Chapter 3: Using the plan’s coverage for your health care and other covered services

[Plans should refer members to other parts of the handbook using the appropriate chapter number, section, and/or page number. For example, "see Chapter 9, Section A, page 1." An instruction [plans may insert reference, as applicable] is listed next to each cross reference throughout the handbook.]

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# About “services,” “covered services,” “providers,” and “network providers”

**Services** include medical care, behavioral health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and others. **Covered services** are any of these services that our plan pays for. Covered services are listed in the Benefits Chart in Chapter 4 [plans may insert page number, as applicable].

**Providers** are doctors, nurses, behavioral health specialists, and other people who give you services and care. The term *providers* also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

**Network providers** are providers who work with the health plan**.** These providers have agreed to accept our payment as full payment.

# Rules for getting your health care and long-term services and supports [*insert if applicable:* and other services] covered by the plan

<Plan name> covers services covered by Medicare and MassHealth. This includes behavioral health, long-term services and supports, and prescription and over-the-counter drugs. [Plans may also insert reference to any plan-covered services listed in their approved Plan Benefit Package.]

<Plan name> will pay for the health care and services you get if you follow the plan rules that follow.

* The care you get must be a **plan benefit.** This means that it must be included in the plan’s Benefits Chart. (The chart is in Chapter 4 [plans may insert reference, as applicable] of this handbook).
* The care must be **medically necessary.** *Medically necessary* means that the services are reasonable and necessary:
* For the diagnosis and treatment of your illness or injury; ***or***
* To improve the functioning of a malformed body member; ***or***
* Otherwise medically necessary under Medicare law.

In accordance with Medicaid law and regulation, and per MassHealth, services are medically necessary if:

* They could be reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger your life, cause you suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; ***and***
* There is no other medical service or place of service that is available, works as well, and is suitable for you that is less expensive. The quality of Medically Necessary services must meet professionally recognized standards of health care, and Medically Necessary services must also be supported by records including evidence of such medical necessity and quality.
* [Plans may omit or edit the PCP-related bullets as necessary, including modifying the name of the PCP and the description of the referral requirements and process.] You must have a network **primary care provider** **(PCP).** As a plan member, you [insert as applicable: may **or** must] choose a network provider to be your PCP.
  + To learn more about choosing a PCP, see page <page number>.
  + In most cases, [insert as applicable: your network PCP **or** our plan] must give you approval before you can use other providers in the plan’s network. This is called a **referral**. To learn more about referrals, see page <page number>.
  + You do not need a referral from your PCP for emergency care or urgently needed care. You can also get other kinds of care without having a referral from your PCP. To learn more about this, see page <page number>.
  + **Please note:** In your first 90 days with our plan, you may continue to see your current providers, at no cost to you, if they are not a part of our network. During the [plans should insert the transition period (e.g., “90 days or until assessment and Personal Care Plan are completed”)], our Care Coordinator will contact you to help you find providers in our network. After [plans should insert the transition period (e.g., “90 days or until assessment and Personal Care Plan are completed”)], we will no longer cover your care if you choose to see out-of-network providers.
* **You must get your care from network providers**. Usually, the plan will not cover care from a provider who does not work with the health plan. But sometimes this rule does not apply:
  + The plan covers emergency or urgently needed care from an out-of-network provider. To learn more about what *emergency* or *urgently needed care* means, see page <page number>.
  + If you need care that our plan covers, and our network providers cannot give it to you, then you can get the care from an out-of-network provider. [Plans may specify whether authorization should be obtained from the plan prior to seeking care.] In this situation, we will cover the care [insert as applicable: as if you got it from a network provider **or** at no cost to you]. To learn about getting approval to see an out-of-network provider, see page<page number>.
  + The plan covers kidney dialysis services when you are outside the plan’s service area for a short time. You can get these services at a Medicare-certified dialysis facility.
  + If you need family planning services, you may get those services from any One Care plan provider or from any MassHealth contracted Family Planning Services Provider.
  + When you first join the plan, you can continue seeing the providers you see now for [plans should discuss the state’s continuity of care requirement].
  + [Plans should add additional exceptions as appropriate.]

# Your Care Coordinator and Long Term Supports (LTS) Coordinator

[Plans should provide applicable information about care coordination, including answers to the following questions. Plans should replace the terms “Care Coordinator” and “Care Team” with terms they use.

* What is care coordination?
* How can you contact your Care Coordinator or LTS Coordinator?

How can you change your Care Coordinator?]

# Getting care from your primary care provider, specialists, other network providers, and out-of-network providers

## Getting care from a primary care provider

[**Note:** Insert this section only if your plan uses PCPs. Plans may edit this section to refer to a Physician of Choice (POC) instead of a PCP.]

You [insert as applicable: may **or** must] choose a primary care provider (PCP) to provide and manage your care.

### What is a PCP, and what does a PCP do for you?

[Plans should describe the following in the context of their plans, as appropriate:

* What is a PCP?
* What types of providers may be a PCP?
* What is the role of a PCP in coordinating covered services?
* What is the role of a PCP in making a referral?
* What is the role of a PCP when you need prior authorization (approval before you can get a service)?

Can a clinic be your primary care [insert as appropriate: physician **or** provider]? (RHC/FQHC)]

### How do you choose your PCP?

[Plans must describe how to choose a PCP.]

### Changing your PCP

You may change your PCP for any reason, at any time. Also, it’s possible that your PCP might leave our plan’s network. In that case, you would have to find a new PCP.

[Plans should describe how to change a PCP and indicate when that change will take effect   
(e.g., on the first day of the month following the date of the request, immediately upon receipt of the request, etc.).]

[Plans that are obligated under state Medicaid programs to have a transition benefit when a doctor leaves a plan must discuss that benefit here.]

### Services you can get without first getting approval from your PCP

[**Note:** Insert this section only if plans use referrals to network providers.]

In most cases, you need a **referral** to see any provider that is not your PCP. A referral is approval from [plans should insert as applicable: your PCP or our plan].

Sometimes you **do not need a referral.** You can get services like the ones listed below without first getting a referral or authorization from your PCP:

* Emergency services from network or out-of-network providers.
* Urgently needed care from network providers.
* Urgently needed care from out-of-network providers when you can’t get to network providers (for example, when you are outside the plan’s service area).
* Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are outside the plan’s service area. (Please call Member Services before you leave the service area. We can help you get dialysis while you are away.)
* Flu shots [insert if applicable: hepatitis B vaccinations, and pneumonia vaccinations] [insert if applicable: as long as you get them from a network provider].
* Routine women’s health care. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams [insert if applicable: as long as you get them from a network provider].

[Plans should add additional bullets as appropriate.]

## How to get care from specialists and other network providers

A *specialist* is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples.

* *Oncologists* care for patients with cancer.
* *Cardiologists* care for patients with heart problems.

*Orthopedists* care for patients with bone, joint, or muscle problems.

[Plans should describe how members access specialists and other network providers, including:

* What is the role (if any) of the PCP in referring members to specialists and other providers?
* What is the process for getting prior authorization? Explain that prior authorization means that the member must get approval from the plan before getting a specific service or drug. Include information about who makes the prior-authorization decision (e.g., the plan, the PCP, or another entity) and who is responsible for getting the prior authorization (e.g., the PCP, the member). Refer members to the Benefits Chart in Chapter 4 [plans may insert reference, as applicable] for information about which services require prior authorization.

Does the selection of a PCP result in being limited to specific specialists or hospitals to which that PCP refers (i.e., subnetworks or referral circles)?]

## What if a network provider leaves our plan?

[Plans may edit this section if they are obligated under state Medicaid programs to have a transition benefit when a doctor leaves the plan.]

A network provider you are using might leave our plan. If one of your providers does leave our plan, you have certain rights and protections that are summarized below:

* Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
* We will make a good faith effort to give you at least 30 days’ notice so that you have time to select a new provider.
* We will help you select a new qualified provider to continue managing your health care needs.
* If you are undergoing medical treatment, you have the right to ask, and we will work with you to ensure, that the medically necessary treatment you are getting is not interrupted.
* If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file a complaint.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. [Plans should provide contact information for assistance.]

## How to get care from out-of-network providers

[One Care plans should tell members under what circumstances they may obtain services from out-of-network providers (e.g., when providers of specialized services are not available in network). Include Medicaid out-of-network requirements. Describe the process for getting authorization, including who is responsible for getting it.]

* **Please note:** If you go to an out-of-network provider, the provider must be eligible to participate in Medicare or MassHealth. We cannot pay a provider who is not eligible to participate in Medicare or MassHealth. If you go to a provider who is not eligible to participate in Medicare or MassHealth, you must pay the full cost of the services you get. Providers must tell you if they are not eligible to participate in Medicare or MassHealth.

# How to get long-term supports and services (LTSS)

[Plans should provide applicable information about getting LTSS.]

# How to get behavioral health services

[Plans should provide applicable information about getting behavioral health services.]

# How to get self-directed care

[Plans should provide applicable information about getting self-directed care. This description should include:

* What is self-directed care?
* Who can get self-directed care?

How to get help in employing personal care providers (if applicable)

How to request that a copy of all written notices be sent to Care Team participants identified by the member]

# How to get dental and vision services

[Plans should provide applicable information about getting dental and vision services.]

# How to get covered services when you have a medical emergency or urgent need for care, or during a disaster

## Getting care when you have a medical emergency

### What is a medical emergency?

A *medical emergency* is a medical condition with symptoms such as severe pain or serious injury. The condition is so serious that if it doesn’t get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:

* serious risk to your health or to that of your unborn child; ***or***
* serious harm to bodily functions; ***or***
* serious dysfunction of any bodily organ or part; ***or***
* in the case of a pregnant woman in active labor, when:
  + there is not enough time to safely transfer you to another hospital before delivery.
  + a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

### What should you do if you have a medical emergency?

If you have a medical emergency:

* **Get help as fast as possible.** Call 911 or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first.
* [Plans add if applicable: **As soon as possible, make sure that you tell our plan about your emergency.** We need to follow up on your emergency care. You or someone else [plans may replace “someone else” with “your Care Coordinator” or other applicable term] should call to tell us about your emergency care, usually within 48 hours. However, you will not have to pay for emergency services because of a delay in telling us.] [Plans must either provide the toll-free phone number and days and hours of operation or explain where to find the number (e.g., on the back of the Member ID Card).]

### What is covered if you have a medical emergency?

[Plans that cover emergency medical care outside the United States or its territories through Medicaid may describe this coverage based on the state Medicaid program coverage area. Plans must also include language emphasizing that Medicare does not provide coverage for emergency medical care outside the United States and its territories.]

[Plans may modify the following sentence to identify whether this coverage is also offered outside the United States and its territories:]You may get covered emergency care whenever you need it, anywhere in the United States or its territories. If you need an ambulance to get to the emergency room, our plan covers that. To learn more, see the Benefits Chart in Chapter 4 [plans may insert reference, as applicable].

[Plans that offer a supplemental benefit covering emergency/urgent coverage or ambulance services outside of the United States or its territories, mention the benefit here and then refer members to Chapter 4 [plans may insert reference, as applicable] for more information.]

If you have an emergency, we will talk with the doctors who give you emergency care. Those doctors will tell us when your medical emergency is over.

[Plans may modify this paragraph as needed to address the post-stabilization care for your plan.] After the emergency is over, you may need follow-up care to be sure you get better. Your follow-up care will be covered by our plan. If you get your emergency care from   
out-of-network providers, we will try to get network providers to take over your care as soon as possible.

### What should you do if you have a behavioral health emergency?

[Plans should provide applicable information about getting behavioral health emergency services, including Emergency Service Program (ESP) information.]

### What if it wasn’t an emergency after all?

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You might go in for emergency care, but the doctor may say it wasn’t really an emergency. As long as it was reasonable for you to think your health was in serious danger, we will cover your care.

However, after the doctor says it was *not* an emergency, we will cover your *additional* care *only* if:

* you go to a network provider; ***or***

the care you get is considered “urgently needed care” and you follow the rules for getting this care. (See the next section.)

## Getting urgently needed care

### What is urgently needed care?

*Urgently needed care* is care you get for a sudden illness, injury, or condition that isn’t an emergency but still needs care right away. For example, you might have a flare-up of an existing condition and need to have it treated.

###### Getting urgently needed care when you are in the plan’s service area

In most situations, we will cover urgently needed care *only* if:

* you get this care from a network provider; ***and***

you follow the other rules described in this chapter.

However, if you can’t get to a network provider, we will cover urgently needed care that you get from an out-of-network provider.

[Plans must insert instructions for how to access urgently needed services (e.g., using urgent care centers, a provider hotline, etc.).]

###### Getting urgently needed care when you are outside the plan’s service area

When you are outside the service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care that you get from any provider.

[Plans that cover urgently needed care outside the United States or its territories through Medicaid may describe this coverage based on the state Medicaid program coverage area.]

Our plan does not cover urgently needed care or any other [insert if plan covers emergency care outside of the United States and its territories: non-emergency] care that you get outside the United States.

[Plans that offer emergency/urgent coverage outside of the United States and its territories as a supplemental benefit, modify this section.]

## Getting care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from <plan name>.

Please visit our website for information on how to obtain needed care during a declared disaster: <web address>. [*In accordance with 42 CFR 422.100(m), plans are required to include on their web page, at a minimum, information about coverage of benefits at non-contracted facilities at network cost sharing without required prior authorization; terms and conditions of payment for non-contracted providers; and each declared disaster’s start and end dates.*]

During a declared disaster, if you cannot use a network provider, we will allow you to get care from out-of-network providers at [insert as applicable: the in-network cost-sharing rate **or** no cost to you]*.* If you cannot use a network pharmacy during a declared disaster, you will be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5 for more information.

# What if you are billed directly for services covered by our plan?

If a provider sends you a bill instead of sending it to the plan, you can ask us to pay the bill.

* **You should not pay the bill yourself. If you do, the plan may not be able to pay you back.**

If you have paid for your covered services or if you have gotten a bill for [plans with cost sharing, insert: the full cost of] covered medical services, **see Chapter 7 [plans may insert reference, as applicable] to learn what to do**.

<Plan name> covers all services:

* that are medically necessary; ***and***
* that are listed in the plan’s Benefits Chart (see Chapter 4 [plans may insert reference, as applicable])*;* ***and***

that you get by following the plan’s rules.

If you get services that aren’t covered by our plan, **you will have to pay the full cost yourself.**

If you want to know if we will pay for any medical service or care, you have the right to ask us verbally or in writing. If we say we will not pay for your services, you have the right to appeal our decision.

Chapter 9 [plans may insert reference, as applicable] explains what to do if you want the plan to pay for a medical service it doesn’t usually pay for. It also tells you how to appeal a decision about a service. You may also call Member Services at <toll-free number> to learn more about this.

We will pay for some services up to a certain limit. If you go over the limit, you will have to pay the full cost to get more of that type of service. Call Member Services to find out what the limits are and how close you are to reaching them.

# How are your health care services covered when you are in a clinical research study?

## What is a clinical research study?

A *clinical research study* (also called a *clinical trial*) is a way for doctors to test new types of health care or drugs. They ask for volunteers to help with the study. This kind of study helps doctors decide if a new kind of health care or drug works, and if it is safe.

Once Medicare [plans that conduct or cover clinical trials that are not approved by Medicare, insert: or our plan]approves a study that you want to be in, someone who works on the study will contact you. That person will tell you about the study and see if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

While you are in the study, you may stay enrolled in our plan. That way, you can continue to get care from our plan not related to the study.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us [plans that do not use PCPs may delete the rest of this sentence] or your primary care provider. The providers that give you care as part of the study do *not* need to be network providers.

[If applicable, plans should describe Medicaid’s role in providing coverage for clinical research studies.]

**You *do* need to tell us before you start participating in a clinical research study.**   
If you plan to be in a clinical research study, you or your Care Coordinator should contact Member Services to let us know you will be in a clinical trial.

## When you are in a clinical research study, who pays for what?

If you volunteer for a clinical research study that Medicare approves, you will pay nothing for the services covered under the study and Medicare will pay for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you are covered for most items and services you get as part of the study. This includes:

* room and board for a hospital stay that Medicare would pay for even if you weren’t   
  in a study;
* an operation or other medical procedure that is part of the research study; and

treatment of any side effects and complications of the new care.

[Plans that conduct or cover clinical trials that are not approved by Medicare insert: We will pay any costs if you volunteer for a clinical research study that Medicare does not approve but that our plan approves.] If you are part of a study that Medicare [plans that conduct or cover clinical trials that are not approved by Medicare, insert: or our plan]has *not* approved, **you will have to pay any costs for being in the study**.

[If applicable, plans should describe Medicaid’s role in paying for clinical research studies.]

## Learning more

You can learn more about joining a clinical research study by reading “Medicare & Clinical Research Studies” on the Medicare website (https://www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users (people who are deaf, hard of hearing, or speech disabled) should call 1-877-486-2048.

# How are your health care services covered when you are in a religious nonmedical health care institution?

[If applicable, plans should revise this section as needed to describe Medicaid’s role in providing care in religious non-medical health care institutions.]

## What is a religious nonmedical health care institution?

A *religious nonmedical health care institution* is a place that provides care that you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, then we will cover care in a religious nonmedical health care institution. You may choose to get health care at any time for any reason. This benefit is only for Medicare Part A inpatient services (nonmedical health care services). Medicare will pay for nonmedical health care services provided only by religious nonmedical health care institutions.

## What care from a religious nonmedical health care institution is covered by our plan?

To get care from a religious nonmedical health care institution, you must sign a legal document that says you are against getting medical treatment that is “non-excepted.”

* “Non-excepted” medical treatment is any care that is *voluntary* and *not required* by any federal, state, or local law.

“Excepted” medical treatment is any care that is *not* voluntary and *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious nonmedical health care institution must meet the following conditions.

* The facility providing the care must be certified by Medicare.
* Services are limited to *nonreligious* aspects of care.
* If you get services in a facility:
  + the services must be for a medical condition that we would cover as inpatient hospital care or skilled nursing facility care; and
  + [Omit this bullet if not applicable] you must get approval from our plan before you are admitted to the facility, or your stay will not be covered.

[Plans must explain whether Medicare Inpatient Hospital coverage limits apply (include a reference to the Benefits Chart in Chapter 4 [plans may insert reference, as applicable]) or whether there is unlimited coverage for this benefit.]

# Rules for owning durable medical equipment (DME)

## Will you own your DME?

*DME* means certain items ordered by a provider for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You will always own certain items, such as prosthetics. In this section, we discuss DME you must rent.

In Medicare, people who rent certain types of DME own it after 13 months. As a member of <plan name>, however, you [insert if the plan sometimes allows transfer of ownership to the member: usually] will not own DME, no matter how long you rent it.

[If the plan allows transfer of ownership of certain DME items to members, the plan must modify this section to explain the conditions under which and when the member can own specified DME.]

[If the plan sometimes allows transfer of ownership to the member for DME items other than prosthetics, insert: In certain situations, we will transfer ownership of the DME item to you. Call Member Services to find out about the requirements you must meet and the papers you need to provide.]

[If the plan never allows transfer of ownership to the member (except as noted above, for example, for prosthetics), insert:Even if you had DME for up to 12 months in a row under Medicare before you joined our plan, you will not own the equipment.]

[Plans should modify this section as necessary to explain any additional Medicaid coverage of DME.]

## What happens if you switch to Medicare?

You will have to make 13 payments in a row under Original Medicare to own the DME item if:

* you did not become the owner of the DME item while you were in our plan; ***and***

you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program.

If you made payments for the DME item under Original Medicare before you joined our plan, those Medicare payments do not count toward the 13 payments. You will have to make 13 new payments in a row under Original Medicare to own the DME item.

* There are no exceptions to this case when you return to Original Medicare.