any other prescription drugs.); artificial insemination; egg and inseminated egg procurement and placement; in-vitro fertilization; gamete or zygote intra-fallopian transfers; intracytoplasmic sperm injection; sperm cryopreservation, preparation or thawing, evaluation or storage; banking of sperm or inseminated eggs.

Laboratory Services: CeltiCare covers medically necessary diagnostic testing in an office, outpatient hospital, or independent diagnostic or laboratory facility (less any applicable co-payments, deductible or coinsurance). Certain diagnostic tests require your provider to obtain authorization prior to the services being rendered such as breast, ovarian, colorectal, or melanoma genetic testing.

Maternity Services: CeltiCare covers outpatient and inpatient pre and postpartum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and hospital stays for delivery or other medically necessary reasons (less any applicable co-payments, deductible or coinsurance). An inpatient stay is covered for at least 48 hours following a vaginal delivery and for at least 96 hours following a caesarean delivery. CeltiCare also covers one home healthcare visit following your delivery by a registered nurse, physician, or nurse midwife and additional home

healthcare visits if medically necessary. Other maternity benefits include, parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.

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

Neuropsychological Assessment Services: These services will be covered in a manner identical to all other medical services.

Newborn/Dependent Care: Care and treatment of medically diagnosed congenital defects, birth abnormalities or premature birth.

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

Off-label uses of prescription drugs for cancer and HIV/AIDS: CeltiCare will cover drugs for the treatment of cancer or HIV/AIDS treatment when the off-label use of the drug has not been approved by the federal food and drug administration (FDA) for that indication, if the drug is recognized for treatment of the condition in one of the standard reference compendia, or in the medical literature, or by the State of Massachusetts Insurance Commissioner under the provisions of section forty-seven P of MGL 175; unless contraindicated by the FDA for the treatment of the condition it will be used. Your provider is required to obtain prior authorization from CeltiCare for the off label use of drugs for cancer and HIV/AIDS treatment.

Note: If your Specific Health Benefit Plan does not include a Pharmacy Benefit, prescription drug coverage as described above for cancer and HIV/AIDS is not a covered benefit.

Office visits: Office visits to see your participating CeltiCare primary care provider (PCP) or a specialist is covered (less any applicable co-payments, deductible or coinsurance). Your PCP may need to obtain an authorization from CeltiCare for office visits or services by certain specialist providers prior to the visit or services being rendered.

Orthotics: Non-dental braces and other mechanical or molded devices are covered by CeltiCare when medically necessary to support or correct any defects of form or function of the human body due to surgery, disease or injury. Arch supports, shoe inserts, therapeutic and molded shoes (not attached to a brace) and inserts are

covered for diabetics only. Certain orthotic devices require authorization by your provider from CeltiCare prior to receiving related orthotic services. Orthotics are covered less any applicable copayment, deductible or coinsurance.

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

Preventive Health Care Services: Routine exams and services performed by your primary care, obstetric, family, nurse, or other qualified participating practitioner to keep you healthy are covered by CeltiCare. Preventive healthcare services include but are not limited to general health and/or annual gynecological exams, immunizations, laboratory and radiology diagnostic testing, hearing exam and/or screening, cytologic (PAP smear) screening, health education, nutritional counseling and mammography (at least a baseline mammogram for women between the ages of thirty-five and forty; a mammogram on an annual basis for women forty years of age and older),. Adult preventive health care visits are limited to one visit during the benefit year.

Preventive and Primary Health Care Services for Children: CeltiCare covers the following services to the dependent child of an insured member from the date of birth through attainment of six (6) years of age:

- Physical exam, history, measurements, sensory screening, neuropsychiatric evaluation and development screening, and assessment at the following intervals
 - Six (6) times during the child's first year after birth
 - Three (3) times during the next year
 - Annually until age six (6).
- Hereditary and metabolic screening at birth
- Newborn Hearing screening test prior to discharge from the hospital or birthing center
- Immunizations, tuberculin tests, hematocrit, hemoglobin, blood lead screening or other blood tests and urinalysis as recommended by the physician

These preventive health care services for children are comparable to the Massachusetts Health Quality Partners' (MHQP") Preventive Care recommendations and guidelines [refer to 956 CMR 5.03((2))((h)2)].

Prosthetics: CeltiCare covers prosthetic devices including evaluation, fabrication, and fitting from a participating provider when prior authorized by CeltiCare by your treating provider. Scalp hair prosthetics (wigs) worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia is covered. Coverage for scalp hair prosthesis is limited to a maximum coverage amount of \$350.00 per benefit year.

Psychopharmacological Services: This benefit will be covered in a manner identical to all other medical services.

Radiation and Chemotherapy: Radiation and/or chemotherapy are covered when services are provided by a CeltiCare participating provider.

Radiology Services: CeltiCare covers medically necessary diagnostic testing in an office, outpatient hospital, or independent diagnostic or laboratory facility (less any applicable co-payments, deductible or coinsurance). Certain diagnostic imaging procedures require your provider to obtain authorization from CeltiCare prior to the services being rendered such as CT, MRI, PET, and cardiac nuclear scans.

Therapy – Outpatient Physical, Occupational, and Speech Therapy: CeltiCare covers short term physical, occupational, and/or speech therapy in an office, outpatient hospital, or free standing outpatient rehabilitation facility when received through a participating provider and authorization obtained from CeltiCare by your treating provider. Physical therapy and occupational therapy have a combined benefit limit of 60 visits per benefit year. Speech Therapy does not have a visits or dollar benefit limit. Covered therapy services include diagnostic evaluation and therapeutic intervention that are designed to improve, develop, correct, rehabilitate, or prevent the worsening of functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries.

Physical therapy emphasizes a form of rehabilitation focused on treatment of dysfunctions involving neuromuscular, musculoskeletal, cardiovascular/pulmonary, or integumentary systems through the use of therapeutic interventions to optimize functioning levels.

Occupational therapy programs are designed to improve quality of life by recovering competence and preventing further injury or disability, and to improve the individual's ability to perform tasks required for independent functioning, so that the individual can engage in activities of daily living.

Speech, hearing and language disorders are those that affect articulation of speech, sounds, fluency, voice, swallowing (regardless of presence of a communication disability), and those that impair comprehension, spoken, written, or other symbol systems used for communication.

Substance Abuse Services: See **Behavioral Health Services** section.

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

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

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

BEHAVIORAL HEALTH SERVICES

Mental Health and Substance Abuse Services

All mental health and substance abuse benefits are provided on a non-discriminatory basis to all enrollees for the diagnosis and medically necessary and active treatment of mental, emotional and substance use disorders as described in the most recent edition of the DSM, that are scientifically recognized and approved by the commissioner of mental health in consultation with the commissioner of the Division of Insurance. Deductible, co-payments and treatment limits for behavioral health services will be applied in the same manner as physical health services.

If you need Behavioral Health Services, CeltiCare works with Cenpatico Behavioral Health (Cenpatico) to deliver the appropriate services. Cenpatico manages CeltiCare's behavioral health program. You may choose any Provider in Cenpatico's behavioral health network and do not need a referral from your PCP.

Inpatient, Intermediate and Outpatient Mental Health and Substance Abuse services are covered in accordance with medical necessity and may be subject to pre-authorization. Cenpatico's medical necessity guidelines are based on currently accepted standards of practice and are reviewed, updated as needed and approved at least annually by a panel of qualified practitioners. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not medically necessary will be made by a qualified licensed mental health professional. The medical necessity guidelines are available upon request and are published on our website at www.cenpatico.com.

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

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

Intermediate Mental Health and Substance Abuse Services: Non-inpatient services that provide more intensive and extensive treatment interventions when outpatient services alone are not sufficient to meet the patient's needs.

Outpatient Mental Health and Substance Abuse Services: Services provided in person in an ambulatory care setting. Outpatient services may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office or home-based services. Such services delivered in such offices or settings are to be rendered by a licensed mental health professional (a licensed physician who specializes in the

practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist) acting within the scope of his/her license.

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

Covered services requiring authorization include:

- Inpatient hospitalization for mental health or substance abuse
- Observation Bed
- Crisis Stabilization Unit
- Community Based Residential Treatment Programs (CBAT)
- Partial Hospitalization
- Day Treatment
 - Intensive Outpatient Treatment
 - Adult Day Treatment
 - Family Stabilization Team
 - Community Support Services
 - Electroconvulsive Therapy (ECT)
 - Structured Outpatient Addiction Program (SOAP)
 - Psychological and Neuropsychological Testing
 - Methadone Services
 - Outpatient office visits for evaluation and treatment (individual, family or group therapy). No prior authorization is required for the first 12 visits.
 - Medication management visits do not require prior authorization for participating providers
 - Cenpatico will offer benefits on a non-discriminatory basis for individuals seeking treatment following any type of assault or violent act that has caused mental or emotional distress.
 - Diagnosis and treatment of the following biologically based mental disorders: schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, affective disorders, eating disorders, post traumatic stress disorder, substance abuse disorders and autism.
 - Children and Adolescents under the age of 19

- Diagnosis and treatment of non-biologically-based mental, behavioral or emotional disorders which substantially interfere with or limit the functioning and social interactions of a child or adolescent. Benefits may be provided if the ongoing course of treatment is completed beyond age 19.
- Mandated benefits beyond age 19 may be covered even if coverage continues under other benefit contracts.*
- Diagnosis and treatment of all other mental health disorders outlined in the **Specific Benefit Plan Descriptions**.
- Intermediate Services - These services include, but are not limited to, the following:
 - Acute and other residential treatment
 - Clinically managed detoxification services
 - Partial hospitalization
 - Intensive Outpatient Programs (IOP)
 - Day treatment
 - Crisis stabilization
 - In-home therapy services

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

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

VISION SERVICES

Routine Vision

Routine eye exams, prescriptions eyeglasses, and contact lenses are covered for all CeltiCare Health Plans and are managed through OptiCare. For information regarding your specific co-payments and/or deductible please refer to your specific plan information listed in the **Specific Plan Benefit Descriptions** section in this manual.

You may receive one routine eye exam and eyewear once every 12 months. Eyewear includes **either** one pair of eyeglasses **or** contacts.

- **Eyeglasses**

Covered lenses include single vision, lined bifocal, or lined trifocal, in glass or plastic. If you require a more complex prescription lens, contact OptiCare for prior authorization. Lens options such as progressive lenses, polycarbonate lenses, high index tints, UV and anti-reflective coating are not covered.

Your maximum allowance for eyeglass frames is \$75 every 12 months. OptiCare providers offer a wide range of frames that are at no cost to you.

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

- **Contact Lenses**

Coverage includes evaluation, fitting and contact lenses. If you elect contact lenses in lieu of glasses, your maximum allowance for contacts is \$75 every 12 months.

For additional information about covered vision services, participating OptiCare providers, call Member Services at 1-866-895-1786.

Non-Routine Vision

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

EXCLUDED BENEFITS

Services NOT Covered

Any services and benefits that are not described in the Covered Services section of this booklet are not covered. The following are examples of excluded services and benefits; this is not intended to be an exhaustive list:

Excluded Benefit	Description
Acupuncture	Benefit coverage is not provided for acupuncture unless authorized as part of a substance abuse program.
Alternative Medicine	Benefit coverage is not provided for alternative medicine includes but is not limited to homeopathy, naturopathy, traditional Chinese medicine, and Ayurveda.
Benefits from a Another Source	Benefit coverage is not provided for services and supplies to treat an illness or injury for which you have the right to benefits under government programs. These include services from the Veterans Administration for an illness or injury connected to military service, schools, or programs set up by other local, state, federal or foreign laws or regulations that provide or pay for healthcare services and supplies or that require care or treatment to be furnished in a public facility. No benefit coverage is provided if you could have received governmental benefits by applying for them on time. Additionally, no benefit coverage is provided for services which payment is required to be paid by a Workers' Compensation plan or an employer under state or federal law.
Biofeedback	Benefit coverage is not provided for biofeedback except if authorized for urinary incontinence.
Chiropractic Services	Benefit coverage is not provided for chiropractic services including but not limited to evaluation, treatment procedures, equipment, and supplies.
Commercial Diet Programs, Foods, and Supplements	Benefit coverage is not provided for commercial diet plans and foods (i.e. Jenny Craig, Weight Watchers, Seattle Sutton), weight loss or weight control programs and clinics, and any service related to such plans or programs (such as required foods or nutritional, vitamin, or mineral supplements).
Cosmetic Services and Procedures	No benefit coverage is provided for cosmetic surgery <i>unless</i> required to restore bodily function or correct a functional physical impairment following an accidental injury, prior surgical procedure, or congenital/birth defect. Benefit coverage is not provided for services performed solely for the purpose of making you look better and feel better about yourself or treat a mental condition. Such services include but are not limited to acne surgery, brachioplasty, hair removal or restoration, liposuction, panniculectomy, rhinoplasty, spider veins treatment, tattoo removal, teeth whitening or other cosmetic dental procedures, wrinkle treatment, vitiligo or melasma treatment.
Custodial and Personal Care Services	Benefit coverage is not provided for care that is furnished mainly to help a person with activities of daily living and does not require day-to-day attention by medically trained persons.

Dental Services	Benefit coverage is not provided for non-emergent dental services for all of CeltiCare's Health Benefit Plans. Non-emergent dental services include diagnostic, endodontic, exodontic, orthodontic, preventative, periodontal, or restorative dental services, and dentures. Benefit coverage is provided for all CeltiCare Health Benefit Plans for emergent/emergency dental services. Covered emergent/emergency dental services include treatment related to traumatic injury to sound, natural and permanent teeth caused by a source external to the mouth AND the emergency services are provided by a physician in a hospital emergency room or operating room within 48 hours of the injury. Services covered for emergent/emergency include x-rays and emergency oral surgery related to the repair of damaged tissues and/or the repositioning of displaced or fractured teeth.
Educational Evaluation, Testing, and Treatment Services	Benefit coverage is not provided for educational services or evaluations provided solely to enhance educational achievement (e.g. subject achievement testing or IQ testing); resolve problems regarding school performance; treat learning disabilities, behavior problems, and/or developmental delays; or are school based services to treat speech, language, and/or hearing disorders.
Excluded Service Locations	Benefit coverage is not provided for services provided to enrollees in jail, prison, a house of correctional or custodial facility or in long-term residential treatment
Exams and Services Required by a Third Party	Benefit coverage is not provided for physical, psychiatric and psychological examinations, testing, or other services required by a third party, including but not limited to employment, insurance, licensing, recreational or sport activities, and court-ordered or school ordered exams and drug testing that are not medically necessary, considered evaluations for work related performance, or are for paternity, forensic, or post-mortem purposes.
Exercise Equipment and Supplies	Benefit coverage is not provided for charges related to the use, rental, or purchase of exercise equipment and devices or related supplies such as but not limited to treadmills, weights, or other gym equipment.
Experimental or Investigational Procedures and Related Services	Benefit coverage is not provided for healthcare services that are received for or related to care that is determined by CeltiCare as or related to an experimental or investigational service or procedure. Benefit coverage may be provided for certain or all services provided pursuant to a qualified clinical trial if the services received are those that would normally be covered and reimbursed outside of a clinical trial and meet all other provisions related to your evidence of coverage and utilization review guidelines.
Foot Care	Benefit coverage is not provided for routine foot care services such as trimming of corns and calluses, trimming of nails, and other hygienic care; foot orthotics, arch supports, shoe inserts, fittings, castings and other services related to devices, or orthopedic or corrective shoes that are not part of a leg brace except when your care is Medically Necessary due to systemic circulatory diseases (such as diabetes).

Health Club Memberships and Personal Trainers	Benefit coverage is not provided for charges related for joining or the use of health clubs, gyms, sports clubs, related physical fitness facilities, or services provided by a personal trainer.
Hearing Aids	Benefit coverage is not provided for hearing aid devices and supplies, examinations to prescribe, or fittings.
Hypnotherapy and Hypnosis	Benefit coverage is not provided for hypnotherapy or hypnosis.
Infertility Treatment	Benefit coverage is not provided for services and fees related to achieving pregnancy through surrogate or reversal of voluntary sterilization.
Lodging and Transportation	Benefit coverage is not provided for lodging and non-emergent or unauthorized transportation associated with receiving medical services.
Massage Therapy	Benefit coverage is not provided for massage or relaxation therapy.
Maternity	Benefit coverage is not provided for routine maternity services including prenatal and postpartum care when you are traveling outside of the CeltiCare service area and/or are provided without CeltiCare authorization. Home births that are planned are not covered.
Non-participating Providers	Benefit coverage is not provided for services provided by a non-participating provider except those provided due to an emergency medical or mental health condition or prior authorized by CeltiCare.
Orthodontics	Benefit coverage is not provided for the prevention or correction of abnormally positioned or aligned teeth.
Other Non-Covered Services	Benefit coverage is not provided for: <ul style="list-style-type: none"> • Any service or supply that is not described as a Covered Benefit for your Health Benefit Plan. • Any service or supply that is not medically necessary except voluntary termination of pregnancy, voluntary sterilization, prescription contraceptive medications, and preventive health services. • A Provider's charge for shipping and handling or taxes. • Any service or supply that is not medically necessary. • A Provider's charge to file a claim. • A Provider's charge for copies of your medical records. • A Provider's charge for missed appointments. • Medications, devices, treatments and procedures that have not been demonstrated to be medically effective. • Routine or Maintenance Care when traveling outside the CeltiCare Service Area. • Services for which there would be no charge in the absence of insurance. • Special equipment needed for sports or job purposes. • Services or supplies provided by an immediate family member. • Services related or provided in conjunction with a non-covered service, such as professional fees, medical equipment, medications, and facility charges.

	<ul style="list-style-type: none"> • Services received when not enrolled with CeltiCare. • Services that can safely and effectively be obtained in a less intensive setting or level of care or for which a more cost-effective alternative exists.
Personal Comfort and Convenience Items or Services	<p>Benefit coverage is not provided for personal comfort or convenience items or services that are furnished for your personal care or for the convenience of your family. The following items are generally deemed personal comfort or convenience items:</p> <ul style="list-style-type: none"> • Air conditioners • Air purifiers • Bath/bathing equipment such as aqua massagers and turbo jets • Bed lifters that are not primarily medical in nature • Beds and mattresses and non-hospital type adjustable beds • Chair lifts • Computers and/or computer software • Computerized communication devices • Cushions, pads and pillows except those described as covered • Dehumidifiers • Elevators • Electronic or myoelectronic limbs • Heating pads and/or hot water bottles • Home type bed baths requiring installation • Hospital beds in full, queen and king sizes • Hygienic equipment that does not service a primary medical purpose • Non-medical equipment otherwise available to the member that does not serve a primary medical purpose • Private room charges greater than the rate for a semi-private room except when a private room is medically necessary. • Pulse tachometers • Replacement or repair of durable medical equipment, prosthetic, or orthotic devices due to loss, intentional damage, negligence, or theft. • Room humidifiers • Spare or back-up equipment • Special clothing except medically necessary equipment or devices such as gradient pressure support aids, mastectomy bras, stump socks, and therapeutic molded shoes for diabetic foot disease. • Whirlpool equipment generally used for soothing or comfort measures • Telephones, radios and televisions
Pre-implantation Genetic Testing	Benefit coverage is not provided for pre-implantation genetic testing or related services performed on gametes or embryos.
Private Duty Services	Benefit coverage is not provided for private duty services including but not limited to those provided by a nurse (Licensed Professional Nurse or Registered Nurse) nursing assistant, nursing aid, private care attendant, or personal care attendant.

Refractive Eye Surgery	Benefit coverage is not provided for eye surgery such as but not limited to laser surgery, radial keratotomy, and orthokeratology to treat conditions such as myopia, hyperopia, and astigmatism which can be corrected by means.
Respite care	Benefit coverage is not provided for respite care except when provided as part of a hospice program authorized by CeltiCare.
Reversal of Voluntary Sterilization	Benefit coverage is not provided for the reversal of any sterilization procedure.
Self-Monitoring Devices	Benefit coverage is not provided for self-monitoring devices except: <ul style="list-style-type: none"> • Blood glucose monitoring devices for members with diabetes (insulin dependent or non-insulin dependent) and gestational diabetes. • CeltiCare determines a device would give a member, having particular symptoms the ability to detect or stop the onset of a sudden life-threatening condition. • Peak flow meters used in the monitoring of asthma control, COPD or Emphysema.
Sexual/Gender Reassignment	Benefit coverage is not provided for sexual reassignment surgery (sex change or reversal of a sex change) and all related drugs and procedures.
Snoring Treatments and Procedures	Benefit coverage is not provided for the treatment or reduction of snoring such as laser-assisted uvulopalatoplasty, somnoplasty, and snore guards.
TMJ Syndrome	Benefit coverage is not provided for services to treat temporomandibular joint syndrome.

If you have questions about any of these services, call us. We can be reached at 1-866-895-1786 (TDD/TTY 1-866-614-1949). A Member Services Representative will help you understand your benefits.

HOW TO OBTAIN HEALTHCARE

Primary Care Provider (PCP)

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

Your PCP will:

- Make sure that you receive all medically necessary services in a timely manner.
- Follow-up on the care you receive from other medical providers.
- Take care of referrals for specialty care and services.
- Provide any ongoing care you need.
- Update your medical record, which includes keeping track of all the care that you get with your PCP and specialists.
- Accept you as a member, unless the office is full and closed to all new members.
- Provide services in the same manner for all patients.
- Give you regular physical exams as needed.
- Provide preventive care visits.
- Give you regular immunizations as needed.
- Make sure you can contact him/her or another provider at all times.
- Discuss what advance directives are and file the directive appropriately in your medical record.

Physician Profiling Information

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

Choosing Your PCP

The CeltiCare Provider Directory is available online at www.celticarehealthplan.com. The Provider Directory lists all participating PCPs along with their addresses, phone numbers and languages other than English the provider may speak. As a CeltiCare member, you have the freedom to choose any



Family Practice, General Practitioner, Internal Medicine or Nurse Practitioner provider for your PCP and female members may choose a participating Obstetrician/Gynecologist (OB/GYN) as a PCP that is listed in the CeltiCare Provider Directory. Should you receive services from a Nurse Practitioner your benefit coverage, co-payment or deductible amounts are the same as the coverage and co-payments listed for services provided by other in-network providers. Please refer to the Benefits section of this manual for covered service information and to your **Specific Benefit Plan Descriptions** for copayments, deductible or coinsurance requirements.

After you notify Member Services of your selection, you will receive a new ID card with the PCP's name on it.

If you want to know more about the PCP you'd like to select, please call Member Services. You may also see a list of network providers at www.celticarehealthplan.com.

Making an Appointment with Your PCP

Once you have selected a PCP, make an appointment to meet with your doctor. This will give you and your doctor a chance to get to know each other. Your doctor can give you medical care, advice and information about your health. To make an appointment with your PCP, you need to call your PCP's office. Remember to take your member ID card with you every time you go to the doctor's office. **If you have difficulty getting an appointment with or seeing your provider, please call Member Services at 1-866-895-1786.**

After Hours Appointments with Your PCP

You can call your PCP's office for information on receiving after hours care in your area. If you have a medical problem or question and cannot reach your PCP during normal office hours, you can call NurseWise, CeltiCare's 24 hour medical nurse line at 1-866-895-1786, option 7 to speak to a nurse. If you have an emergency, call 911 or go to the nearest emergency room.

NOTE: Except for emergency & family planning, all services must be obtained through CeltiCare network providers or prior authorized out-of-network providers.

IMPORTANT: If you cannot keep an appointment, please call the provider's office to cancel at least 24 hours in advance. If you need to change an appointment, call the provider's office as soon as possible. They can make a new appointment for you. If you need help getting an appointment, call Member Services.

Changing Your PCP

CeltiCare offers members the freedom of choice in choosing any primary care providers in our network. When you joined CeltiCare, you may have selected a PCP. If you did not, we assigned you to a PCP. If you decide you want to change your PCP, you can call Member Services at 1-866-895-1786. If you change your PCP, we will send you an updated ID card with your new PCP's name printed on it. If you need help changing a PCP or selecting a new PCP, call Member Services.

What to Do if Your Provider Leaves the CeltiCare Network

If your PCP is planning to leave the CeltiCare provider network, we will send you a notice at least 30 days before the disenrollment when your provider is scheduled to leave. We will automatically reassign you to another PCP and send you a new member ID card identifying your new PCP. You can also change your PCP by calling Member Services at 1-866-895-1786.

CeltiCare will permit members to continue to be covered for health services, consistent with the terms of this EOC, by the PCP for at least 30 days after the PCP is disenrolled. If you have been seeing a specialist who disenrolls with the CeltiCare provider Network, please call Member Services and we will work with you to ensure your care continues. We will assist you in locating another specialist within the network.

Continued coverage is conditional to the disenrolling PCP or specialist agreeing to:

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

Continuity and Transition of Care - New Members

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



EVIDENCE OF COVERAGE

If you are a new member in your second or third trimester of pregnancy when you enrolled with CeltiCare, you may continue to see your doctor until you have delivered your baby and completed your first post partum visit even if he or she is not contracted with CeltiCare and the provider's contract termination or disenrollment with CeltiCare is not for quality related reasons or for fraud. If you are a member who is terminally ill you may continue to see your doctor until death.

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

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

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

NOTE: If your specialist healthcare provider refers you to another specialist, your specialist may need to obtain authorization by CeltiCare and your PCP.

HEALTH MANAGEMENT

CentAccount Healthy Rewards Program

CeltiCare has a program to reward you for completing designated healthy behaviors. These healthy behaviors begin with the Health Screening. You will receive this award when you make a visit to your PCP within 90 days of enrollment with CeltiCare. You will earn an additional reward each year thereafter when you have an annual check-up visit with your PCP. Information on the CentAccount Healthy Rewards (Healthy Rewards) program can be found in your Welcome Packet and on our website at www.celticarehealthplan.com. Please call Member Services at 1-866-895-1786 for more information.

Behavior	Desired Outcome	Dollar Amount Loaded on Healthy Rewards card
Complete a Health Risk Screening	Your answers help CeltiCare identify the need for any extra needs or services you may require	\$50
Visit with PCP within the first 90 days of becoming a member	Creates a relationship with you and your PCP	\$50
Annual check up with your PCP	Allows the doctor to check your health and provide you with any information that may help improve your health	\$50

Balance Program

Balance is a free and confidential service to help you and your family juggle the daily needs of work, life and health. Balance offers resources to help you remove life barriers and focus on a healthier you. The program includes a website with customized information on work-life topics such as finances, stress and emotional wellbeing, as well as healthy living, fitness and asthma and diabetes management. Information on the Balance program can be found in your Welcome Packet and on our website at www.celticarehealthplan.com. Please call Member Services at 1-866-895-1786 for more information.

Family Planning Services

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

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

- Routine medical exams
- Diagnostic tests and pregnancy testing
- Birth control counseling
- Genetic counseling
- Coverage for all "FDA approved prescription contraceptive methods that have been approved by the United States Food and Drug Administration" as further described in M.G.L. c. 176G §40.
- Coverage for non-prescription contraceptives when given to you by a network provider during an office visit.

Under the plan's prescription drug benefit (see "Prescription Drugs" later in this chapter), prescription contraceptives such as birth control pills and patches are covered. Note: you may have to pay a prescription drug co-payment, deductible or coinsurance for certain prescription contraceptives applicable to your **Specific Benefit Plan**.

The co-payment for office visits is waived when you have a diagnosis related to family planning.

Related Exclusions:

- Reversal of voluntary sterilization.
- Infertility Services- any services, supplies or drugs related to the diagnosis or treatment of infertility.
- Services or fees related to using a surrogate to achieve pregnancy.
- Birth control devices, agents or preparations that by law do not require a prescription (except when given to you by a network provider during an office visit).

When You Are Pregnant

Keep these points in mind if you are pregnant now or want to become pregnant.

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

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

Pregnancy & Maternity Services

There are things you can do to have a safe pregnancy. See your doctor about any medical problems you have such as diabetes and high blood pressure. Do not use tobacco, alcohol or drugs now or while you are pregnant. CeltiCare recommends you see your doctor before becoming pregnant if you have experienced the following problems:

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

A note about folic acid: You should take folic acid before you become pregnant. Some foods that have folic acid in them include: orange juice, green vegetables, beans, peas, fortified breakfast cereals, enriched rice and whole wheat bread. It is difficult to get enough folic acid from food alone. Ask your doctor about taking prenatal vitamins and see your doctor as soon as you think you are pregnant.

Start Smart for Your Baby®

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

If you are pregnant and smoke cigarettes, CeltiCare can help you stop smoking. We have a special smoking cessation program for pregnant women available at no cost. The program has trained healthcare clinicians who are ready to build one-one contacts with you. They will provide education, counseling and support you need to help you quit smoking. Working as a team over the telephone, you and your

health coach develop a plan to make changes in your behavior and life-style. These coaches will encourage and motivate you to stop smoking.

We have many ways to help you have a healthy pregnancy. Before we can help, we need to know you are pregnant. Please call us at 1-866-895-1786 (TDD/TTY 1-866-614-1949) as soon as you learn you are pregnant. We will set up the special care you and your baby need.

Case Management

We understand some members have special needs. CeltiCare offers our members with special needs case management services that are member-centered, family-focused and culturally competent. If you have special healthcare needs or are disabled, case management may be able to help you. Our case managers are registered nurses or social workers. They can help you understand major health problems, identify and address barriers to care and arrange care with your doctors. A case manager will work with you and your doctor to help you get the care you need. If you have a serious medical condition, the case manager will work with you, your PCP and managing providers to develop a plan of care that may include alternative treatments that are not normally covered. If the alternative treatment plan provides the most appropriate medically necessary care the CeltiCare Medical Director may authorize the care providing that:

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

CeltiCare maintains the right to terminate the alternative care plan at any time when it is determined that the alternative care plan is no longer appropriate, effective, or contributing to the improvement of the member's condition or no longer meets the above criteria.

MemberConnections®

MemberConnections is an outreach program that promotes preventive health and connects members to quality healthcare and community social services. Connections Representatives work with Case Managers and are specialty trained staff to provide support to our members. They can help you determine which providers are available in your area, find support services, and help arrange for



needed services. To make contact with a case manager please call 1-866-895-1786 or TDD/TTY 1-866-614-1949.

Asthma and Diabetes Disease Management

The Commonwealth Choice plans provide coverage for Asthma and Diabetes Disease Management services. CeltiCare provides these services through Nurtur, a nationally recognized disease management company. Nurtur provides you with educational materials and health coaches that help you learn how to control your condition more effectively, have fewer complications and manage your condition on an outpatient setting.

For more information call the Member Services Department 1-866-895-1786 (TDD/TTY) 1-866-614-1949.

UTILIZATION MANAGEMENT

Review Criteria

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

A member or the treating providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management Department at 1-866-895-1786.

Experimental, Investigational and Clinical Trial Services

The decision for coverage of a procedure that could be considered experimental and/or investigational is made on a case by case basis. Experimental and/or investigational services may include medical procedures, drugs, devices, and/or clinical trial services. The CeltiCare Medical Director reviews all requests for coverage of a service that may be experimental/investigational. Information reviewed in making the benefit coverage determination includes but is not limited to the review of published peer-reviewed medical literature, policy statements from nationally recognized medical associations and specialty societies, government agency reports including the FDA, and consultation with medical experts regarding the specific procedure, drug, and/or device.

Prior Authorization for Services

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

If there are any major changes to the prior authorization process, we will let members and providers know right away.

Utilization Review

CeltiCare has a Utilization Review (UR) Program that reviews services to make sure the services you are getting are the best way to help you feel better or improve your condition. Medical services, supplies and drugs are reviewed to determine if the services are covered for your **Specific Benefit Plan**, medically necessary, and provided in the most clinically appropriate and cost-effective manner. The following methods are used to accomplish this goal.

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

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

- Approved - We will notify your provider by telephone within one (1) working day of making a decision followed by a written confirmation to your provider which will include the extended number of days or next review date within one (1) working day.
- Not approved – We will notify your provider by telephone within twenty four (24) hours followed by a written confirmation to you and your provider (including instructions for filing an Internal Appeal if you are in disagreement with the decision) within one (1) working day. **NOTE:** You are not financially responsible for inpatient services incurred prior to receiving an adverse determination notice; however, you may be financially responsible for services one (1)



calendar day following the date of the adverse determination notice if given to you.

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

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

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

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

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

- Procedures for obtaining an External Review.

Second Medical Opinion

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

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

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

How to Get Medical Care When You Are Out of the Service Region (Area)

If you are out of the area and have an emergency, **call 911 or go to the nearest emergency room.** Be sure to call CeltiCare and report your emergency **within 48 hours.** You do not need prior approval. CeltiCare will cover only Medically Necessary Emergency and Urgent Care services out of the service area.

If you are away from home and have an **urgent problem**, go to an urgent care clinic. You may go to a PCP where you are. Be sure to show your CeltiCare ID card prior to receiving services.

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

- You are out of state and you have a medical or behavioral health emergency. You can go to an emergency room in any state if you have a true medical or behavioral health emergency. If you are seen at an out-of-state hospital for an emergency, your follow up care must be with a CeltiCare network provider. You may also need to contact your PCP to get a referral if you need to see a specialist.

- It is determined that you need medically necessary care that is not available in Massachusetts. If CeltiCare approves, the cost of the care you get in the other state will be covered. Members are not covered for services outside of the United States.

Out of Network Care

You should always see a provider who is contracted with CeltiCare first unless the service you are in immediate need of is emergency services related to an emergency medical condition – See Emergency Care on page 55 of this manual. If you need to see a provider that is not contracted with CeltiCare, you need to get a referral from your PCP. The referral must be approved by CeltiCare before getting non-emergency or non-urgent treatment from a doctor who is not in the CeltiCare network. Your PCP will need to call CeltiCare to obtain the referral approval for you. If your referral to an out of network provider is approved by CeltiCare your co-payment and deductible will be the same as if the service was provided by an in-network provider. However, if you fail to obtain a referral from your PCP and approval from CeltiCare for a service or services from a nonparticipating provider no benefit coverage or reimbursement will be made by CeltiCare. You will be financially responsible for payment of the service(s) from the non-participating provider. If you are not sure if a provider is in the CeltiCare network, call Member Services at 1-866-895-1786. CeltiCare will notify you when the referral is approved.

Referrals

You may need to see a certain provider for specific medical problems, conditions, injuries, and/or diseases. Talk to your PCP first. Your PCP will refer you to a network specialist who can diagnose and/or treat your specific problem. **Do not go to a specialist without being referred by your PCP.** The specialist may not be able to see you without a referral from your PCP except for those covered services listed in the Self-Referrals section of this manual. Always make sure you have a referral from your PCP first.

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

- Specialist Services, including standing or ongoing referrals to a specific provider.
- Diagnostic tests (X-ray & lab)
- Scheduled outpatient hospital services
- Planned Inpatient admission
- Clinic services

- Renal dialysis (kidney disease) (Out of Network Providers require CeltiCare Approval)
- Durable Medical Equipment (DME) (Requires CeltiCare approval)
- Home healthcare (Requires CeltiCare approval)

Self-Referrals

You may self refer for certain covered services. No referral is required from your PCP or authorization from CeltiCare for these services.

Services for which you may self refer and receive benefit coverage minus applicable deductibles, co-payment or coinsurance for your **Specific Benefit Plan** when received by a participating CeltiCare provider include the following services. Your CeltiCare provider will communicate with your PCP information regarding your condition, treatment, and as appropriate follow up care including referral to another specialist if needed.

- Annual preventive gynecological health examinations by a obstetrician, gynecologist, certified nurse midwife, or family practitioner; including subsequent obstetric or gynecological services determined as a result of the examination.
- Maternity care.
- Medically necessary evaluations and resultant healthcare services for acute gynecological conditions. For emergency gynecological conditions see Emergency Care in this manual.
- OB/GYN services, including those of a CeltiCare participating Certified Nurse Midwife Women's health specialist.
- Federally Qualified Health Center (FQHC) or Certified Nurse Practitioner (CNP).
- Routine outpatient mental health and chemical dependency/substance abuse office visits
- Family Planning Services and supplies.

For more information on women's services, see page 67-70 of this manual.

Services for which you may self refer and receive benefit coverage minus applicable copayment, deductible or coinsurance whether or not the provider is a participating provider with CeltiCare include:

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

For more information on emergency services, see Emergency Care in this manual.



Urgent Care-After Hours

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

Only go to the emergency room if your doctor tells you to go or you have a life-threatening emergency. When you need urgent care, follow these steps:

- Call your PCP. The name and phone number are on your CeltiCare ID card. An after hours number may also be listed. Your PCP may give you care and directions over the phone.
- If it is after hours and you cannot reach your PCP, call NurseWise at 1-866-895-1786 (TDD/TTY 1-866-614-1949). Press option 7. You will be connected to a nurse. Have your CeltiCare ID card number handy. The nurse may help you over the phone or direct you to other care. You may have to give the nurse your phone number. During normal office hours, the nurse will assist you in contacting your PCP.

If you are told to see another doctor or go to the nearest hospital emergency room, bring your CeltiCare ID card. Ask the doctor to call your PCP or CeltiCare.

Emergency Care

CeltiCare covers emergency medical and emergency mental health services 24 hours a day, seven (7) days a week when provided within or outside the Service Area. Emergency services are required to treat an accidental injury or an onset of what reasonably appears to be a medical condition (see Emergency Service under definitions section of this manual). An emergency arises when the lack of medical attention could be expected by a reasonable layperson to result in jeopardy to a member's health or in the case of a pregnant woman, the health of her unborn child.

When to go to the Emergency Room

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

When NOT to go to the Emergency Room

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

Emergency rooms are for emergencies. If you can, call your doctor first. If your condition is severe call 911 or go to the nearest hospital. You do not need a doctor's approval. If you are not sure if it is an emergency, call your PCP. Your PCP will tell you what to do. If your PCP is not available, a doctor taking calls can help. There may be a message telling you what to do. You can also call NurseWise, our 24-hour medical advice line at 1-866-895-1786 (TDD/TTY 1-866-614-1949) if you have questions. Press option 7.

It is okay if the hospital does not belong to the CeltiCare network. You can use any hospital to receive emergency services. You or someone acting on your behalf **MUST** call your PCP and CeltiCare within 48 hours of admission. This helps your PCP to provide or arrange for any follow-up care that you may need. We will help you get follow-up care. Call us at 1-866-895-1786 (TDD/TTY 1-866-614-1949). Depending on your **Specific Benefit Plan**, co-payments may apply for emergency care received in an emergency room.



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

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

If your Cenpatico case manager has requested that you contact Cenpatico, CeltiCare, or your PCP within 48 hours of receiving emergency services, notification will be considered given if the attending emergency room provider has communicated with Cenpatico, CeltiCare, or your PCP.

Emergency Transportation Services

CeltiCare covers emergency ambulance ground transportation to the nearest Hospital for emergency care. Ambulance transport to the Hospital Emergency Room in non-emergency situations is not a covered service under CeltiCare. Ambulance transportation from one healthcare facility to another is covered only when medically necessary, arranged and approved by a CeltiCare provider. Transportation is not covered to or from medical appointments, via taxi, chair lift or public transportation.

Post Stabilization Services

These are services that are needed to stabilize your condition after an emergency. They do not require prior authorization. It does not matter whether you receive the emergency care in or outside of the CeltiCare network. We will still cover services to make sure you are stable after an emergency.



PHARMACY

Pharmacy Program

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

Preferred Drug List

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

For the most current CeltiCare PDL you may call Member Services at 1-866-895-1786 or visit the CeltiCare website www.celticarehealthplan.com

Prior Authorizations

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

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

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

If CeltiCare does not grant prior authorization we will notify you and your provider and provide information regarding the appeal process. See page 85 for information about our Member Grievances and Appeals section. If you want more information about our pharmacy program, visit our Website at www.celticarehealthplan.com or call us at 1-866-895-1786.

Exclusions

The following drug categories are not part of the CeltiCare PDL and **are not covered by the 72-hour emergency supply policy**:

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

Refer to page 3 of the CeltiCare PDL for more information on the 72-hour emergency supply policy.

Step Therapy

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

If CeltiCare does not grant prior authorization we will notify you and your provider and provide information regarding the appeal process.

Quantity Limits

To make sure the drugs you take are safe CeltiCare may limit how much of your medication you can get at one time. If your provider feels you have a medical reason for getting a larger amount, he or she can ask for prior authorization.

If CeltiCare does not grant prior authorization we will notify you and your provider and provide information regarding the appeal process.

Generic Drugs

When generic drugs are available, the brand-name drug will not be covered without prior CeltiCare authorization. Generic drugs have the same active ingredient, work the same as brand-name drugs, and have lower co-payments. If you and your provider feel a brand-name drug is medically necessary, your provider can ask for prior authorization.

We will cover the brand-name drug according to our clinical guidelines if there is a medical reason you need the particular brand-name drug.

If CeltiCare does not grant prior authorization we will notify you and your provider and provide information regarding the appeal process.

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

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

Newly Approved Products

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

If CeltiCare does not grant prior authorization we will notify you and your provider and provide information regarding the appeal process.

Specialty Pharmacy Provider

Certain medications are only covered when supplied by CeltiCare's specialty pharmacy provider. Caremark is our specialty pharmacy provider. Our Pharmacy Program Director and Medical Director oversee the clinical review of these medications and Caremark provides you with the following services:

- Delivers drugs to your home or provider's office
- Provide staff pharmacists who can help you 24 hours a day, seven days a week to answer your questions and offer help with your drugs
- Give you information, materials, and ongoing support to help you take the drugs to appropriately manage your health condition



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

Filling a Prescription

You can have your prescriptions filled at a network pharmacy or by CeltiCare's mail order pharmacy.

- If you decide to have your prescription filled at a network pharmacy you can locate a pharmacy near you by using your Provider Directory. You may also call a Member Services Representative to help you find a pharmacy. At the pharmacy you will need to provide the pharmacist with your prescription and your CeltiCare ID card.
- If you decide to have your prescription maintenance medication filled by the mail order pharmacy please contact a CeltiCare Member Service Representative to help you.

Please contact CeltiCare at 1-866-895-1786 (TDD/TTY 1-866-614-1949) if you have questions about filling your prescriptions.

Mail Order Program

CeltiCare offers a 90 day supply (3 month supply) of maintenance medications by mail for **Specific Benefit Plans**. These drugs are used to treat long-term conditions or illnesses. You can find a list of covered maintenance medications on our website www.celticarehealthplan.com. Information on how to order a supply is included in your Welcome Packet. Please contact a CeltiCare Member Service Representative if you have any questions. To transfer a current prescription or to have you doctor phone a prescription directly to our mail order pharmacy – they may call RxDirect at 1-800-785-4197.

If you want more information about our pharmacy program, visit our Website at www.celticarehealthplan.com or call us at 1-866-895-1786.

See page 77 for information about our Member Grievances and Appeals section.

MEMBER SATISFACTION

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

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

CeltiCare maintains records of each grievance/appeal filed by a member or by the member's authorized representative, and responses thereto, for a period of seven years, which records shall be subject to inspection by the Commissioner of Insurance and the Office of Patient Protection as described in 105 CMR 128.303.

Internal Inquiry Process

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

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

Internal Grievance Process

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



Determination (this agreement with the Medical Necessity determination) is an appeal and the steps for an Internal Appeal are followed.

How to File a Grievance

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

To file a Grievance, call Member Services at 1-866-895-1786. You can also write a letter and mail or fax your Grievance to CeltiCare at 1-866-614-1951.

Be sure to include:

- Your first and last name
- Your Member ID number
- Your address and telephone number
- What you are unhappy with
- What you would like to have happen (desired outcome)
-

You have up to **180 calendar days** to file a Grievance. The 180 calendar days start on the date of the situation you are not satisfied with. We would like for you to contact us right away so we can help you with your concern as soon as we can. A Grievance may be filed in writing by mail at the address below or electronically by fax at 1-866-614-1951. You can also call us at 1-866-895-1786 or file the Grievance in person at:

**Appeals and Grievance Coordinator (AGC)
CeltiCare**

1380 Soldiers Field Road, Suite 300
Brighton, Massachusetts 02135

If you submit your Grievance by phone or in person a Member Services Representative will write a summary of your grievance and send you a copy within 48 hours (unless the time limit is waived or extended by mutual written agreement between you or your authorized representative and CeltiCare). This summary serves as both a written record of your grievance as well as an acknowledgement. If you file a written grievance, the AGC will send you a letter within 10 days letting you know that we have received your grievance and the expected date of resolution.

If someone else is going to file a grievance for you, we must have your written permission for that person to file your Grievance or Appeal. You can call Member Services to receive a form or go to www.celticarehealthplan.com. This form is to assign your right to file a Grievance or Appeal to someone else.



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

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

You can expect a resolution and a written response within 30 days of your Grievance. If CeltiCare needs more than 30 days to resolve the Grievance, we will contact you to receive approval and inform you within two working days.

There will be no retaliation against you or your representative for filing a grievance or appeal.

Internal Appeal Process

An Internal Appeal is a form of grievance for review of an adverse determination. An adverse determination is a decision that was made, based on review of information that was provided, to deny, reduce, modify or terminate an admission, continued inpatient stay, or the availability of any other healthcare services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of healthcare setting and level of care, or effectiveness. An Internal Appeal is reviewed as either a Standard/Non-expedited Internal Appeal or as an Expedited Internal Appeal. If a decision on an appeal is required immediately due to your health needs, an expedited appeal may be requested. The following outlines the process for each.

Standard/Non-expedited Internal Appeal

Internal Appeal Submission and Acknowledgement

An Internal Appeal can be filed by you or your authorized representative (with your written consent) up to 180 days after the receipt of an Adverse Determination letter.

An Internal Appeal may be submitted in writing by mail at the address below, electronically by fax at 1-866-614-1951 by calling us at 1-866-895-1786 in person at the address below.



Mail the letter to:
Appeals and Grievance Coordinator
CeltiCare
1380 Soldiers Field Road, Suite 300
Brighton, Massachusetts 02135

An Internal Appeal submitted by phone or in person will be received by a Member Services Representative who will write a summary of the Internal Appeal request and forward a copy to you within 48 hours (unless the time limit is waived or extended by mutual written agreement between you or your authorized representative and CeltiCare).

An Acknowledgement letter will be sent within 15 working days of receipt of the internal appeal.

Internal Appeal Continuation of Care

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

Internal Appeal Review

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

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

Internal Appeal Determination Notification

A standard Internal Appeal is resolved and a written response sent to you and your authorized representative within 30 days of our receipt of the Internal Appeal or if medical information is needed within 30 days of receiving a signed Authorization to

Release Medical Records form. If the Internal Appeal request was not over-turned or resolved to you or your authorized representative's satisfaction an External Review by an independent external review agency may be requested. The external review agency contracts with the state of Massachusetts Department of Public Health/Office of Patient Protection. Information for pursuing an External Review is included in the Internal Appeal determination letter. If you do not receive a response to your Internal Appeal within the timeframes outlined or those that are mutually agreed upon, your appeal will be deemed to be decided in your favor.

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

- The specific medical and scientific reasons for the adverse determination;
- A discussion of the member's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical; evidence fails to meet the relevant medical review criteria
- Other covered alternative treatment, service(s), or supplies if applicable;
- Criteria and/or clinical guidelines or standards of care used in making the determination;
- Information for obtaining an independent external review through the Office of Patient Protection including the timeframe for filing.

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

Internal Appeal Reconsideration

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

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

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

Should you or your authorized representative request reconsideration, the time period for requesting an external review will begin the date of the resolution of the reconsideration

Expedited Internal Appeal

Expedited Internal Appeal Qualifying Conditions

If a decision on an appeal is required immediately due to your health needs which cannot wait with the standard resolution time, an Expedited Internal Appeal may be requested. An Expedited Internal Appeal may be requested if:

- A provider certifies a delay in receiving the requested service would result in a substantial risk of serious or immediate harm to the member;
- You are currently admitted as a patient in a hospital; or
- You have a terminal illness; or
- A provider certifies a delay in receiving durable medical equipment would result in substantial risk of serious or immediate harm to the member.

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

Expedited Internal Appeal Submission

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

Expedited Internal Appeal Continuation of Care

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

Expedited Internal Appeal Review

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

Expedited Determination Notification

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

- Within 48 hours if a delay in receiving the requested service would result in a substantial risk of serious or immediate harm;
- Before discharge if you are currently admitted as a patient in a hospital;
- Within 5 days if you are terminally ill; and
- Within less than 48 hours if a delay in receiving requested durable medical equipment would result in a substantial risk of serious or immediate harm.

Written notification of the resolution of the Internal Expedited Appeal will include:

- The specific medical and scientific reasons for the adverse determination;
- A discussion of the member's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;
- Other covered alternative treatment, service(s), or supplies if applicable;
- Criteria and/or clinical guidelines or standards of care used in making the determination;
- Information for obtaining an expedited external review and continuation of services through the Office of Patient Protection including the timeframe for filing.

An Expedited Internal Appeal not handled timely will be deemed over-turned. If the request for continued services is approved by the Office of Patient Protection, CeltiCare will continue coverage at our expense minus applicable co-pays and deductible.

Expedited Appeal Reconsideration - Services for Member's with Terminal Illness

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

External Review

If you or your authorized representative is not satisfied with the final outcome of the Internal Appeal or Expedited Internal Appeal an External Review of the decision



EVIDENCE OF COVERAGE

through the Office of Patient Protection (OPP) of the Massachusetts Department of Public Health may be requested.

You or your authorized representative may request the External Review. Forms and instructions for submitting the request will be included with the Final Adverse Determination sent. The required forms must be completed then submitted to OPP within 45 days of the receipt of the Final Adverse Determination we sent along with the applicable filing fees (\$25.00). External Reviews will be completed and a decision sent within 60 business days of the external agency receipt of the request unless extended or accepted as an Expedited External Review.

An Expedited External Review may be requested if:

- A physician certifies in writing a delay in receiving the requested service would result in a substantial risk of serious or immediate harm to you;
- You are currently admitted as a patient in a hospital;
- You are terminally ill; or
- A physician certifies in writing a delay in receiving requested durable medical equipment would result in a substantial risk of serious or immediate harm to you.

The request for an Expedited External Review must be made by the end of the second business day following receipt of the Final Adverse Determination. If OPP determines the request qualifies for Expedited Review, a determination will be made within 5 business days of the external review agency receipt of the request.

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

If you have questions, concerns, would like additional information regarding member rights, or have questions about the External Review process you can contact the Office of Patient Protection:

Department of Public Health
Office of Patient Protection
99 Chauncy Street
Boston, MA 02111
Phone (800) 436-7757 Fax: (617) 624-5046
Website www.mass.gov/dph/opp

The following information is also available from the Office of Patient Protection (OPP):

- A list of sources of independently published information assessing member satisfaction and evaluating the quality of healthcare services offered by the health plan.
- The percentage of physicians who voluntarily and involuntarily terminated participation contracts with the health plan during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary physician disenrollment.
- The percentage of premium revenue expended by the health plan for healthcare services provided to members for the most recent year for which information is available.
- A report detailing, for the previous calendar year, the total number of: (1) filed grievances, grievances that were approved internally, grievances that were denied internally, and grievances that were withdrawn before resolution; and (2) external appeals pursued after exhausting the internal grievance process and the resolution of all such external appeals.



Waste, Abuse and Fraud (WAF) Program Authority and Responsibility

CeltiCare is serious about finding and reporting fraud and abuse. Our staff is available to talk to you about this. **Here is the address and phone number:**

**CeltiCare
Compliance Department**
1380 Soldiers Field Road, Suite 300
Brighton, Massachusetts 02135
Phone: 1-866-685-8664

Fraud means that a member, provider, or another person is misusing CeltiCare's program resources. This could include things like:

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

Your healthcare benefits are given to you based on your eligibility for the program. You must not share your benefits with anyone. Providers must report any misuse of benefits to CeltiCare. If you misuse your benefits, you could lose them altogether.

Abuse means physical, sexual or emotional harm or injury. It also means neglect or exploitation by others. Your safety and well being are very important to us. If you or your family has any concerns, please call us right away.

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

What to do if you get a bill

Be sure to talk with your doctor about services that are covered and services that are not covered. You should not be billed for services, except for applicable co-payments, deductible or coinsurance that are covered as long as you follow any plan rules. If you get a bill for a service that should be covered by CeltiCare, call your provider right away. Make sure your provider has all of your insurance information, and knows to bill CeltiCare. If you still get bills from the provider after you give your insurance information, call Member Services for help.

If you ask for a service that is not covered, your doctor will ask you to sign a statement saying you will pay for the service yourself. If you sign a statement saying you will pay for the non-covered service, then you are responsible for the bill. If you have any questions about a bill, you can call Member Services.

Other Insurance

CeltiCare arranges payment of covered services with other health insurance plans when you have more than one insurance plan. Coordination of Benefits (COB) is the process CeltiCare uses to coordinate the payment of covered services with other insurance plans. The COB process involves two or more insurance plans:

- 1) *Primary Plan* - the plan that covers services as if another plan did not exist; and
- 2) *Secondary Plans* - the plan(s) that pays *after* the Primary Plan has completed paying.

Secondary Plans consider the Primary Plan's payment when determining how much it will pay. The laws of Massachusetts and regulations of the Massachusetts Department of Insurance determine if a plan is primary or secondary and how the plans will pay out benefits.

You must notify CeltiCare if you add or change health insurance coverage. If CeltiCare requests more information about your other insurance you must supply that information.

If you have another insurance plan, CeltiCare will not reduce (or increase) benefits as described in this *document*.

Accidental Injury or Illness (Subrogation)

If a CeltiCare member has to see a doctor for an injury or illness that was caused by another person or business, you must call the Member Services department to let us know. For example, if you are hurt in a car wreck, by a dog bite, or if you fall and are hurt in a store, then another insurance company might have to pay the doctor's and/or hospital bills. When you call, we will need the name of the person at fault, their insurance company and the names of any attorneys involved.

Member Rights

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

- **Information:** You have the right to get from your Primary Care Provider (PCP) information about what might be wrong (to the level known), treatment and any known likely results. Your PCP can tell you about treatments that may or may not be covered by the plan, regardless of the cost. You have a right to know about any costs you will need to pay. This should be told to you in words you can understand. When it is not appropriate to give you information for medical reasons, the information can be given to a legally authorized person. Your doctor will ask for your approval for treatment unless there is an emergency and your life and health are in serious danger.
- You have the right to see your medical records.
- You have the right to be informed of changes within our CeltiCare network.
- You have the right to be kept informed of CeltiCare and Commonwealth Choice covered and non-covered services, program changes, how to access services, PCP assignment, providers, Advance Directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and other CeltiCare rules and guidelines. CeltiCare will notify you at least 60 days before the effective date of the modifications. Such notices shall include the following:
 - Any changes in clinical review criteria
 - A statement of the effect of such changes on the personal liability of the insured for the cost of any such changes.
- You have a right to information about CeltiCare and the Commonwealth Choice system.
- You have the right to a current list of CeltiCare providers. You can also get information on your providers' education, training, and practice.
- You have the right to talk to your provider about new uses of technology. You can also ask CeltiCare for information on our quality plan, how members use the plan and how we review new technology.
- **Respect & Dignity:** You have the right to have considerate, respectful care at all times. You have the right to have assistance in a prompt, courteous and responsible manner. You have the right to be treated with dignity when receiving care. You have the right to be free from harassment by the health plan or the plan's providers if there are any business disagreements between the plan and provider.
- You have the right to select a health plan or switch health plans, within the Commonwealth Choice guidelines, without any threats or harassment.

- **Access:** You have the right to adequate access to qualified health professionals.
- You have the right to access treatment or services that are medically necessary regardless of age, race, creed, sex, sexual preference, national origin or religion.
- You have the right to access medically necessary urgent and emergency services 24 hours a day and seven days a week.
- If you have a disability, you have the right to receive information in a different format in compliance with the Americans with Disabilities Act.
- **Informed Consent:** Members or their legal guardians or legal representatives have the right to join in decision making about their healthcare. This includes working on any treatment plans and making care decisions. You should know any possible risks, problems related to recovery, and the likelihood of success. You shall not have any treatment without consent freely given by you or your legally authorized surrogate decision-maker. You will be informed of your care options. You have the right to know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly. You have a right to refuse treatment.
- **Grievance:** You have the right to file an Appeal or Grievance if you have had an unsatisfactory experience with CeltiCare or with any of our contracted providers or if you disagree with certain decisions made by CeltiCare.
- **External Review:** You have the right to apply for an independent external review with the Massachusetts Department of Public Health's Office of Patient Protection for appeals or grievances not resolved to your satisfaction by CeltiCare.
- **Rights and Responsibilities Policies:** Members have a right to make recommendations regarding the organization's Member Rights and Responsibilities policies.
- **Refusal of Treatment:** You may refuse treatment to the extent the law allows. You are responsible for your actions if treatment is refused or if the PCP's instructions are not followed. You should discuss all concerns about treatment with your PCP. Your PCP can discuss different treatment plans with you, if there is more than one plan that may help you. You will make the final decision.
- **Primary Care Provider (PCP):** You have the right to pick your PCP within the plan network. You also have the right to change your PCP or request information on CeltiCare doctors close to your home or work.
- **Identity:** You have the right to know the name and job title of people giving you care. You also have the right to know which doctor is your PCP.

- **Language:** You have the right to an interpreter when you do not speak or understand the language of the area.
- **Second Opinions:** You have the right to a second opinion by an in-network doctor, at no cost to you, if you believe your provider is not authorizing the requested care, or if you want more information about your treatment.
- **Advance Directives:** All CeltiCare members have a right to make Advance Directives for healthcare decisions. CeltiCare members also have the right to refuse to make Advance Directives. You should not be discriminated against for not having an Advance Directive. (see page 76)

Member Responsibilities

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

- **Giving Information:** You should give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about your health. You should make it known whether you clearly understand your care and what is expected of you. You need to ask questions of your doctor until you understand the care you are receiving. You need to review and understand the information you receive about CeltiCare. You need to know the proper use of services covered by CeltiCare.
- **Your Doctor's Advice:** You should follow the treatment plan suggested by providers of medical care. You should ask questions if you do not understand any part of the treatment plan. You should work with your PCP to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.
- **ID Card:** It is important that you show your CeltiCare ID card before you receive care.
- **Emergency Room Use:** You should use any emergency room only when you think you have a medical emergency. For all other care, you should call your PCP.
- **Appointments:** You need to keep appointments. If you cannot keep an appointment, you must call to cancel or reschedule. You should schedule appointments during office hours whenever possible.
- **Primary Care Provider (PCP):** You should know the name of your assigned PCP. You should establish a relationship with your doctor. You may change your PCP verbally or in writing by contacting our Member Services Department.
- **Treatment:** You should treat all CeltiCare staff, providers, and other members with respect and dignity. Any concerns that you have about your care should be given to CeltiCare in a useful manner.

- **Changes:** You need to tell the Connector about any changes in your address, name, telephone number, or any changes in your family.
- **Other Medical Insurance:** When you enroll in the CeltiCare, you need to give all information about any other medical insurance coverage you have. If, at any time, you get other medical coverage besides your CeltiCare coverage, you must tell the Connector.
- **Costs:** If you access care without following CeltiCare rules, you may be responsible for the charges. If applicable, you are responsible to pay your portion of the monthly Commonwealth premium to the Connector and all copayments, deductible or coinsurance at the time of service.

Advance Directives

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

Examples of Advance Directives include:

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

You should not be discriminated against for not having an Advance Directive.

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

Protecting Your Privacy

NOTICE OF PRIVACY PRACTICES

Privacy Notice

Effective: January 1, 2010

For help to translate or understand this, please call 1-866-895-1786. If you are hearing impaired, call our TDD/TTY line at 1-866-614-1949.

Si necesita ayuda para traducir o entender este texto, por favor llame al telefono. 1-866-895-1786. TDD/TTY 1-866-614-1949.

Interpreter services are provided free of charge to you.

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

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

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

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

How We Use or Share Your Health Records

Here are ways we may use or share your health records:

- To help pay your medical bills given to us by healthcare providers.

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

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

- To state and federal agencies that oversee us, such as the Commonwealth Health Insurance Connector or United States Department of Health and Human Services.
- For public health actions. For example, the Food and Drug Administration may need to check or track medicines and medical device problems.
- To public health groups if we believe there is a serious public health or safety threat.
- To a health agency for certain activities. This might include audits, inspections, and licensure or enforcement actions.
- To a court or administrative agency.
- To law enforcement. For example, records may be used to identify or find someone who is a suspect, fugitive, material witness or missing person.
- To a government person about child abuse, neglect or violence in your home.
-
- To a coroner or medical examiner to identify a dead person or help find a cause of death. These may be needed by a funeral director to help them carry out their duties.

- For organ transplant purposes. For special government roles, such as military and veteran activities, national security and intelligence activities, and to help protect the President and others.
- For job-related injuries due to your state's worker compensation laws.
- If one of the above reasons does not apply, we must obtain your written approval to use or share your health records with others. If you change your mind, you may retract your written approval at any time.
- If sharing your health information is not allowed by or limited by a state law, we will obey the law that protects your health information best.

What Are Your Rights?

The following are your rights with regards to your health records. If you would like to exercise any of the following rights, please contact us. We can be reached at 1-866-895-1786.

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

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

- Information contained in psychotherapy notes.

- Information collected in reasonable anticipation of, or for use in a court case or another legal proceeding.
- Information subject to certain federal laws about biological products and clinical laboratories.
- In certain situations, we may not let you get a copy of your health records. You will be informed in writing. You may have the right to have our action reviewed.
- **You have the right to ask us to make changes to wrong or incomplete health records we keep about you.** These changes are known as amendments. Any request for an amendment must be in writing. You need to give a reason for your change(s). We will get back to you in writing no later than 30 days after we receive your request. If your health information is not maintained on-site, we will respond no later than 60 days after we receive your request. If we need additional time, we may take up to another 30 days. We will inform you of any delays and the date when we will get back to you.
- If we make your changes, we will let you know they were made. We will also give your changes to others who we know have your health records and to other persons you name. If we choose not to make your changes, we will let you know why in writing. You will have a right to submit a letter disagreeing with us. We have a right to answer your letter. You then have the right to ask that your original request for changes, our denial and your second letter disagreeing with us be put with your health records for future disclosures.
- You have the right to receive an accounting of disclosures of your health records to others for six years beginning January 1, 2010. By law, we do not have to give you a list of the following:
 - Health records given or used for treatment, payment and healthcare operations purposes.
 - Health records given to you or others with your written approval.
 - Information that is incidental to a use or disclosure otherwise permitted.
 - Health records given to persons involved in your care or for other notification purposes.
 - Health records used for national security or intelligence purposes.
 - Health records given to prisons, police, FBI and others who enforce laws or health oversight agencies.
 - Health records given or used as part of a limited data set for research, public health or healthcare operations purposes.

To receive an accounting of disclosures, your request must be in writing. We will act on your request within 60 days. If we need more time, we may take up to another 30



days. Your first list will be free. We will give you one free list every 12 months. If you ask for another list within 12 months, we may charge you a fee. We will tell you the fee in advance and give you a chance to take back your request.

Using Your Rights

- *You have a right to receive a copy of this notice at any time. We reserve the right to change the terms of this notice.* Any changes in our privacy practices will apply to all the health records that we keep. If we make changes, we will send a new notice to you.
- *If you have any questions about this notice or how we use or share your health records, please call.* We can be reached at 1-866-895-1786. That office is open Monday through Friday from 8:00 a.m. to 5:00 p.m.

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

**Privacy Official
CeltiCare**

1380 Soldiers Field Road, Suite 300
Brighton, Massachusetts 02135
Phone: 1-866-895-1786
Fax: 1-888-828-5698

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

**Office for Civil Rights - Region I
U.S. Department of Health & Human Services
Government Center**

J.F. Kennedy Federal Building - Room 1875
Boston, MA 02203
Voice phone (617) 565-1340
FAX (617) 565-3809
TDD (617) 565-1343

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

Important Definitions

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

Annual Deductible: “The annual dollar amount that must be paid by you for certain covered services before CeltiCare becomes obligated to pay for covered services.”

Annual Out-of-Pocket Expense: “The annual dollar amount that you will pay for covered services under a CeltiCare Health Plan, not including premiums. Except for applicable Prescription Drug deductibles and co-payments, all other deductibles and co-payments will count toward the annual out-of-pocket expense.”

Annual Renewal Date: “Twelve months following the effective date of the specific benefit plan.”

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

Authorized Representative “A person CeltiCare can document has been authorized by the member in writing to act on the member's behalf with respect to a grievance or internal appeal.”

Behavioral Health Manager “a company, organized under the laws of the Commonwealth of Massachusetts or organized under the laws of another state and qualified to do business in the Commonwealth that has entered into a contractual arrangement with a carrier to provide or arrange for the provision of behavioral health services to voluntarily enrolled members of the carrier.”

Benefit Year “The period of time beginning on the first day of the month for which a subscriber/employer is eligible for coverage and ending after 12 months .” For example, if a subscriber/employer benefit plan is effective 04/01/2010, the benefit year will end on 03/31/2011.

Complaint “An inquiry made by or on behalf of a CeltiCare member to CeltiCare or a CeltiCare subcontractor that is not explained or resolved to the insured's satisfaction.”



Covered Services/Benefits "Health care services a member is entitled to under the terms of the member eligibility with CeltiCare (as described in the member's evidence of coverage)."

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

Creditable Coverage "coverage of an individual under any of the following health plans with no lapse of coverage of more than 63 days: (a) a group health plan; (b) a health plan, including, but not limited to, a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under section 18 of chapter 15A or a qualifying student health program of another state, (c) Part A or Part B of Title XVIII of the Social Security Act; (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (e) 10 U.S.C. 55; (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under 5 U.S.C. 89; (i) a public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701 (c) (I) (I), as amended by Public Law 104-191; (j) a health benefit plan under the Peace Corps Act, 22 U.S.C. 2504(e); (k) coverage for young adults as offered under section 10 of chapter 176J; or (l) any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996, as it is amended, or by regulations promulgated under that act," as further described in M.G.L. c. 176J §1."

Date of Enrollment "with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

Eligible Dependent: "a lawful spouse or domestic partner (same or opposite sex) of the subscriber, a biological child of the subscriber or other covered dependent, foster children for whom the member has been receiving foster care payments, newborn infants of a dependent and adoptive children immediately from the date of the filing of a petition to adopt. Dependent child includes step child, legally adopted child from the date of a placement in the home, or a disabled adult child of the subscriber or spouse." Dependents are covered up to 26 years of age or for up to 2 years after the end of the calendar year following the loss of dependent status.

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

Eligible Individual “an individual who is a resident of the commonwealth.”

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

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

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

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

Final Adverse Determination “An adverse determination made after a member has exhausted all remedies available through a carrier's formal internal grievance process.”

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

Group Health Plan “an employee welfare benefit plan, as defined in section 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1002, to the extent that the plan provides medical care, and including items and services paid for as medical care to employees or their dependents, as defined under the terms of the plan directly or through insurance, reimbursement or otherwise. For the purposes of this chapter, medical care means amounts paid for (i) the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body; (ii) amounts paid for transportation primarily for and essential to medical care referred to in clause (i); and (iii) amounts paid for insurance covering medical care referred to in clauses (i) and (ii). Any plan, fund or program which would not be, but for section 2721 (e) of the federal Public Health Service Act, an employee welfare benefit plan, and which is established or maintained by a partnership, to the extent that the plan, fund or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to clause (a), as an employee welfare benefit plan which is a group health plan. In a group health plan, (a) the term “employer” also includes the partnership in relation to any partner; and (b) the term “participant” also includes: (1) in connection with a group health plan maintained by a partnership, an individual who is a partner of the partnership; or (2) in connection with a group health plan maintained by a self-employed individual, under which 1 or more employees are participants, the self-employed individual if that individual is, or may become, eligible to receive a benefit under the plan or that individual's beneficiaries may be eligible to receive any benefit.”



Health benefit plan “an individual or group health maintenance contract issued by a health maintenance organization under chapter 176G.

Infertility “the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year.”

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

Medical necessity or medically necessary “healthcare services that are consistent with generally accepted principles of professional medical practice as determined by whether: (a) the service is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual; (b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or (c) for services and interventions not in widespread use, is based on scientific evidence.”

Member “a person eligible with CeltiCare through the Connector Authority Commonwealth Choice Health Insurance Program. “

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

Non-participating Provider “a provider who does not have a contract with CeltiCare or with its subcontractor to provide health care services to CeltiCare members.”

Nurse Practitioner “a registered nurse who holds authorization in advanced nursing practice as a nurse practitioner under M.G.L. c. 112, §80B.”

Office of Patient Protection (OPP) “Office of the Department of Public Health established to develop regulations and statutory requirements to govern managed care carriers internal grievance and the external review procedures. “

Participating provider “a provider, including a certified nurse anesthetist or nurse practitioner, psychologist, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist who, under a contract with the carrier, including a dental or vision carrier, or with its contractor or subcontractor, has agreed to provide health, dental or vision care services to insureds with an expectation of receiving payment, other than



coinsurance, co-payments or deductible, directly or indirectly from the carrier, including a dental or vision carrier."

Pre-existing Conditions Provision "with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date. Genetic information shall not be treated as a condition in the absence of a diagnosis of the condition related to that information. Pregnancy shall not be a preexisting condition. Trade Act/HCTC-eligible persons shall not be subject to any pre-existing conditions provision.

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

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

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

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

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

Trade Act/HCTC-Eligible Persons "any eligible trade adjustment assistance recipient or any eligible alternative trade adjustment assistance recipient as defined in section 35(c)(2) of section 201 of Title II of Public Law 107-210, or an eligible Pension Benefit Guarantee Corporation pension recipient who is at least 55 years old and who has qualified health coverage, does not have other specified coverage, and is not imprisoned, under Public Law 107-210."

Utilization review "a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, healthcare services, procedures or settings. Such techniques may include, but are



EVIDENCE OF COVERAGE

not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review."



AUTHORIZED REPRESENTATIVE FORM

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

1. I hereby give permission to _____ to act as my Authorized
Name of designated representative

Representative to CeltiCare and to share information listed below in Section II regarding my Appeal or Grievance with CeltiCare or its delegate.

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

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

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

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

5. This permission is good until: ____/____/____.
Date

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

CeltiCare
ATTN: Appeals and Grievances Coordinator
1380 Soldiers Field Road, Suite 300
Brighton, Massachusetts 02135

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

____/____/____ _____
Date Printed Name Signature