Are you shopping for a new health plan this Open Enrollment?

Use the Health Connector ***Shopping Guide*** to help you think about your health plan options this Open Enrollment. These and other helpful resources can be downloaded from: mahealthconnector.org/help-center/resource-download-center

If you choose a new health plan, take these steps to transition (move) your health care from the health insurance plan you have now to your new health plan.

What are the first steps I should take to transition (move) my health care to a new health insurance plan?

If you need to change health care providers (such as doctors and hospitals you use) under your new plan, you may want to:

- ✓ Make sure you have enough refills on your prescriptions to last until your new plan starts and your new doctor can write you a prescription.
- ✓ Ask your current doctor or health plan for copies of your medical records, including any prior authorizations or referrals for other providers that you have right now. In some cases, you may be able to download this information from your current plan's member website. This will help your new doctors give you the best care.
- ✓ If your current doctor or hospital is not in your new plan's network, contact your new plan to ask for a new **in-network provider**. If you have a plan with a HMO network, you may need to have a primary care provider before you can get referrals to other providers.
- ✓ Your new plan will have a member website. You should sign up on their member website as soon as possible so you can get your plan information.

What does it mean for providers to be in-network or out-of-network?

A provider network is a group of doctors, hospitals, and other providers that works with a health plan to give you care. Each plan has a different network. "In-network" means the provider is part of the health plan network. If you get care from an in-network provider, it will cost you less. "Out-of-network" means the provider is not part of the health plan network. If you get care from an out-of-network provider, your plan may not pay for those services and you could have to pay all or part of the cost yourself.

What if I already scheduled surgery, tests, or doctor visits for after my new plan starts?

If you have health care services planned after the start date of your new plan, call your doctor to discuss your options. Your current referrals or authorizations for care may or may not be valid (allowed) with your new plan. You should also call your new plan to ask how any of your ongoing care needs will be handled.

What if my doctor or hospital is not covered through my new plan's network?

If a health care service is medically necessary for you and covered by your plan, but you can't find an in-network provider for the care, or if you have already scheduled care with a particular provider, call your new health insurance company's customer service phone number for help.

The health insurance company's customer service staff will work with you to see if there is a doctor or hospital in their network who can treat you. In most cases, they will require that you see an in-network medical provider.

If there is no in-network provider who can give you the care, your new plan may sometimes arrange for you to see an out-of-network provider. However, if there is a provider in the network who can give you the care, your new plan will require you to change providers.

If there is an emergency: Your new plan cannot require you to pay more than the in-network cost if you get emergency care from an out-of-network hospital's emergency room. If you go to an out-of-network hospital for emergency care, remember to call your health insurance company and tell them as soon as possible.

What if my medication is not covered through my new plan?

If you switch plans and need a medication that is not on the list of prescription medications covered by your new plan (also called a "formulary"), you can contact your health plan's customer service hotline to ask about their **prescription drug exceptions process**, which allows you to get a prescribed drug that's not normally covered by your health plan.

Every plan must have a prescription drug exceptions process that allows you to request coverage of a prescribed drug not covered by your plan. While the process will be different for each plan, usually your doctor will send a request to your plan that the non-covered drug is clinically appropriate for your medical condition. You should contact your new health plan to learn more about its process.

What should I do when my new plan starts?

Your new plan will send you a new ID card. Show that new card to any providers you are keeping. In the meantime, if you change plans, call your doctor's office and let them know. That way, they can help you avoid any billing issues and ensure any new referrals or approvals are in place for your care.

What if I followed these steps, but am having trouble accessing health care in my new plan?

If your health plan denies coverage, you have a right to appeal the health plan's decision. Your denial letter from the insurance company should explain the services the health plan is denying and why. You have the right to ask your insurance company to reconsider this decision through an "internal appeal" with your health plan. If your insurance company denies your internal appeal, you have the right to an "external appeal" with an independent decision-maker.

Contact your health plan to learn more about your appeal rights. You can also learn more by reading the **Evidence of Coverage** booklet from your health plan.

How can I contact my new health plan with questions?

You can call your new health plan's customer service hotline to work with them to determine how to transition your care from one health plan to another. Your new plan may also have helpful resources on its website. The next page shows a list of contact information for the insurers that offer plans through the Health Connector.

Health Insurer	Customer Service Center	Helpful Links
Ambetter from Celticare Health	877-687-1186 Monday–Friday, 8:00 a.m.–5:00 p.m.	https://ambetter.celticarehealthplan.com/resources/handbooks-forms.html
Blue Cross Blue Shield of Massachusetts	800-262-2583 Monday–Friday, 8:00 a.m.–6:00 p.m.	www.bluecrossma.com/connector/
Boston Medical Center HealthNet Plan	Pre-Enrollment Questions 888-566-0010 and 888-566-0012 Monday–Friday, 8:00 a.m.–6:00 p.m. Enrolled Members 800-792-4355 Monday–Friday, 8:00 a.m.–6:00 p.m.	www.bmchp.org/members/new-member-faq
Fallon Health Plan	Pre-Enrollment Questions 866-345-2486 (Monday-Friday, 8:00 a.m.–5:00 p.m.) Enrolled Members 800-868-5200 Monday, Tuesday, Thursday, Friday, 8:00 a.m.–6:00 p.m. Wednesday, 10:00 a.m.–6:00 p.m.	www.fchp.org/members/New-FCHP-members.aspx
Harvard Pilgrim Health Care	888-333-4742 Monday, Tuesday, Thursday 8:00 a.m.–6:00 p.m. Wednesday, 10:00 a.m.–6:00 p.m. Friday, 8:00 a.m.–5:30 p.m.	www.harvardpilgrim.org/portal/page?_pageid=213,223367&_dad=portal&_schema=PORTAL
Health New England	888-310-2815 Monday–Friday, 8:00 a.m.–6:00 p.m.	http://healthnewengland.org/member/FAQ
Minuteman Health	Pre-Enrollment Questions 855-428-2382 Monday–Friday, 8:00 a.m.–6:00 p.m.	http://minutemanhealth.org/Resources

	Saturday, 8:00 a.m.–12:00 p.m. Enrolled Members 855-644-1776 Monday–Friday, 8:00 a.m.–6:00 p.m.	
Neighborhood Health Plan	866-414-5533 Monday–Friday, 9:00 a.m.–6:00 p.m. Thursday 8:00 a.m.–8:00 p.m.	www.nhp.org/member/benefits/pages/medical.aspx
Tufts Health Plan Direct	Pre-Enrollment Questions 888-257-1985 Monday–Friday, 8:00 a.m.–5:00 p.m. Enrolled Members 888-257-1985 Monday–Friday, 8:00 a.m.–5:00 p.m.	https://tuftshealthplan.com/explore-our-plans/tufts-health-direct
Tufts Health Plan Premier	617-972-9400 Monday–Thursday, 8:00 a.m.–7:00 p.m. Friday, 8:00 a.m.–5:00 p.m.	https://tuftshealthplan.com/explore-our-plans/tufts-health-premier

Glossary of Terms:

Health Maintenance Organization (HMO): A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Medically Necessary: Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Primary Care Provider: primary care provider is a doctor (physician), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Prior Authorizations: Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

Referrals: A written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services.