[Mass. Gen. Laws ch. 176O, § 6.]

§ 6. Evidence of coverage to be delivered to covered adults by health, dental and vision care providers; contents: Health Insurance Consumer Protections

(a) A carrier shall issue and deliver to at least one adult insured in each household residing in the commonwealth, upon enrollment, an evidence of coverage and any amendments thereto. Said evidence of coverage shall contain a clear, concise and complete statement of:

(1) the health care services and any other benefits which the insured is entitled to on a nondiscriminatory basis;

(2) the prepaid fee which must be paid by or on behalf of the insured;

(3) the limitations on the scope of health care services and any other benefits to be provided, including: (i) all restrictions relating to preexisting condition exclusions; (ii) an explanation of any facility fee, allowed amount, co-insurance, copayment, deductible or other amount that the insured may be responsible to pay to obtain covered benefits from network or out-of-network providers; and (iii) the toll-free telephone number and website established by the carrier under section 22 and an explanation of the information that an insured may obtain through such toll-free telephone number and website;

(4) the locations where, and the manner in which, health care services and other benefits may be obtained, including: (i) an explanation that whenever a proposed admission, procedure or service that is a medically necessary covered benefit is not available to an insured within the carrier's network, the carrier shall cover the out-of-network admission, procedure or service and the insured will not be responsible to pay more than the amount which would be required for similar admissions, procedures or services offered within the carrier's network; and (ii) an explanation that whenever a location is part of the carrier's network, that the carrier shall cover medically necessary covered benefits delivered at that location and the insured shall not be responsible to pay more than the amount required for network services even if part of the medically necessary covered benefits are performed by out-of-network providers unless the insured has a reasonable opportunity to choose to have the service performed by a network provider.

(5) the criteria by which an insured may be disenrolled or denied enrollment and the involuntary disenrollment rate among insureds of the carrier;

(6) a description of the carrier's method for resolving insured complaints, including a description of the formal internal grievance process required by section 13, and the external grievance process established pursuant to section 14, for appealing decisions pursuant to said grievances, as required by this chapter;

(7) the requirement that an insured's coverage may be canceled, or its renewal refused, only in the following circumstances: (i) failure by the insured or other responsible party to make payments required under the contract; (ii) misrepresentation or fraud on the part of the insured; (iii) commission of acts of physical or verbal abuse by the insured which pose a threat to providers or other insureds of the carrier and which are unrelated to the physical or mental condition of the insured; provided, that the commissioner prescribes or approves the procedures for the implementation of the provisions of this clause; (iv) relocation of the insured outside the service area of the carrier; and (v) non-renewal or cancellation of the group contract through which the insured receives coverage;

(8) a summary description of the procedure, if any, for out-of-network referrals and any additional charge for utilizing out-of-network providers;

(9) a summary description of the utilization review procedures and quality assurance programs used by the carrier, including the toll-free telephone number to be established by the carrier that enables consumers to determine the status or outcome of utilization review decisions;

(10) a statement detailing what translator and interpretation services are available to assist insureds; provided, that the commissioner shall determine in which languages other than English such statement shall be printed;

(11) a list of prescription drugs excluded from any restricted formulary available to insureds under the health benefit plan; provided, that the carrier shall annually disclose any changes in such a formulary, and shall provide a toll-free telephone number to enable consumers to determine whether a particular drug is included in the formulary;

(12) a summary description of the procedures followed by the carrier in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials;

(13) a statement on how to obtain the report regarding grievances from the office of patient protection pursuant to paragraph (3) of subsection (a) of section 16 of chapter 6D;

(14) the toll-free telephone number, facsimile number, and internet site for the office of patient protection or, if applicable, the designated state consumer assistance program; and

(15) such other information as the commissioner may by regulation require.

(b) A dental or vision carrier shall issue and deliver to at least 1 adult insured in each household residing in the commonwealth, upon enrollment, an evidence of coverage and any amendments thereto, a summary of the information contained in the evidence of coverage or refer the insured to resources where the information can be accessed, including, but not limited to, an internet website. If the dental or vision carrier chooses to deliver an evidence of coverage, it shall contain a clear, concise and complete statement of:—

(1) the dental or vision care services and any other benefits which the insured is entitled to on a nondiscriminatory basis;

(2) the limitations on the scope of dental or vision care services and any other benefits to be provided, including an explanation of any deductible or copayment feature and all restrictions relating to preexisting condition exclusions;

(3) the locations where, and the manner in which, dental or health care services and other benefits may be obtained;

(4) the criteria by which an insured may be disenrolled or denied enrollment and the involuntary disenrollment rate among insureds of the carrier;

(5) a description of the carrier's method for resolving insured complaints;

(6) the requirement that an insured's coverage may be canceled, or its renewal refused, only in the following circumstances: (i) failure by the insured or other responsible party to make payments required under the contract; (ii) misrepresentation or fraud on the part of the insured; (iii) commission of acts of physical or verbal abuse by the insured which pose a threat to providers or other insureds of the carrier and which are unrelated to the physical or mental condition of the insured; provided, that the commissioner prescribes or approves the procedures for the implementation of the provisions of this clause; (iv) relocation of the insured outside the service area of the carrier; and (v) nonrenewal or cancellation of the group contract through which the insured receives coverage;

(7) a summary description of the procedure, if any, for out of network referrals and any additional charge for using out of network providers;

(8) a summary description of the utilization review procedures and quality assurance programs used by the carrier, including the toll-free telephone number to be established by the carrier that enables consumers to determine the status or outcome of utilization review decisions;

(9) a statement detailing what translator and interpretation services are available to assist insureds. The commissioner shall determine in which languages other than English such statement shall be printed;

(10) such other information as the commissioner may by regulation require.