211 CMR 152.00: HEALTH BENEFIT PLANS USING SELECTIVE, REGIONAL OR TIERED PROVIDER NETWORKS

Section

152.01: Purpose, Scope and Authority

211 CMR 152.00 applies to the design and Marketing of Insured Health Benefit Plans that make use of: (1) a Selective Provider Network that differs from the Carrier's General Provider Network; (2) a Regional Provider Network; or (3) a Tiered Provider Network in which the Health Benefit Plan copayments, coinsurance or deductibles are tied to the Health Care Provider's assigned benefit level tier. 211 CMR 152.00 also governs the offering by Carriers of at least one Health Benefit Plan with a reduced, Selective or Tiered network to Eligible Small Businesses or Eligible Individuals as defined in M.G.L. c. 176J. 211 CMR 152.00 is promulgated pursuant to the Commissioner's authority under SECTION 103 of Chapter 359 of the Acts of 2010 and SECTION 32A of Chapter 288 of the Acts of 2010, M.G.L. c. 176D, § 11, M.G.L. c. 176J, § 11 and M.G.L. c. 176O, §§ 2 and 17.

152.02: Definitions

As used in 211 CMR 152.00, the following words mean:

Advertisement: Advertisement shall include:

(a) Printed and published material, audio-visual material and descriptive literature used by a Carrier in direct mail, newspapers, magazines, internet websites, radio scripts, television scripts, billboards and similar displays;

(b) Descriptive literature and sales aids of all kinds issued by a Carrier, insurance producer or other entity for presentation to the insurance-buying public including, but not limited to,

circulars, leaflets, booklets, internet webpages, depictions, illustrations, and form letters; and

(c) Prepared sales talks, presentations and material for use by providers and insurance producers.

Commissioner: The Commissioner of Insurance appointed pursuant to M.G.L. c. 26, § 6.

Carrier: An insurer licensed or otherwise authorized to transact health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a nonprofit medical service corporation organized under M.G.L. c. 176B; a health maintenance organization licensed under M.G.L. c. 176G; an organization entering into a preferred provider arrangement under M.G.L. c. 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer. Carrier shall not include any entity to the extent it offers a policy, certificate or contract that provides coverage solely for dental care services or vision care services.

Covered Benefits: Those Health Care Services to which an Insured is entitled under the terms of the Health Benefit Plan.

Division: The Division of Insurance established pursuant to M.G.L. c. 26, § 1.

Emergency Services: Services to treat 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 section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. 1395dd(e)(1)(B).

Evidence of Coverage: Any certificate, contract or agreement of health insurance including riders, amendments, endorsements and any other supplementary inserts or a summary plan description pursuant to § 104(b)(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1024(b), issued to an Insured specifying the benefits to which the Insured is entitled.

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.

General Provider Network: The most comprehensive provider network offered by a Carrier in its Massachusetts Service Area.

Health Benefit Plan: A policy, contract, certificate or agreement entered into, offered, or issued by a Carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of covered Health Care Services.

Health Care Professional: A physician or other health care practitioner licensed, accredited or certified by the Commonwealth of Massachusetts or other authorized entity to perform specified Health Care Services.

Health Care Provider or Provider: A Health Care Professional or a Facility.

Health Care Services: Services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

Insured: An enrollee, covered person, member, policyholder or subscriber of a Carrier.

Marketing or Marketing Material: Any of the following including, but not limited to, Advertisements, when they are used by any person with the intent of soliciting an offer to contract for a Health Benefit Plan:

(a) Printed, published or web based material, audio-visual material and descriptive literature used in direct mail, newspapers, magazines, radio or TV scripts, billboards, computer or electronic transmissions and similar displays;

(b) Descriptive literature and sales aids of all kinds issued for presentation to members of the insurance-buying public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, internet web pages and form letters;

(c) Prepared sales talks, presentations and material; and

(d) All oral and written solicitations and presentations.

Network Adequacy: Sufficient access to Covered Benefits with a Provider Network within the Health Benefit Plan's Service Area.

Network Provider: A person or entity under contract with a Carrier or with its subcontractor to provide covered Health Care Services to Insureds.

PCP: A Provider that is a primary care Provider designated by the Insured.

Provider Network: A group of Health Care Providers contracted with a Carrier or affiliate to provide Health Care Services to Insureds covered by any or all of the Carrier's or affiliate's plans, policies, contracts or other arrangements.

Reclassification Date: The specified date on which the Carrier completes its annual reclassification of tiered Providers.

Regional Provider Network: A Provider Network that includes only those Providers that have agreed to participate in the Carrier's plan in a limited geographic area. A Regional Provider Network may be a subset of the Carrier's General Provider Network.

Selective Provider Network: A Provider Network that is not a Regional Provider Network but includes a subset of Providers available through the Carrier's Regional Provider Network or General Provider Network.

Service Area: The geographical area, as approved by the Commissioner, within which the Carrier has developed a Provider Network to afford adequate access to Insureds for Covered Benefits.

Tiered Provider Network: A Provider Network in which a Carrier assigns Providers to different benefit tiers based on the Carrier's assessment of a Provider's relative cost and, if applicable, quality and in which Insureds pay the cost-sharing (copayment, coinsurance or deductible) associated with a Provider's assigned benefit tiers.

152.03: Selective and Regional Provider Network Plans

(1) A Carrier proposing to offer a Health Benefit Plan that uses a Selective Provider Network or a Regional Provider Network shall submit to the Division materials demonstrating that:

(a) The Carrier grants each Provider the right to opt out of a new Health Benefit Plan with a Selective Provider Network or a Regional Provider Network at least 60 days before the new plan is submitted to the Commissioner; and

(b) The Carrier maintains enrollment systems, Marketing Materials and Evidences of Coverage that identify for all Providers, employers and Insureds the Provider Network available through the Insured's Health Benefit Plan.

(2) A Carrier shall use defined criteria and evaluation systems that are coordinated by appropriate Carrier staff and overseen by the Carrier's medical director to develop Provider Networks to maintain Network Adequacy.

152.04: Tiered Provider Network Plans

(1) A Carrier proposing to offer a Health Benefit Plan that uses a Tiered Provider Network with variations on cost-sharing between Provider tiers, shall submit to the Division materials demonstrating that:

(a) The Carrier grants each Provider the right to opt out of a new Health Benefit Plan with a Tiered Provider Network at least 60 days before the new plan is submitted to the Commissioner for approval.

(b) The Carrier maintains enrollment systems, Marketing Materials and Evidences of Coverage that identify for all Providers, employers and Insureds the Provider Network available through the Insured's Health Benefit Plan.

(c) The Carrier has a system in place for Providers to appeal the tier in which each is placed. Descriptions of criteria such as data sources and methodologies for placing Providers in specific tiers shall be made available to a Provider prior to the appeal process.

(d) Variations on cost-sharing between Provider tiers are reasonable in relation to the premium charged:

1. Carriers may offer more than two benefit level tiers of Providers within the Tiered Provider Network; and

2. Variations among each of the benefit level tiers must be reasonable in relation to the premium charged.

(2) A Carrier must use defined criteria and evaluation systems that are coordinated by appropriate Carrier staff and overseen by the Carrier's medical director to classify Providers by benefit level tier.

(3) A Carrier shall provide detailed information on its website and available in paper form, on request, about its Tiered Network Plan(s), including, but not limited to:

(a) The Providers participating in the Tiered Network Plan;

(b) The selection criteria used to select the Providers;

(c) The potential for Providers to move from one tier to another at any time; and

(d) If applicable, the tier in which each Provider is classified.

(4) A Carrier may reclassify Providers within Health Benefit Plans using a Tiered Provider Network among the tiers as follows:

(a) A provider may be reclassified from a lower cost sharing tier to a higher cost sharing tier only on the Carrier's Reclassification Date.

(b) A Carrier that is reclassifying a Provider from a lower cost-sharing tier to a higher cost-sharing tier shall submit the following information to the Division:

1. At least five months prior to the effective date of the change in tier, the Carrier shall submit to the Division a copy of the material the Carrier will use to notify all Providers within the Tiered Provider Network who are expected to be reclassified to a higher cost-sharing tier, which shall explain:

a. The process and the Health Benefit Plan-specific data used by the Carrier to make the reclassification decision;

b. The process by which the Provider may obtain additional information regarding the Carrier's reclassification decision;

c. Notification of the Provider's right to appeal the reclassification decision within 30 days after receiving notice of such decision from the Carrier; and

d. The process by which the Provider may appeal the reclassification decision, which shall be completed within 60 days after the Provider received notice of such decision from the Carrier;

2. A copy of Provider directories and internet-based listing of the Providers in Health Benefit Plans using the Tiered Provider Network, which shall be updated and submitted to the Division at least 90 days before the Reclassification Date with the listing of the tier to which each Provider will be assigned; and

3. At least 90 days before the Reclassification Date, a Carrier shall provide to the Division a copy of any material changes to Marketing Material that will be used in employer and individual open enrollment documents for coverage effective on or after the Reclassification Date to notify all prospective Insureds and renewing Insureds of the new tiering classifications.

4. At least 90 days before the Reclassification Date, the Carrier shall submit a copy of all information that shall be provided to Insureds pursuant to 152.04(5).

(5) For any Health Benefit Plans that will be in effect on the Reclassification Date, the Carrier shall provide certain information to Insureds at least 30 days before the Reclassification Date. This information shall include, but not be limited to the following notices:

(a) If the Carrier allows or requires the designation of a PCP, a statement provided to all Insureds whose PCP has been reclassified to a higher cost-sharing tier which shall describe the process used to reclassify Providers, explain how to access a list of the reclassified Providers and describe the procedure for choosing an alternative PCP to obtain treatment at the same cost-sharing level.

(b) If an Insured is in her second or third trimester of pregnancy and a Provider in connection with her pregnancy is reclassified to a higher cost-sharing level, the statement provided to such an Insured shall identify the process used to reclassify the Provider, the new benefit tier for the Provider and the new cost-sharing level for continued treatment by that Provider. The statement also shall include a description of the procedure for choosing an alternative Provider to continue treatment associated with the pregnancy.

(c) If an Insured is terminally ill and a Provider providing treatment in connection with such illness is reclassified to a higher cost-sharing level, a statement shall be provided to such Insured identifying the process used to reclassify the Provider, the new benefit tier for the Provider treating the illness and the new cost-sharing level for continued treatment by

that Provider and a description of the procedure for choosing an alternative Provider to continue treatment associated with the illness.

152.05: Network Adequacy

(1) The Commissioner shall determine Network Adequacy for a Tiered Provider Network plan based on the availability of a sufficient number of Providers in the Carrier's overall Tiered Provider Network plan.

(2) Factors considered in a Provider Network Adequacy determination may include, but are not limited to, the following:

(a) The location of Providers contracted to participate in the Provider Network;

(b) Employers or Insureds that enroll in the plan;

(c) The range of services offered by Providers in the plan; and

(d) Plan provisions that recognize and provide for extraordinary medical needs of members that cannot be adequately treated by Providers within the plan.

152.06: Provider Contracts in Selective, Regional and Tiered Provider Network Plans

(1) Prior to implementing a Health Benefit Plan with a Selective, Regional or Tiered Provider Network, a Carrier shall have signed contracts with those Providers that will be in that Network which are in compliance with the requirements of 211 CMR 52.12.

(2) Provider contracts shall include a statement that the Carrier shall notify the Provider, in writing, at least 60 days before the effective date of the following modifications. The Provider and the Carrier may agree, in writing, on an alternative date for notice of such modifications in the contract.

(a) Modification to the process used to classify Providers by benefit tier;

(b) Modification to the timelines that the Carrier will use to make decisions and implement any reclassification of Providers by benefit tier;

(c) Modification in the information collected from Providers to make classifications; and

(d) Modification in the criteria used to make classifications.

(3) Provider contracts shall state the Provider's right to:

(a) Receive notification of the Carrier's classification of a Provider to a benefit tier;

(b) Be provided with an explanation of the past experience and other criteria used by the Carrier to make classification decisions; and

(c) Appeal the classification decisions and receive a decision on such appeal prior to the new classification being made available on the Carrier's website and in material provided to employers and individuals.

(4) Provider contracts shall explain the way that the Carrier will notify Providers about its Health Benefit Plans such that a Provider may clearly identify the Health Benefit Plans that use a Tiered Provider Network, a Regional Provider Network, a Selective Provider Network or a General Provider Network.

(5) Provider contracts shall state that the Provider has the right to opt out of any new Health Benefit Plan that uses a Selective Provider Network or a Tiered Provider Network at least 60 days before the Health Benefit Plan is submitted to the Commissioner for approval.

152.07: Marketing of and Enrollment in Selective, Regional and Tiered Provider Network Plans

(1) Marketing of Selective, Regional and Tiered Provider Network Plans

(a) Nothing in 211 CMR 152.07 shall affect a Carrier's obligation to comply with the requirements of 211 CMR 40.00.

(b) All Advertisements and Marketing Materials shall clearly identify the Health Benefit Plans being offered by the Carrier that only provide access through a Selective Provider Network, Regional Provider Network or Tiered Provider Network. Carriers shall ensure that such Advertisements and Marketing Materials specifically use the terms "Selective Provider Network", "Regional Provider Network" or "Tiered Provider Network" so that Providers, employers and Insureds may be fully informed about the Provider Network features applicable to the offered Health Benefit Plan. In addition, Carriers shall establish auditable internal marketing procedures, methods for assuring compliance by insurance producers and prohibitions against high-pressure tactics.

(c) All Advertisements and Marketing Materials used in the sale, solicitation or negotiation of a Carrier's Health Benefit Plan that uses a Selective Provider Network, a Regional Provider Network or a Tiered Provider Network shall clearly disclose to prospective Insureds the type of Provider Network and the exact name of the Provider Network used for the plan. Insurance producers selling, soliciting or negotiating a Carrier's Health Benefit Plan that uses a Selective Provider Network, Regional Provider Network or Tiered Provider Network shall use only those Advertisements or Marketing Materials that contain such a disclosure.

(d) All Advertisements and Marketing Materials used in the sale, solicitation or negotiation of a Carrier's Health Benefit Plan that uses a Selective Provider Network, a Regional

Provider Network or a Tiered Provider Network shall adequately disclose all provisions of the Health Benefit Plan, including but not limited to the following provisions:

1. The first or cover page of the Advertisements or Marketing Material shall disclose the applicable Provider Network description statement in a box in the center in at least 12-point type:

   a. "[Selective/Regional Provider Network] ¶ This plan provides access to providers that are not the same as [name of Carrier]'s general provider network. Please be aware that this plan only provides access to covered benefits from the providers in [name of network]. Please consult the associated provider directory for information on available providers."

   b. "Tiered Provider Network ¶ This plan assigns network providers to benefit tiers. You may pay different [copayments, coinsurance, deductibles] based on a provider's assigned benefit tier. This plan updates the providers' assigned benefit tier each year on [identify date]. You may pay different [copayments, coinsurance, deductibles] if your provider is reassigned to a different benefit tier. Please consult the [network's name] provider directory for information on the tier levels of available providers."

(e) A Carrier shall provide appropriate training to any employee or insurance producer selling, soliciting or negotiating its insurance products about the Carrier's Health Benefit Plans that use Selective Provider Networks, Regional Provider Networks or Tiered Provider Networks. Carriers shall maintain records of those employees and insurance producers who have satisfactorily completed such training and make such information available to the Commissioner upon request.

(2) Enrollment in Selective, Regional and Tiered Provider Network Plans

(a) All applications or other forms a Carrier or insurance producer uses to enroll a prospective Insured in a Health Benefit Plan that uses a Selective Provider Network, a Regional Provider Network or a Tiered Provider Network shall include language identified in 211 CMR 152.07(1)(d)1 and the prospective Insured shall initial and date such section to indicate that he/she understand the plan's modified Provider Network features.

(b) All applications or other forms a Carrier or insurance producer uses to enroll a prospective Insured in a Health Benefit Plan that uses a Selective Provider Network, a Regional Provider Network or a Tiered Provider Network shall include a disclosure notice in a form approved by the Commissioner and the prospective Insured shall initial and date such disclosure notice to indicate that he/she has received the disclosure notice and that he/she understands the plan's modified Provider Network features.

(c) A Health Benefit Plan that uses a Selective Provider Network, a Regional Provider Network or a Tiered Provider Network may only be effective for an employer group or

an individual if the prospective Insured receives prior to the time that the prospective Insured is presented with an application or enrollment form for such plan an access guide designated by the Commissioner.

(3) Any Carrier or insurance producer that fails to comply with any provisions of 211 CMR 152.07 shall be deemed to have committed an unfair or deceptive act or practice in the business of insurance in violation of M.G.L. c. 176D, § 3.

152.08: Evidences of Coverage for Selective, Regional and Tiered Provider Network Plans

(1) In addition to containing the information required under 211 CMR 52.13, the first or cover page of the Evidence of Coverage for a Health Benefit Plan that uses a Selective Provider Network, a Regional Provider Network of a Tiered Provider Network shall disclose the following:

(a) A statement of applicable Provider Network:

1. "[Selective/Regional Provider Network]. This plan provides access to providers that are not the same as [name of carrier]'s general provider network. Please be aware that this plan only provides access to covered benefits from the providers in [name of network]. Please consult the associated provider directory for information on available providers."

2. "Tiered Provider Network. This plan assigns network providers to benefit tiers. You may pay different [copayments, coinsurance, deductibles] based on a provider's assigned benefit tier. This plan updates the providers' assigned benefit tier each year on [identify date]. You may pay different [copayments, coinsurance, deductibles] if your provider is reassigned to a different benefit tier. Please consult the [network's name] provider directory for information on the tier levels of available providers."

(b) A statement regarding access to Health Care Services:

1. A statement that the insured will be notified if a Provider is no longer participating in a Selective Provider Network, Regional Provider Network, or Tiered Provider Network, or has been reclassified to a different benefit level tier in a Tiered Provider Network.

2. A description of coverage for Emergency Services, including a statement that Insureds may obtain Health Care Services for an emergency medical condition, including local pre-hospital emergency medical service systems, whenever the Insured has an emergency medical condition which in the judgment of a prudent layperson would require pre-hospital emergency medical services, and that the Carrier will provide coverage of Emergency Services from any Provider. For Health Benefit Plans using Tiered Provider Networks, this statement shall also note that Emergency Services will be covered from all Providers at the cost level of the lowest

cost-sharing tier regardless of the tier in which the Health Benefit Plan has classified the Provider providing such Emergency Services within the Tiered Provider Network.

(2) The member identification card shall prominently display the name of the Provider Network that applies to the Health Benefit Plan. If the Provider Network is a Selective Provider Network, Regional Provider Network or Tiered Provider Network, the term abbreviation "SEL", "REG" or "TIER", respectively, should be prominently displayed on the top right hand side of the card.

(3) A Carrier may use evidences of coverage issued prior to July 1, 2011 in compliance with 211 CMR 152.08. Evidences of Coverage for plans issued or renewed on or after July 1, 2011 shall comply with all of the requirements of 211 CMR 152.08. Carriers shall issue, upon renewal, to at least one adult Insured in each household whose coverage renews between July 1, 2011, and June 30, 2012, an Evidence of Coverage that complies with 211 CMR 152.08.

(4) A Carrier shall include in all Evidences of Coverage for a Selective Provider Network, a Regional Provider Network or a Tiered Provider Network a statement detailing the translator and interpretation services that are available to assist Insureds, including a statement that the Carrier will provide, upon request, interpreter and translation services related to the Carrier's application and administrative procedures. The statement regarding available translator and interpretation services shall appear in the Evidence of Coverage in at least the following languages: Arabic, Cambodian, Chinese, English, French, Greek, Haitian-Creole, Italian, Lao, Portuguese, Russian and Spanish.

152.09: Provider Directories for Selective, Regional and Tiered Provider Network Plans

(1) In addition to containing the information required under 211 CMR 52.15, the first or cover page of a printed provider directory or the first screen of an internet-based provider directory for a Health Benefit Plan that uses a Selective Provider Network, a Regional Provider Network or a Tiered Provider Network shall include the following statement of applicable Provider Network:

(a) "[Select/Regional Provider Network] This plan provides access to providers that are not the same as [name of carrier]'s general provider network. Please be aware that this plan only provides access to covered benefits from the providers in [name of network]. Please consult this provider directory for information on available providers."

(b) "Tiered Provider Network. This plan assigns network providers to benefit tiers. You may pay different [copayments, coinsurance, deductibles] based on a provider's assigned benefit tier. This plan updates the providers' assigned benefit tier each year on [identify date]. You may pay different [copayments, coinsurance, deductibles] if your provider is reassigned to a different benefit tier. Please consult this [network's name] provider directory for information on the tier levels of available providers."

(2) For Health Benefit Plans using Tiered Provider Networks, a symbol shall be displayed next to each Provider listing that prominently identifies the exact tier that the Provider is assigned to in the Provider Network.

(3) For Health Benefit Plans using Tiered Provider Networks, there shall be a descriptor at the bottom of each printed page, or in the case of an internet listing, at the bottom of each screen print, notifying the reader of the next date on which the Carrier will update the classification of Providers among the benefit tiers.

152.10: Plan Reporting for Selective, Regional and Tiered Provider Network Plans

Carriers shall submit to the Division by April 30 of that year information identifying the prior year's utilization trends of employers and individuals enrolled in the Carrier's Selective Provider Network plans and Tiered Provider Network plans. The information shall be submitted in a format and according to specifications identified by the Commissioner, which shall include, but shall not be limited to:

a. The number of Insureds enrolled by plan type;

b. Aggregate demographic and geographic information on all Insureds;

c. Direct premium claims incurred as defined in M.G.L. c. 176J, § 6 for the Carrier's Selective Provider Network plans and Tiered Provider Network plans as compared to direct premium claims incurred for the Carrier's non-tiered and non-selective plans;

d. Utilization by tier during the plan year; and

e. Requests by Insureds enrolled in Selective Provider Network plans for out-of-network coverage within the plan year.

152.11: Severability

If any section or portion of a section of 211 CMR 152.00, or the applicability thereof to any person or circumstance is held invalid by any Court of competent jurisdiction, the remainder of 211 CMR 152.00, or the applicability thereof to other persons or circumstances, shall not be affected thereby.

152.12: Appendix A: Applicant Disclosure Notice

APPLICANT DISCLOSURE NOTICE
PROVIDER NETWORK ACCESS

[Carrier Name
Mailing Address
Customer Service Toll-Free Number]

[[SELECTIVE] [REGIONAL]] PROVIDER NETWORK

PLAN PROVIDES ACCESS TO PROVIDERS THAT ARE NOT THE SAME AS [NAME OF CARRIER]'S GENERAL PROVIDER NETWORK

Your member identification card will display the name of your provider network ["SEL", "REG"] on the top right hand side of the card that applies to the health benefit plan you have chosen.

- I understand that I may not change plans during a policy year.
- I understand that the plan provides access to providers that are not the same as [name of carrier]'s general provider network.
- I have reviewed the [name of network] provider directory and understand that this plan only provides access to covered benefits from the providers in the [name of network] directory.
- I understand that it is my responsibility to ensure that a provider I voluntarily choose is enrolled in the [name of network] provider network prior to obtaining care.
- In choosing the [name of network] plan, I understand a change in treating providers will be required if they are not enrolled in the [name of network] provider network.
- I certify that I have received the [guide designated by the Commissioner] prior to reviewing and completing the application/enrollment form.

Initials _____ Date _____]]

[[**TIERED PROVIDER NETWORK**
PLAN ASSIGNS NETWORK PROVIDERS TO BENEFIT TIERS

Your member identification card will display the name of your provider network ["TIER"] on the top right hand side of the card that applies to the health benefit plan you have chosen.

- I understand that I may not change plans during a policy year.
- I understand that the plan I have chosen assigns network providers to benefit tiers.
- I understand that I will pay different [copayments, coinsurance, deductibles] based on a provider's assigned benefit tier.
- I understand that the carrier may reassign a provider's assigned benefit tier each year on [identify date].
- I understand that if a provider is reassigned to a different benefit tier, I am responsible to pay a different [copayments, coinsurance, deductibles].
- I have reviewed the [name of network] provider directory and understand that symbols displayed next to each provider identify the exact tier that the provider is assigned.
- I certify that I have received the [guide designated by the Commissioner]" prior to reviewing and completing the application/enrollment form.

Initials _____ Date _____]]

[Assigned Form#]