January 1, 2023 – December 31, 2023

Evidence of Coverage for MassHealth-Only Members:

Your Health Benefits and Services and Prescription Drug Coverage as a Member of CCA Senior Care Options (HMO D-SNP) offered by Commonwealth Care Alliance, Inc.

Please contact our Member Services number at 866-610-2273 for additional information. (TTY users should call 711.) Hours are 8 am to 8 pm, 7 days a week, from October 1 to March 31. (April 1 to September 30: 8 am to 8 pm, Monday to Friday, and 8 am to 6 pm, Saturday and Sunday.)

Este documento está disponible de forma gratuita en español.

You can get this document for free in other formats, such as large print, braille, or audio. Call 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week, from October 1 to March 31. (April 1 to September 30: 8 am to 8 pm, Monday to Friday, and 8 am to 6 pm, Saturday and Sunday.) The call is free.

We will keep your request for alternative formats and special language on file for future mailings.

Benefits may change on January 1, 2024.

H2225_23_MHEOC_C Approved

The List of Covered Drugs (formulary), pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

CCA Senior Care Options (HMO D-SNP) is a health plan that contracts with both Medicare and the Commonwealth of Massachusetts Medicaid program to provide benefits of both programs to enrollees. Enrollment in the plan depends on contract renewal.

This plan, CCA Senior Care Options, is offered by Commonwealth Care Alliance, Inc. (When this Evidence of Coverage says “we,” “us,” or “our,” it means Commonwealth Care Alliance, Inc. When it says “plan” or “our plan,” it means CCA Senior Care Options.)

In the Commonwealth of Massachusetts, Commonwealth Care Alliance, Inc. does business as Commonwealth Care Alliance Massachusetts (CCA).

Multi-language Interpreter Services

English: ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-866-610-2273 (TTY 711).

Spanish (Español): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-610-2273 (TTY 711).

Chinese (繁體中文): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-610-2273（TTY 711）。

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-610-2273 (TTY 711).

French (Français): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-610-2273 (ATS 711).

Vietnamese (Tiếng Việt): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-610-2273 (TTY 711).

German (Deutsch): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-610-2273 (TTY 711).

Korean (한국어): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-610-2273 (TTY 711)번으로 전화해 주십시오.

Russian (Русский): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-610-2273 (телетайп 711).

Arabic (العربية): ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل على الرقم 1-866-610-2273 (رقم هاتف الصم والبكم 711).

Hindi (हिंदी): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-610-2273 (TTY 711) पर कॉल करें।

Italian (Italiano): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-610-2273 (TTY 711).

Portuguese (Português): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-610-2273 (TTY 711).

French Creole (Kreyòl Ayisyen): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-610-2273 (TTY 711).

Polish (Polski): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-610-2273 (TTY 711).

Greek (Ελληνικά): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-866-610-2273 (TTY 711).

Japanese (日本語): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-610-2273（TTY 711）まで、お電話にてご連絡ください。

Cambodian (ខ្មែរ): ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-866-610-2273 (TTY 711)។

Lao/Laotian (ພາສາລາວ): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-866-610-2273 (TTY 711).

Gujarati (ગુજરાતી): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-610-2273 (TTY 711).

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SECTION 1: Welcome to CCA Senior Care Options

We, at **Commonwealth Care Alliance Massachusetts (CCA),** are pleased to introduce you to our **CCA Senior Care Options** plan**.** We welcome you as a member in the plan and urge you to review this document carefully. Feel free to ask us questions about any of the sections. We will be happy to answer them for you. If you have recently enrolled with our program, please use this booklet as a guide for understanding CCA Senior Care Options. This booklet will serve as an explanation of your benefits covered under CCA Senior Care Options.

Commonwealth Care Alliance Massachusetts (CCA) is an integrated care system influencing innovative models of complex care nationwide. We're a not-for-profit, community-based payer and provider serving over 40,000 individuals with significant health needs. Our mission is to improve the health and well-being of people with significant needs by innovating, coordinating, and providing the highest-quality, individualized care. CCA aims to help members enjoy the best possible quality of life through better health and greater independence.

To enroll in CCA Senior Care Options, you must be:

- At least 65 years old
- A Massachusetts resident living in our service area (See Section 20: **Service Area** for a list of cities and towns that are in the plan's service area)
- Enrolled in MassHealth Standard (Medicaid): You can have both Medicare and MassHealth Standard, or just MassHealth Standard alone.
- Not have any other comprehensive health insurance coverage that meets a basic benefit standard, other than Medicare
- Living at home or in a long-term-care facility (The member cannot be inpatient at a chronic or rehabilitation hospital or reside in an intermediate care facility for people with intellectual disabilities.)

You may also qualify if you are eligible for the Frail Elder Waiver (FEW). For information about the FEW program, contact Serving the Health Insurance Needs of Everyone (SHINE) at 1-800-243-4636 (TTY 1-800-439-2370).

Please note: If you lose your MassHealth Standard (Medicaid) eligibility but can reasonably be expected to regain eligibility within one (1) month, then you are still eligible for membership in our plan.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

CCA Senior Care Options helps you remain as independent as possible by improving your ability to access the most appropriate and necessary services you require. Our program allows for your **primary care provider (PCP) and your care team** to coordinate a comprehensive range of health and health-related services that bests suits your healthcare needs. Your PCP and care team is dedicated to providing a personalized approach to your care so that you, your family member, or anyone else you appoint to participate in your care, and our network of providers are able to work together on your behalf.

CCA Senior Care Options will work in partnership with you, your family member, or anyone else you appoint to participate in your care, your PCP, and/or your care team to coordinate all appropriate services.

CCA Senior Care Options provides access to all necessary and required services 24 hours a day, seven days a week. All covered services are provided through the CCA Senior Care Options extensive network: specialists, hospitals, community-based home care providers, skilled nursing facilities, and other providers. Your PCP/care team coordinates hospital and nursing home care in the plan's network facilities.

Please take the time to review our list of network providers (**Provider and Pharmacy Directory**). As a member of our plan, you will need to receive all your care from our network of providers, with the exception of emergency and urgently needed care or services otherwise approved by your PCP/care team.

SECTION 2: Telephone numbers and other information for reference

Section 2.1: How to contact Member Services

Member Services is an essential component of our organization. The Member Services staff is ready to assist by answering any questions you have. It does not matter if you are a member of CCA Senior Care Options or whether you are just inquiring about enrolling with a Commonwealth Care Alliance Massachusetts plan, our staff is happy to help you. Our staff can speak your language or has access to someone who does. Whether you have questions concerning the information that you have read in this booklet or if your questions are more general in nature, you may call our toll-free phone

number and a Member Services Representative will help you.

Our Member Services representatives are here to help.

Here are some examples of how to use our Member Services staff. They can:

- Explain the list of covered services in detail
- Help you to select or change a primary care provider (PCP) or assist you if your PCP leaves our program
- Update your address and other demographic information
- Discuss and assist with complaints, appeals and, reimbursements
- Assist you with any barriers to care that you may encounter

If you have any questions or concerns, please call or write to Commonwealth Care Alliance Massachusetts Member Services. We will be happy to help you.

Commonwealth Care Alliance Massachusetts Member Services	
CALL	866-610-2273 Calls to this number are free. April 1 to September 30: 8 am to 8 pm, Monday to Friday and 8 am to 6 pm, Saturday to Sunday October 1 to March 31: 8 am to 8 pm, 7 days a week Member Services also has free language interpreter services available.
TTY	711 This number is for people who are deaf, hard of hearing, or speech disabled. You must have special telephone equipment to call it. Calls to this number are free.

	April 1 to September 30: 8 am to 8 pm, Monday to Friday and 8 am to 6 pm, Saturday to Sunday October 1 to March 31: 8 am to 8 pm, 7 days a week
FAX	617-426-1311
WRITE	Commonwealth Care Alliance, Inc. Member Services Department 30 Winter Street Boston, MA 02108
WEBSITE	www.ccama.org

Help us keep your membership record up to date

CCA Senior Care Options has a membership record (centralized enrollee record) in your name. Doctors, hospitals, and other plan providers use the membership record to record and keep track of the services you use. The membership record includes information from your enrollment form, including your address and telephone number. It shows your specific plan coverage, including your primary care provider (PCP). Section 14.4: **We must protect the privacy of your personal health information (PHI)** tells how we protect the privacy of your personal health information.

Your care team is responsible for updating the membership record concerning your most recent medical and support needs. A current listing of medications is available in the membership record along with any referrals you have from your PCP.

Please help us keep your membership record up to date by informing Member Services if there are any changes in your name, address, or phone number, or if you go into a nursing home. Also, tell Member Services about any changes in health insurance coverage you have from other sources, such as from your employer, your spouse's employer, workers' compensation, MassHealth (Medicaid), or liability claims such as claims against another driver in an automobile accident.

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Section 2.7.

All changes that affect eligibility must be reported to MassHealth (Medicaid) within ten (10) days, or earlier, if possible.

If you have changes to report to MassHealth (Medicaid), you can reach them through one of the following ways:

- By phone: at 1-800-841-2900 (TTY 1-800-497-4648)
- By fax: at 1-857-323-8300
- By mail: Health Insurance Processing Center
  P.O. Box 4405
  Taunton, MA 02780

For information about requesting a copy of your medical records that Commonwealth Care Alliance, Inc. maintains, please see the Notice of Privacy Practices in Section 14 of this booklet.

Section 2.2: You can get assistance from the Nurse Advice Line

CCA Senior Care Options provides you with around the clock access to an on-call skilled healthcare professional if you need medical or behavioral health information and advice. When you call, a registered nurse or behavioral health clinician or equivalent, will answer your general health and wellness-related questions. They have access to your Individualized Care Plan and can provide clinical advice regarding your physical or emotional needs. If you have an urgent health need but it is not emergency, you can call our Nurse Advice Line 24 hours a day, 7 days a week for medical, behavioral health, and substance use questions.

Contact the Nurse Advice Line about:

- Questions about your healthcare
- General health and wellness-related questions
- Need advice regarding your physical or emotional status

If you are experiencing a medical emergency, please call 911.

Nurse Advice Line	
CALL	866-610-2273 Calls to this number are free. Available 24 hours a day, 7 days a week. Free interpreter services are available.

TTY	711 Calls to this number are free. Available 24 hours a day, 7 days a week.

Section 2.3: You can get assistance from a Senior Agencies

In Massachusetts, the following agencies offer help to seniors ages 60 or older and their families, friends, and caregivers:

- **Aging Services Access Points (ASAPs)** are one-stop entry points for all of the services and benefits available to seniors in Massachusetts. These agencies provide information, applications, direct services, and referrals.

- **Councils on Aging (COAs)** are local volunteer organizations that offer information and direct services to seniors, their caregivers, and other people with aging issues. COAs are part of the local government, and work with other senior agencies and city/town departments to provide social, recreational, health, safety, and educational programs for seniors in their communities.

- **MassOptions.org** is a website where seniors and their families can get information about programs and services for the elderly in Massachusetts. It is a service of the Massachusetts Executive Office of Health and Human Services.

For information on any of these agencies call MassOptions at 1-800-243-4636 (TTY: 711) or visit their web site at www.massoptions.org.

Aging Services of North Central Massachusetts provides comprehensive information and quality services so that older people, individuals with disabilities, and their families are empowered to make personalized choices to ensure a life of dignity, safety, and respect. **Service Area**: Ashburnham, Ashby, Ayer, Berlin, Bolton, Clinton, Fitchburg, Gardner, Groton, Hubbardston, Lancaster, Leominster, Lunenburg, Princeton, Pepperell, Shirly, Sterling, Templeton, Townsend, Westminster, and Winchendon.

Method	**Aging Services of North Central Massachusetts – Contact Information**
CALL	800-734-7312 9 am to 5 pm, Monday to Friday

TTY	978-514-8841 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.
Website	www.agingservicesma.org

BayPath Elder Services, Inc. offers home care and related services enabling people to live independently and comfortably in their homes while promoting their well-being and dignity. **Service Area**: Ashland, Dover, Framingham, Holliston, Hopkinton, Hudson, Marlborough, Natick, Northborough, Sherborn, Southborough, Sudbury, Wayland, and Westborough.

Method	Bay Path Elder Services, Inc. – Contact Information
CALL	508-573-7200 9 am to 5 pm, Monday to Friday Calls to this number are **not** free.
TTY	711 (MassRelay)
Website	www.Baypath.org

Boston Senior Home Care links older adults and individuals with disabilities to programs and services that help them live independently in their own homes and communities. They also provide support, information, and resources to caregivers of family members, friends or loved ones. **Service Area**: Beacon Hill, Boston, Charlestown, Dorchester, Downtown, East Boston, North end, South Boston, South Cove, and West End.

Method	Boston Senior Home Care – Contact Information
CALL	617-451-6400 9 am to 5 pm, Monday to Friday Calls to this number are **not** free.

TTY	617-451-6404 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.
Website	www.Bshcinfo.org

Bristol Elder Services, Inc. provides and advocates for community-based services that promote independence and dignity for all elders and disabled individuals. **Service area**: Attleboro, Berkley, Dighton, Fall River, Freetown, Mansfield, North Attleboro, Norton, Raynham, Rehoboth, Seekonk, Somerset, Swansea, Taunton, and Westport.

Method	**Bristol Elder Services, Inc. – Contact Information**
CALL	508-675-2101 9 am to 5 pm, Monday to Friday Calls to this number are **not** free.
TTY	711 (MassRelay) 508-646-9704 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.
Website	www.bristolelder.org

Central Boston Elder Services, Inc. provides short and long-term care services designed to help Elders and Disabled persons remain self-sufficient and in their homes. **Service Area**: Allston, Back Bay, Boston, Brighton, Fenway, Jamaica Plain, Kenmore/Fenway, Mission Hill, Roxbury, and South End.

Method	**Central Boston Elder Services, Inc. – Contact Information**
CALL	617-277-7416 9 am to 5 pm, Monday to Friday Calls to this number are **not** free.

TTY	844-495-7400 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Website	www.centralboston.org

Coastline Elderly Services, Inc. is a private, non-profit corporation which develops, provides, and coordinates a range of home care services designed to support and maintain the independent living of older adults. **Service Area**: New Bedford, Acushnet, Dartmouth, Fairhaven, Gosnold, Marion, Mattapoisett, and Rochester.

Method	**Coastline Elderly Services, Inc. – Contact Information**
CALL	508-999-6400 8 am to 5 pm, Monday to Friday Calls to this number are **not** free.
TTY	508-994-4265 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.
Website	www.coastlinenb.org

AgeSpan provides and advocates for community-based services that promote independence and dignity for all elders and disabled individuals. **Service Area**: Amesbury, Andover, Billerica, Boxford, Chelmsford, Danvers, Dracut, Dunstable, Georgetown, Groveland, Haverhill, Lawrence, Lowell, Marblehead, Merrimac, Methuen, Middleton, Newbury, Newburyport, North Andover, Peabody, Rowley, Salisbury, Salem, Tewksbury, Tyngsboro, Westford, and West Newbury.

Method	AgeSpan – Contact Information
CALL	800-892-0890 8 am to 5 pm, Monday to Friday
TTY	800-924-4222 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Website	www.agespan.org

Elder Services of Worcester Area, Inc. helps elders and individuals with disabilities, and their families obtain essential services so that older adults can remain at home with dignity and independence for as long as possible. **Service Area**: Auburn, Barre, Boylston, Grafton, Hardwick, Holden, Leicester, Millbury, New Braintree, Oakham, Paxton, Rutland, Shrewsbury, West Boylston, and Worcester.

Method	Elder Services of Worcester Area, Inc. – Contact Information
CALL	800-243-5111 8 am to 5 pm, Monday to Friday
TTY	774-312-7291 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.
Website	www.eswa.org

Ethos is a private, not-for-profit organization that promotes the independence, dignity, and well-being of the elderly and disabled through the coordination and delivery of high-quality home and community-based care. **Service Area**: Jamaica Plain, Roslindale, West Roxbury, Hyde Park, and Mattapan.

Method	Ethos – Contact Information
CALL	617-522-6700 9 am to 5 pm, Monday to Friday Calls to this number are **not** free.
TTY	711 (MassRelay)
Website	www.ethocare.org

Greater Lynn Senior Services provides a wide range of social services to help those 60 and older to live fuller, more independent lives, safely and with dignity. **Service Area**: Lynn, Lynnfield, Nahant, Saugus, and Swampscott.

Method	Greater Lynn Senior Services – Contact Information
CALL	800-594-5164 8 am to 5 pm, Monday to Friday
TTY	844-580-1926 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Website	www.glss.net

Greater Springfield Senior Services, Inc. is a private nonprofit organization dedicated to maintaining a quality of life for older adults, caregivers, and persons with disabilities. **Service Area**: Agawam, Brimfield, East Longmeadow, Hampden, Holland, Longmeadow, Monson, Palmer, Springfield, Wales, West Springfield, and Wilbraham.

Method	Greater Springfield Senior Services, Inc. – Contact Information
CALL	800-649-3641 8 am to 5 pm, Monday to Friday
TTY	413-781-0632 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.
Website	www.gsssi.org

HESSCO is a private nonprofit organization dedicated to maintaining a quality of life for older adults, caregivers, and persons with disabilities. **Service Area**: Canton, Dedham, Foxborough, Medfield, Millis, Norfolk, Norwood, Plainville, Sharon, Walpole, Westwood, and Wrentham.

Method	HESSCO – Contact Information
CALL	800-462-5221
TTY	800-462-5221 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Website	www.hessco.org

Highland Valley Elder Services serves older adults and their families through collaboration, education, advocacy, and a range of programs designed to support them where they live. **Service Area**: Amherst, Blandford, Chester, Chesterfield, Cummington, Easthampton, Goshen, Granville, Hadley, Hampden County, Hampshire County, Hatfield, Huntington, Middlefield, Montgomery, Northampton, Pelham, Plainfield, Russell, Southampton, Southwick, Tolland, Westfield, Westhampton, Williamsburg, and Worthington.

Method	**Highland Valley Elder Services – Contact Information**
CALL	413-586-2000 9 am to 5 pm, Monday to Friday Calls to this number are **not** free.
TTY	711 (MassRelay)
Website	www.highlandvalley.org

Minuteman Senior Services helps seniors and people with disabilities live in the setting of their choice by engaging community resources and supporting caregivers. **Service Area**: Acton, Arlington, Bedford, Boxborough, Burlington, Carlisle, Concord, Harvard, Lexington, Lincoln, Littleton, Maynard, Stow, Wilmington, Winchester, and Woburn.

Method	**Minuteman Senior Services – Contact Information**
CALL	888-222-6171 9 am to 5 pm, Monday to Friday

TTY	711 (MassRelay) 1-800-439-2370 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Website	www.minutemansenior.org

Lifepath is a private, nonprofit corporation that develops, provides, and coordinates a range of services to support the independent living of elders and persons with disabilities with a goal of independence. **Service Area**: Ashfield, Athol, Bernardston, Buckland, Charlemont, Colrain, Conway, Deerfield, Erving, Gill, Greenfield, Hawley, Heath, Leverett, Leyden, Monroe, Montague, New Salem, Northfield, Orange, Petersham, Phillipston, Rowe, Royalston, Shelburne, Shutesbury, Sunderland, Warwick, Wendell, and Whately.

Method	**Lifepath – Contact Information**
CALL	800-732-4636 9 am to 5 pm, Monday to Friday
TTY	711 (MassRelay) 800-439-2370 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Website	www.lifepathma.org

Mystic Valley Elder Services promotes the health and independence of older adults, adults living with disabilities, and their caregivers. **Service Area**: Chelsea, Everett, Malden, Medford, Melrose, North Reading, Reading, Revere, Stoneham, Wakefield, and Winthrop.

Method	Mystic Valley Elder Services – Contact Information
CALL	781-324-7705 7:45 am to 5 pm, Monday to Friday Calls to this number are **not** free.
TTY	711 (MassRelay)
Website	www.mves.org

Old Colony Elder Services supports the independence and dignity of older adults and individuals with disabilities by providing essential information and services that promote healthy and safe living. **Service Area**: Abington, Avon, Bridgewater, Brockton, Carver, Duxbury, East Bridgewater, Easton, Halifax, Hanover, Hanson, Kingston, Lakeville, Marshfield, Middleboro, Pembroke, Plymouth, Plympton, Rockland, Stoughton, Wareham, West Bridgewater, and Whitman

Method	Old Colony Elder Services – Contact Information
CALL	508-584-1561 Calls to this number are **not** free.
TTY	508-587-0280 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.
Website	www.ocesma.org

SeniorCare, Inc. provides and coordinates services to elders and adults with disabilities. **Service Area**: Beverly, Essex, Gloucester, Hamilton, Ipswich, Manchester-by-the-Sea, Rockport, Topsfield, and Wenham.

Method	SeniorCare, Inc. – Contact Information
CALL	866-927-1050
TTY	978-282-1836 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.
Website	www.seniorcareinc.org

Somerville Cambridge Elder Services helps older people and people living with disabilities remain safe and independent in their own homes by providing a wide range of supportive services, as well as information and advice. **Service Area**: Cambridge and Somerville.

Method	Somerville Cambridge Elder Services – Contact Information
CALL	617-628-2601 8 am to 5 pm, Monday to Friday Calls to this number are **not** free.
TTY	617-628-1705 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.

Website	www.eldercare.org

South Shore Elder Services recommends and coordinates resources for elders in the South Shore area to help them to remain as independent as possible. **Service Area**: Braintree, Cohasset, Hingham, Holbrook, Hull, Milton, Norwell, Quincy, Randolph, Scituate, and Weymouth.

Method	**South Shore Elder Services – Contact Information**
CALL	781-848-3910 9 am to 5 pm, Monday to Friday Calls to this number are **not** free.
TTY	781-356-1992 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.
Website	www.sselder.org

Springwell, Inc. is a private, non-profit organization that has been creating, managing, and coordinating a wide range of services for more than 35 years. **Service Area**: Belmont, Brookline, Needham, Newton, Waltham, Watertown, Wellesley, and Weston.

Method	**Springwell, Inc. – Contact Information**
CALL	617-926-4100 9 am to 5 pm, Monday to Friday Calls to this number are **not** free.

TTY	617-923-1562 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.
Website	www.springwell.com

Tri-Valley helping seniors and people with disabilities to live independently with dignity in their own homes or settings of their choice. **Service Area**: Bellingham, Blackstone, Brookfield, Charlton, Douglas, Dudley, E. Brookfield, Franklin, Hopedale, Medway, Mendon, Milford, Millville, Northbridge, N. Brookfield, Oxford, Southbridge, Spencer, Sturbridge, Sutton, Upton, Uxbridge, Warren, Webster, and W. Brookfield.

Method	**Tri-Valley – Contact Information**
CALL	800-286-6640 8:30 am to 5 pm, Monday to Friday
TTY	508-949-6654 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.
Website	www.trivalleyinc.org

West Mass Elder Care provides information, resources, and long-term services to older adults, elders, and people with disabilities, as well as to support caregivers. **Service Area**: Holyoke, Chicopee, Granby, South Hadley, Ludlow, Belchertown, and Ware.

Method	**West Mass Elder Care – Contact Information**
CALL	800-462-2301 8 am to 5 pm, Monday to Friday

TTY	800-875-0287 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Website	www.wmeldercare.org

Section 2.4: How to contact the MassHealth (Medicaid) Agency

Note: In order to enroll with CCA Senior Care Options, you must have MassHealth Standard (Medicaid).

MassHealth is the name of the Massachusetts Medicaid program. MassHealth (Medicaid) is a joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. Some people with MassHealth (Medicaid) are also eligible for Medicare.

Because you get assistance from MassHealth (Medicaid), you will have no out-of-pocket expenses for your CCA Senior Care Options healthcare services. Our plan will help manage all of these benefits for you so that you can get the healthcare services and payment assistance that you are entitled to.

To find out more about MassHealth (Medicaid) and its programs, contact MassHealth (Medicaid) Customer Service.

MassHealth (Medicaid)	
CALL	1-800-841-2900 Self-service available 24 hours/day in English and Spanish. Other services available 8 am to 5 pm, Monday to Friday.
TTY	1-800-497-4648 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	MassHealth Customer Service One Ashburton Place Boston, MA 02108
WEBSITE	www.mass.gov/orgs/masshealth

Section 2.5: How to contact the Massachusetts Ombudsman Program

The My Ombudsman Program helps people enrolled in MassHealth (Medicaid) with service or billing problems. They can help you file a grievance or appeal with our plan. They can also help people get information about nursing homes and resolve problems between nursing homes and residents or their families.

My Ombudsman Program	
CALL	1-855-781-9898 9 am to 4 pm, Monday to Friday
TTY	711 (MassRelay) 339-224-6831 (Videophone for deaf and hard of hearing)
WRITE	25 Kingston St, 4th FL Boston, MA 02111
EMAIL	info@myombudsman.org
WEBSITE	www.myombudsman.org

Section 2.6: How to contact the Massachusetts LongTerm Care Ombudsmand

The LTC Ombudsman Program helps people get information about nursing homes and helps to resolve problems between nursing homes and residents or their families.

A Bridge to Quality Care, the Massachusetts Long Term Care Ombudsman	
CALL	1-800-243-4636
TTY	711 (MassRelay)
WRITE	Executive Office of Elder Affairs One Ashburton Place, 5th Floor Boston, MA 02109
WEBSITE	https://www.mass.gov/service-details/ombudsman-programs

Section 2.7: How to contact MassOptions

MassOptions is a free resource linking elders, individuals with disabilities, caregivers, and family members to services that help you or a loved one live independently in the setting of your choice. We help individuals avoid the frustration of calling multiple agencies and navigating various networks.

MassOptions	
CALL	1-800-243-4636 9 am to 5 pm, Monday to Friday
TTY	711 (MassRelay) MassOptions works with telephonic interpreter for the deaf, heard of hearing and speech impaired who wants to communicate with us.
WEBSITE	massoptions.org/ Online chat available at the link above.

Section 2.8: How to contact the Massachusetts State Health Insurance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Massachusetts, the SHIP is called SHINE (**S**erving the **H**ealth **I**nsurance **N**eeds of **E**veryone).

SHINE is an independent (not connected with any insurance company or health plan) state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

SHINE counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. SHINE counselors can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

SHINE Program (Massachusetts SHIP) – Contact Information	
CALL	1-800-AGE-INFO (1-800-243-4636)
TTY	1-800-439-2370 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Call the number above to find the address of the SHINE program in your area.
WEBSITE	www.mass.gov/health-insurance-counseling

Section 2.9: How to contact the Medicare Program

Medicare is the Federal health insurance program for people 65 years of age or older, for some people under age 65 with disabilities, and for people with End Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called “CMS”). CMS contracts with and regulates Medicare Health Plans (including CCA Senior Care Options) and Medicare Private Fee-for-Service organizations. Here are ways to get help and information about Medicare from CMS:

Medicare	
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in Massachusetts. The Medicare website also has detailed information about Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an **estimate** of what your out-of-pocket costs might be in different Medicare plans. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

Section 2.10: KEPRO/Quality Improvement Organization (QIO)

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and

other healthcare experts paid by the Federal government to check on and help improve the care given to Medicare and Medicaid patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. In Massachusetts, the QIO is called KEPRO. KEPRO is an independent organization. It is not connected with our plan. The doctors and other health experts in KEPRO, the Quality Improvement Organization, review certain types of complaints made by Medicare and MassHealth (Medicaid) patients. These include complaints about quality of care and complaints from Medicare and MassHealth (Medicaid) patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon.

KEPRO	
CALL	1-888-319-8452 9 am to 5 pm, Monday to Friday 11 am to 3 pm, Saturday to Sunday. 24-hour voicemail service is available. Translation services are available for beneficiaries and caregivers who do not speak English.
TTY	711 (MassRelay)
WRITE	KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131
WEBSITE	https://www.keproqio.com/

Section 2.11: Other Organizations (Social Security Administration and Railroad Retirement Board)

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits, disability, family benefits, survivors' benefits, and benefits for the aged, blind, and disabled.

The Social Security Administration is also responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for

Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Social Security Administration	
CALL	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use our automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday.
WEBSITE	http://www.ssa.gov

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board and have questions, you can contact the agency using the information below.

Railroad Retirement Board	
CALL	1-877-772-5772 Calls to this number are free. If you press “0,” you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press “1”, you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.
WEBSITE	www.rrb.gov

SECTION 3: Use your CCA Senior Care Options member identification (ID) card instead of your MassHealth (Medicaid) card

While you are a member of our plan, you must use your membership card whenever you get services covered by this plan and for prescription drugs you get at network pharmacies. Here’s a sample member ID card to show you what yours will look like:

As long as you are a member of our plan you must not use your MassHealth (Medicaid) card to get covered medical services. Keep your MassHealth (Medicaid) card in a safe place in case you need it later.

If your plan membership card is damaged, lost, or stolen, please call Member Services right away and we will send you a new card. Call Member Services at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week, from October 1 to March 31. (April 1 to September 30: 8 am to 8 pm, Monday to Friday, and 8 am to 6 pm, Saturday and Sunday.)

SECTION 4: Special Features of CCA Senior Care Options

Section 4.1: Primary Care Provider (PCP)

Each of our members enrolled in CCA Senior Care Options is required to have a primary care provider (PCP). If you do not choose a PCP, we will assign one for you. When you become a member of our plan, you must choose a PCP from the **CCA Senior Care Options provider network**. During the enrollment process, an onboarding specialist will work with you to choose a PCP. You may also call Member Services if you need more information about selecting or changing your PCP or help.

The PCP that you select can be a licensed primary care physician, a nurse practitioner, a physician assistant, or a women's health specialist who meets state requirements and is trained to give you basic medical care.

Our plan contracts with PCPs who know your community and who have developed working relationships with specialists, hospitals, community-based homecare providers, and skilled nursing facilities in your area. Prior authorization (approval in advance) from the plan is required for some of your services before you receive them. Your PCP/care team works closely with the plan to arrange for these services when necessary.

Your PCP, along with the other members of your care team, is responsible for coordinating all your healthcare and support service needs. "Coordinating" your services includes checking or consulting with you and other plan providers about your care and how it is going. For more information on care teams, please see section 4.2 below.

Section 4.2: Care Team

Once you are enrolled in CCA Senior Care Options, you will be assigned a **care team** to work in partnership with your PCP. The care team will assist your PCP in coordinating medical and support service needs. In addition to your PCP, the care team may include a **geriatric support services coordinator (GSSC)**, (See Section 19: **Definitions,** for more detailed description of GSSC) as well as a care partner, and others as appropriate. Each member of the care team has demonstrated experience in caring for seniors. You will get to know each member of your team very well as they will work closely with you to provide

the best coordinated care so you can remain as healthy and independent as possible.

Your PCP/care team, together with you and anyone else you choose to have involved, such as a family member, will work with you to develop an **Individualized Care Plan** designed just for you. The **Individualized Care Plan** includes all of the services that have been authorized for you to receive as a member of our program. These services are coordinated and arranged by your PCP/care team. To ensure you are receiving the most appropriate care at all times, your PCP/care team reviews, approves, and authorizes changes to the IPC. With your active participation, your PCP/care team reassesses your needs at least every 6 months, but more frequently if necessary.

Section 4.3: One Source for All Your Care

As a member of our plan, you will benefit from coordination of care and improved access to the most appropriate and necessary services. Your PCP/care team will work with you and your family to identify the best plan of care for you. Our contract with MassHealth (Medicaid) allows us to work with your PCP and other network specialists to provide comprehensive services and flexible benefits.

CCA Senior Care Options is able to provide its members with an array of health and health-related services. You will have the convenience of a single point of contact (your care partner or a clinician on call) for any problems or questions as well as access to care 24 hours a day, seven days a week once you have enrolled with our plan.

Section 4.4: Coordination of Services

CCA Senior Care Options offers a comprehensive array of healthcare and social services. The key objectives of the program are:

- Improve the quality and coordination of care provided to seniors
- Expand member access to covered services
- Maximize member satisfaction with services provided
- Increase the cost effectiveness of care
- Reduce the likelihood that hospitalizations or nursing home placements will be required

The end product of this unique arrangement with MassHealth (Medicaid) is that CCA Senior Care Options, in partnership with your PCP and care team, has greater flexibility in providing care and offering solutions that best fit your needs.

Section 4.5: Services are provided through CCA Senior Care Options

Our organization contracts with primary care providers (PCPs), specialists, hospitals, community-based home care providers, skilled nursing facilities and other providers that make up the extensive CCA Senior Care Options network.

Once you are enrolled in CCA Senior Care Options, you agree to receive services from our network of contracted providers and facilities. As a member of our plan, you will no longer be able to obtain services from other doctors or medical providers under the conventional MassHealth (Medicaid) program. In certain circumstances, you may receive services from out-of-network providers, such as in emergency or urgent situations without prior authorization (approval in advance) from our plan (please see Section 11: **Access to After-Hours Care, Emergency, and Urgent Care** for more information).

Your PCP, care team, or the plan may also authorize services from providers or facilities that are not part of our contracted network in unusual circumstances. **The care you receive from an out-of-network provider must be authorized prior to seeking this care.** In such a situation, we will cover these services at no cost to you. If you do not get authorization for out-of-network care in advance, you will be responsible for payment for the service. Some examples of unusual circumstances which may lead to out-of-network care are the following:

- You need medical care, including family planning services, that MassHealth (Medicaid) requires us to cover and the providers in our network cannot provide that care.
- You have a unique medical condition, and the services are not available from network providers.
- Services are available in network but are not available timely as warranted by your medical condition.
- Your PCP/care team determines that a non-network provider can best provide the service.
- You need to obtain a second opinion from out-of-network provider. Your PCP/care team will help you to arrange to receive a second opinion services from out-of-network provider.

Our **Provider and Pharmacy Directory** gives you a complete list of our network providers—that means all of the providers who have agreed to accept our payment as a payment in full. We have arranged for these providers to deliver covered services to members in our plan.

If you don't have your copy of the **Provider and Pharmacy Directory**, you can request a copy from Member Services. You may ask Member Services for more information about our network providers, including their qualifications. You can also see the **Provider and Pharmacy Directory** at www.ccama.org, or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

Some of the services require CCA Senior Care Options members to obtain authorization (approval) prior to receiving a service.

CCA Senior Care Options members do not require prior authorization (approval in advance) for the following services involving an **emergency condition*:***

- Emergency room use
- Emergency behavioral healthcare

Other services not requiring advance authorization (approval) include but are not limited to:

- Urgent care received out of the service area
- Urgent care provided in the service area but under unusual circumstances
- Women's health services provided by a network provider, including breast exams, mammograms, pap tests and pelvic exams (as long as you get them from a plan provider)
- Flu shots (as long as you get them from a plan provider)
- Out of area renal dialysis services

Please see Section 8: **Benefits and Coverage** for detailed information on covered services and authorization requirements.

Please see Section 11: **Access to After-Hours Care, Emergency, and Urgent Care** to

learn more about emergency and urgent care.

CCA Senior Care Options encourages its members to inform their PCP/care team of all visits regardless of the requirements in order to help ensure better care coordination for all service types. Members, who obtain non-emergency services without authorization when an authorization is required, may be financially responsible for the costs of the unauthorized services.

Section 4.6: Facilities

CCA Senior Care Options contracts with certain facilities involved in acute, chronic, and rehabilitative care. As a member of our plan, you will be referred to hospitals that are affiliated with your PCP and in which they have admitting and visiting privileges. These healthcare facilities will hopefully be familiar to you as they are often located in or close to the community in which you live. Please refer to our **Provider and Pharmacy Directory** to locate facilities in your network. For information on how to locate our **Provider and Pharmacy Directory**, go to Section 4.5: **Services are provided through CCA Senior Care Options.** SECTION 5: Advantages of Enrolling in CCA Senior Care Options

Commonwealth Care Alliance Massachusetts (CCA) is committed to ensuring that the member's voice is built into all of its activities. Our plan has established several ways that members can offer feedback about their experiences with their healthcare. We work with our members to learn about what works and to identify opportunities for improvement.

Our mission to promote integrated systems of community-based healthcare and related services is unique. It is achieved by contracting with committed community-based health centers and community practices that have demonstrated experience and commitment to the elder population.

Members have a single point of contact for health-related problems or questions, and access to care 24 hours a day, 7 days a week.

Other advantages to participating in CCA Senior Care Options include:

- Healthcare professionals from an array of disciplines (such as physicians, nurse practitioners, nurses, and social workers) experienced in providing care to elders
- Comprehensive long-term care services
- Coordinated care 24 hours a day, 7 days a week

- Providers who speak your language
- Assistance for family caregivers
- Individualized Care Plan
- In most cases, providers from your community that you know and trust
- Dental services
- No out-of-pocket expenses for covered services, prescription drugs or over-the-counter (OTC) medication

SECTION 6: Eligibility

You are eligible to enroll in the CCA Senior Care Options if you are:

- At least 65 years of age or older
- Enrolled in MassHealth Standard (Medicaid) or dually eligible (enrolled with Medicare and MassHealth Standard (Medicaid))
- Living in our plan's service area (Please see Section 20: **Service Area** for a detailed county and zip code listing)
- You are a United States citizen or are lawfully present in the United States
- Do not have any other comprehensive health insurance coverage that meets a basic benefit standard, other than Medicare
- Living at home or in a long-term-care facility (The member cannot be inpatient at a chronic or rehabilitation hospital or reside in an intermediate care facility for people with intellectual disabilities.)

SECTION 7: Enrollment

Enrollment in CCA Senior Care Options is VOLUNTARY.

Enrollment will be effective on the first calendar day of the month following approval of your enrollment information by MassHealth (Medicaid). CCA Senior Care Options is responsible to ensure that you are provided with all the **covered services** you require beginning on the effective date of enrollment.

Your coverage begins on the first day of the month after MassHealth (Medicaid) has approved your enrollment.

When you enroll in our program, you retain your current eligibility for MassHealth Standard (Medicaid). However, you will receive your MassHealth Standard (Medicaid) services through CCA Senior Care Options exclusively. If you have private health insurance, you may find that you no longer require additional health insurance coverage and decide to cancel your private health insurance coverage. Our staff, a caregiver, or a family member may help you make this decision. You may choose to voluntarily disenroll from our program. Voluntary disenrollment becomes effective on the first day of the month following the month in which the request is made. (See Section 16: **Termination of Enrollment from CCA Senior Care Options** for further clarification.)

SECTION 8: Benefits and Coverage

CCA Senior Care Options offers MassHealth Standard (Medicaid) **covered services** and may also include the provision of additional services not traditionally covered by MassHealth Standard (Medicaid). **Some services and benefits provided under our plan are fully covered only when authorized in advance by your PCP/care team or the plan**. Your PCP/care team works closely with the plan to arrange for these services when necessary. All prior authorization (approval in advance) requirements are marked in ***bold and italics***.

You will not have any out-of-pocket expenses for covered services as long as you meet the coverage requirements and follow the plan's rules described in this booklet.

Some services may require approval in advance (prior authorization). For more information on covered services and prior authorization requirements please see Section 8: Benefits and Coverage

Section 8.1: Outpatient Health Services and Medical Supplies

Covered services include, but are not limited to:

- General medical and specialist care, including consultation, routine care, preventive healthcare, and physical examinations. **Prior authorization is not required for services provided by a network provider.**
- Outpatient/ambulatory surgery. ***Prior authorization is required.***

- Physical, occupational and speech therapies. ***Prior Authorization is required for physical therapy, occupational therapy, and speech therapy.*** For more information, please contact your care team or Member Services

- Other therapeutic services such as cardiac and intensive cardiac rehabilitation services or pulmonary rehabilitation services. ***Prior authorization is required.***

- Nutrition counseling and education. **Prior authorization is not required for services provided by a network provider.**

- Podiatry. **Prior authorization is not required, except for podiatric surgery and podiatry services provided in a nursing home.**

- Chiropractic services. ***Prior authorization is required.***

- Acupuncture services. ***Prior authorization is required.***

- Laboratory tests, X-rays and other diagnostic procedures. ***Prior authorization may be required for outpatient diagnostic tests and therapeutic services and supplies***. For example, specialized imagining and specialized screening tests (i.e. genetic testing) may require a prior authorization. For more information, please call Member Services.

In the event that clinical input is necessary to determine whether a course of treatment is appropriate, we reserve the right to have an expert review the proposed treatment plan or request.

- Diabetic Services and supplies. CCA Senior Care Options provides select blood glucose monitors and test strips to our members with diabetes from preferred vendors. ***Prior authorization is required for glucometers and therapeutic continuous glucose monitors (CGMs). Certain diabetic test strips may require a prior authorization under specific circumstances*.** For more information, please call Member Services.

- Durable medical equipment and related supplies. Limits may apply. ***Prior authorization may be required.*** For a detailed list, please call Member Services.

- Prosthetics and orthotics. ***Prior authorization may be required****.* For a detailed list, please call Member Services.

- Vision care and eyewear. **The plan pays up to $300 per calendar year for prescription eyewear without prior authorization, including**:
    - Eyeglass frames, or
    - Contact lenses
    - Contact lenses may be dispensed only upon a written and dated prescription. The prescription must be based upon the results of a vision examination performed by the prescriber. The prescription must include all information that is necessary to enable a dispensing practitioner to order the prescription and the plan to cover the service under the MassHealth (Medicaid) benefit The plan covers the following vision care services:
        - Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration.
        - For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older
        - For individuals with diabetes, screening for diabetic retinopathy is covered once per year.
        - One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)
        - Routine vision exams
        - Prescription lenses, which includes base lenses (single, bifocal, trifocal)

      Prior authorization is not required for outpatient vision services provided by a network provider.

For questions about your vision benefits, call Member Services.

- Dental care as defined in Section 8.9: **Dental Care**. ***Prior authorization may be required.***
- Psychiatry, including evaluation, consultation, diagnostic and treatment service. **Prior authorization is not required except for neuropsychological testing, electroconvulsive therapy, transcranial magnetic stimulation, and services provided in a day program**.
- Routine hearing exams and tests, hearing aids, repairs, and replacements. Prior authorization is not required for routine hearing exams, evaluations, repairs, and replacements provided by a network provider. ***Prior authorization is required for hearing aids costing more than $500.***The plan uses NationsHearing as the benefit administrator for hearing services, including exams and hearing aids. **Members must use NationsHearing to be covered for this benefit.** Please contact NationsHearing at 877-277-9196 (TTY 711) for questions about your hearing services benefit.
- Supervised Exercise Therapy (SET) is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a healthcare provider. ***Prior authorization is required.***

Section 8.2: Inpatient Hospital Care

Services include but are not limited to:

- Semi-private room (or a private room if medically necessary)
- Meals including special diets
- Regular nursing services
- Costs of special care units (such as intensive care or coronary care units)
- Drugs and medications
- Lab tests
- X-rays and other radiology services
- Necessary surgical and medical supplies

- Use of appliances, such as wheelchairs
- Operating and recovery room costs
- Physical, occupational, and speech language therapy
- Inpatient substance use services
- Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivesicular. If you need a transplant, we will arrange to have your case reviewed by an approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the agreed-upon rates. If CCA Senior Care Options provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used.
- Physician services

Prior authorization is required except for inpatient substance use and emergency admissions.

Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.

Section 8.3: Skilled Nursing Facility (SNF) Care, Inpatient Rehabilitative Care

Services include but are not limited to:

- Semiprivate room (or a private room if medically necessary)

- Meals, including special diets
- Skilled nursing services
- Physical therapy, occupational therapy, and speech therapy
- Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.)
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need – you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used.
- Medical and surgical supplies ordinarily provided by SNFs
- Laboratory tests ordinarily provided by SNFs
- X-rays and other radiology services ordinarily provided by SNFs
- Use of appliances such as wheelchairs ordinarily provided by SNFs
- Physician/Practitioner services

Prior authorization is required.

If MassHealth (Medicaid) determines you have a monthly Patient Paid Amount (PPA) for your custodial care, you are responsible for these payments.

Section 8.4: Nursing Home Care

Services include:

- Custodial care or long-term nursing home care
- Medications

The plan also helps transition to community.

Prior authorization is required.

CCA Senior Care Options does not cover the costs of private rooms (except when it is considered medically necessary), or other therapeutic services and nonmedical items for your personal convenience such as telephone charges and radio or television rental.

If MassHealth (Medicaid) determines you have a monthly Patient Paid Amount (PPA) for your custodial care, you are responsible for these payments.

Section 8.5: Emergency and Non-Emergency Transportation

Non-emergency medical:

- The plan covers transportation you need for medical reasons other than emergencies to approved destinations in the plan's service area.
- The plan uses Coordinated Transportation Solutions (CTS) for all non-emergency transportation rides. To contact CTS, please call 855-204-1410 (TTY 711). Transportation must be arranged by CTS to be covered by CCA Senior Care Options.
- Prior authorization is not required for non-emergency medical transportation.

Non-medical purposes:

- Eight (8) one-way trips per month are provided for non-medical purposes, such as grocery shopping. Trips not used within the month are not rolled over for future use. Trips must be booked at least 72 hours, Monday through Friday, of the expected trip date.
- If you cannot go on a scheduled ride, you must cancel the ride at least 2 hours before the scheduled pick-up time. If you do not cancel your ride, and you either do not show up or cancel with less than 2 hours' notice, the scheduled ride will count against your eight (8) one-way non-medical trips per month.
- Mile limitation is applicable.

The plan uses Coordinated Transportation Solutions (CTS) for all non-emergency transportation rides. To contact CTS, please call 855-204-1410 (TTY 711). Transportation must be arranged by CTS to be covered by CCA Senior Care Options.

Ambulance services:

- Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan.
- Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.

- Our plan also covers emergency services, including emergency transportation, and urgently needed care outside the United States and its territories up to one hundred thousand dollars ($100,000) per calendar year. See Emergency and Urgent Care sections later in this chart for more information.

Prior authorization is not required for in-network and out-of-network emergency ambulance services.

Prior authorization is required for all non-emergency transportation services.

Section 8.6: Home Health Agency Care

Prior to receiving home health services, a healthcare provider must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.

Covered services include, but are not limited to:

- Part-time or intermittent skilled nursing and home health aide services (To be covered under the home healthcare benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week)
- Physical therapy, occupational therapy, and speech therapy
- Medical and social services
- Medical equipment and supplies

Prior authorization is required.

Section 8.7: Hospice Care

You are eligible for the hospice benefit when your healthcare provider and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice provider can be a network provider or an out-of-network provider. Covered services include:

- Drugs for symptom control and pain relief

- Short-term respite care
- Home care

Services are provided at home, in a hospital or a facility, or on an outpatient basis. **Prior authorization is not required for hospice services provided by a network provider or the member's elected hospice organization.**

We offer palliative care services under our palliative care program, as well as end of life care through hospice services. The palliative care program is focused on relieving pain, stress, and other uncomfortable symptoms for people living with serious illness. The program is designed for our members, their caregivers, and healthcare providers with active involvement of CCA Senior Care Options care team. In appropriate cases, we contract with appropriate outside palliative care and hospice agencies to provide services that augment the program.

When receiving palliative care, you can still receive treatment and therapies meant to improve, or even cure, your medical problems.

The program can help you:

- Find relief for pain & other symptoms
- Manage your medications
- Understand your illness and its course
- Identify what matters most to you
- Get you the right care at the right time
- Make plans and decisions
- Communicate with your providers
- Prepare for future stages

To enroll in this program, please speak with your care partner. If it is right for your needs the care partner will give you a referral to the program. **Prior authorization is not required for services provided by the CCA palliative care program or from a network provider.**

Section 8.8: Community and Long-Term Care Services and Supports

Services include but are not limited to:

- Adult Day Health
- Adult Foster Care and Group Adult Foster Care
- Alzheimer's Coaching
- Chore Services
- Companion Services
- Continuous Nursing Services/Private Duty Nursing
- Day Habilitation
- Grocery Shopping and Delivery
- Home Delivered Meals
- Homemaker
- Interpreter Services
- Laundry
- Non-emergency transportation to approved destination such as medical appointment
- Personal Care Attendant (PCA)
- Homemaker
- Respite Care
- Social Day Care

Prior authorization is required except for interpreter services. Prior authorization may be required for environmental accessibility adaptations and respite care. For a detailed list, please call Member Services.

Section 8.9: Dental Care

Our first priority for dental care is to treat pain and acute infection. Our second priority is to maintain dental functioning. Dental services will be authorized based on your

individual medical needs.

We cover these services under the MassHealth Standard (Medicaid) benefit:

Preventive/Diagnostic:

- Preventive care such as cleanings
- Routine exams
- X-rays

Restorative:

- Fillings
- Crown*
- Replacement Crown*
- Endodontic Therapy (root canals) *

Periodontics:

- Scaling and root planning*
- Periodontal Maintenance

Prosthodontics (removable):

- Complete dentures
- Partial dentures*
- Relines and adjustments of complete dentures

Implant Services:

- Implants are covered for maximum of 2 implants per arch (upper and lower) per year, for a maximum total of 4 implants per year.

Oral and Maxillofacial Surgery:

- Extractions (removal of teeth)
- Biopsy and soft tissue surgery*

- Alveoplasty
- Bone grafting

*__Our plan covers these services without prior authorization:__

- Routine exams and x-rays
- Diagnostic examinations and x-rays
- Preventive services and oral hygiene.
- Restorative fillings
- Complete dentures and relines
- Non-surgical extractions
- Emergency Care

Preventive cleanings and routine exams & x-rays are covered twice per calendar year.

Other limitations may apply.

**** Prior authorization may be required for services listed and additional services.*** For a detailed list, please call Member Services.

In the event that clinical input is necessary to determine whether a course of treatment is appropriate, CCA Senior Care Options reserves the right to have a dental expert review the treatment plan your dentist has proposed.

Services requiring authorization must be sent directly to the CCA dental benefit administrator, Skygen, by your treating network dental provider for review.

Section 8.10: Specialists/Specialty Care

CCA Senior Care Options has contracted with a number of specialists and healthcare facilities to provide specialty care. Whenever your PCP/care team determines that you need these services, they will make arrangements with a specialist they work with, although, you are covered for any specialists who are part of our network.

Our plan also covers a second opinion from a specialist or any other qualified healthcare professional for any covered services within the network. You may also obtain a second opinion from out-of-network provider if a network provider is not available. Your PCP/care team will help you to arrange to receive a second opinion services from out-of-network provider. You must get an authorization for the service you

receive from an out-of-network provider prior to seeking care. In this situation, we will cover these services at no cost to you.

Prior authorization is not required for specialty care provided by a network provider.

For a detailed list of network providers, including specialists and healthcare facilities, please see your **Provider and Pharmacy Directory.** If you don't have your copy of the **Provider and Pharmacy Directory,** you can request a copy from Member Services. Please call Member Services. You can also see the **Provider and Pharmacy Directory** at www.ccama.org. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

The most updated Provider and Pharmacy Directory is available on our website: www.ccama.org

Section 8.11: Behavioral Health Services

We provide behavioral healthcare and substance use benefits that are no more restrictive than the requirements or limitations that we apply to medical, surgical, and community support benefits. This is required under the Mental Health Parity and Addiction Equity law.

Services include but are not limited to:

- Inpatient Services for behavioral health or substance use diagnoses that require a hospital stay. ***Prior authorization is required except for inpatient substance use and emergency admissions.***
- Partial hospitalization. ***Prior authorization is not required for services provided by an in-network provider.***
- Outpatient care, including behavioral health and substance use services. ***Prior authorization is required for neuropsychological testing, psychological testing, electroconvulsive therapy, transcranial magnetic stimulation, esketamine, acupuncture treatment after 36 sessions, and services provided in a day program.***
- Emergency services, including emergency screening services program, medication management crisis, short term crisis counseling and stabilization, specializing services. ***Prior authorization is not required.***

- Diversionary Behavioral health services. Services include, but are not limited to: medically monitored inpatient withdrawal management, community crisis stabilization, community support program, clinical support services for substance use/residential substance use programs, intensive outpatient program, observation/holding beds, partial hospitalization, psychiatric day treatment, structured outpatient addiction program, recovery support navigator, recovery coach, residential rehabilitation services, Programs for Assertive Community Treatment (PACT) and telehealth (virtual care). **Prior authorization is not required.**

Opioid Treatment Program Services

Members of our plan with opioid use disorder (OUD) can receive coverage for these services to treat OUD through an Opioid Treatment Program (OTP). Covered services include:

- FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable
- Substance use counseling
- Individual and group therapy
- Toxicology testing

Prior authorization is not required.

Section 8.12: Prescription and Pharmacy Benefit

CCA Senior Care Options covers outpatient prescription medications through the pharmacy benefit. There is **no out-of-pocket cost** for prescriptions, although, some prescription drugs may require prior authorization, step therapy, or have maximum quantity limits.

We offer additional coverage for certain over-the-counter (OTC) drugs with a prescription because they are covered by MassHealth (Medicaid). Generally, only generic OTCs are covered. Please refer to our complete MassHealth (Medicaid) Over-the-Counter Drug List on our website: www.ccama.org

You will not be charged a premium, copayment, or coinsurance for covered prescription drugs or over-the-counter medications you receive. (See Section 9: **Prescription Drug Coverage** to learn more about your pharmacy benefits and drug coverage.) Please contact Member Services or visit our website if you have questions

about your medications.

Certain Medicare approved over-the-counter (OTC) items can be purchased with the CCA Healthy Savings card. You receive a card with an allowance of $285 that is applied at the beginning of each calendar quarter (every three months) to purchase Medicare-approved OTC items such as hand sanitizer, masks, first aid supplies, toothbrushes, cold symptom supplies, and others, without a prescription.

For members with chronic illnesses, you may use the Healthy Savings card to purchase healthy food products like the Supplemental Nutrition Assistance Program (SNAP) benefit. Members without chronic illness may only use the Healthy Savings card toward the purchase of Medicare-approved items.

If you have any questions about this benefit, you can call Member Services. **Prior authorization is not required for covered items purchased from a contracted retailer when using Healthy Savings card.**

Chronic diseases are generally conditions that require ongoing medical attention or limit activities of daily living. The condition is diagnosed by a licensed medical professional, including your primary care physician, nurse practitioner and similar providers.

Section 8.13: Preventive Care and Screenings

Services include:

- Abdominal aortic aneurysm screening
- Bone mass measurement
- Cardiovascular disease risk reduction visit and screening
- Cervical and vaginal cancer screening
- Colorectal cancer screenings
- Diabetes screening and self-management training
- HIV screening
- Immunizations, including influenza, hepatitis B, COVID-19, and pneumococcal vaccines
- Intensive behavioral counseling for cardiovascular disease
- Intensive behavioral therapy for obesity

- Mammography (breast cancer) screening
- Medical nutrition therapy services
- Obesity screening and therapy to promote sustained weight loss
- Prostate cancer screening
- Physical exams
- Smoking and tobacco use cessation (counseling to stop smoking)
- Screening and behavioral counseling interventions to reduce alcohol misuse
- Screening for depression in adults
- Screening for hepatitis C virus (HCV)
- Screening for lung cancer with low dose computed tomography (LDCT)
- Screening for sexually transmitted infections (STI) and high-intensity behavioral counseling to prevent STIs
- You have the option of getting these services through an in-person visit or by telehealth (virtual care). If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth
- Brief virtual check-ins
- Remote evaluation of pre-recorded video and/or images sent to your healthcare provider
- Consultation your healthcare provider has with other providers by phone, internet, or electronic health record if you're not a new patient

Annual Wellness Visit Reward

An annual wellness visit or an annual physical exam qualifies for one $25 reward per year after you've completed the visit. Routine PCP visits, like a follow-up or sick visit, don't qualify for the reward. To earn this reward, you must have an annual wellness visit or an annual exam. This visit type is longer than routine PCP visits. During an annual wellness visit or an annual exam, you and your provider will review your overall health in detail.

After you complete your qualifying exam and your provider bills us (the health plan), a reward will be loaded to your Healthy Savings card.

Covered once every calendar year.

Prior authorization is not required for services provided by a network provider, except for screening for lunch cancer with low dose computed tomography (LDCT).

Section 8.14: Other Services

Gender Reassignment/Affirmation

The plan covers gender reassignment services. Services may include the following: mastectomy, breast augmentation, hysterectomy, salpingectomy, oophorectomy, or genital reconstructive surgery. ***Prior authorization is required.***

Services and procedures that are considered cosmetic and reversal of gender reassignment surgery are not covered. Your medical provider will be required to submit your medical records for review.

For more information or help, please contact your care team.

Wellness Allowance

The plan reimburses you up to $250 each calendar year toward your cost for membership in a qualified health club or fitness facility including the YMCA, covered instructional fitness classes in-person or online, participation in wellness programs, memory fitness activities, an activity tracker (e.g. Fitbit, Apple watch, etc.), fitness equipment, such as free weights and cardio equipment, and/or weight management programs like weight watchers. You are responsible for all charges over $250 per calendar year. Reimbursement requests for a prior year must be received by CCA Senior Care Options no later than March 31 of the following year. No referral is required for this benefit. Your proof of payment must accompany the reimbursement form found on our website: www.ccama.org

Help with Chronic Conditions

CCA Senior Care Options benefits include the following additional services:

- Food and produce allowance for members diagnosed with a chronic condition. Qualifying members will have access to this allowance through their Healthy Savings OTC quarterly allowance of $285 at contracted retailers.
- Identity theft protection for members diagnosed with a chronic condition. Identity theft protections watches out for your personal information in case someone else uses your social security number or other personal information. They help you

recover your identity and reimburse for costs you may have due to identity theft. Qualifying members will be able to sign up for identity theft protection through our partner. Members must use ID Watchdog (Equifax) to be covered for this benefit. Once you enroll, you are enrolled until the end of the current plan year. If you opt to disenroll, you cannot reenroll until the next year.

Chronic conditions include: chronic alcohol and other drug dependence, autoimmune disorders, cancer, neurologic disorders, chronic and disabling behavioral health conditions, dementia, cardiovascular disorders, diabetes mellitus, chronic heart failure, end-stage liver disease, end-stage renal disease, severe hematologic disorders, HIV/AIDs, chronic lung disorders, stroke, chronic kidney disease (CKD), physical disabilities, musculoskeletal conditions, developmental disabilities, vision and hearing disorders, and more. Please speak with your care partner if you have questions about your eligibility.

Chronic diseases are generally conditions that require ongoing medical attention or limit activities of daily living. The condition is diagnosed by a licensed medical professional, including your primary care provider, nurse practitioner, and similar providers.

Home Infusion Therapy

Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin) equipment (for example, a pump) and supplies (for example, tubing and catheters)

Covered services include but are not limited to:

- Professional services, including nursing services, furnished in accordance with the plan of care
- Patient training and education not otherwise covered under the durable medical equipment benefit
- Remote monitoring
- Monitoring services for the provision of home infusion therapy and home infusion therapy supplier

Prior authorization is required.

Section 8.15: Service Decisions

Requests from members or their representatives regarding coverage for a particular

service will be addressed as quickly as the member's condition warrants, but no later than 14 days after the PCP/care team receives the request.

The 14-day time frame may be extended by 14 additional days for either of the following reasons:

- The member or designated representative requests the extension
- It is determined that additional information is required to make a determination and that the delay is in the interest of the member

If we need to extend past the 14-day deadline, you will be notified by Commonwealth Care Alliance Massachusetts in writing of that decision and the reason why. You will

be notified about your right to file a grievance if you disagree with our decision to extend the deadline.

If your health requires a quick response, you should ask us to make a "fast (expedited) service decision." You can get a fast service decision only if using the standard 14-day deadlines could cause serious harm to your health or hurt your ability to function, or if your healthcare provider tells us that your health requires a "fast service decision." A fast service decision means we will answer as quickly as your health condition requires, but no later than 72 hours after the receipt of the request for a service.

SECTION 9: Prescription Drug Coverage

This section describes the outpatient prescription drug coverage you get as a member of our plan. There are some special rules that apply to your outpatient prescription drug coverage. This section contains information on:

- Network pharmacies
- What a formulary is and how to use it
- Drug management programs

Section 9.1: What are network pharmacies?

With a few exceptions, you must use network pharmacies to get your outpatient prescription drugs covered.

- **What is a "network pharmacy"?** A network pharmacy is a pharmacy where you can get your outpatient prescription drugs through your prescription drug

coverage. We call them “network pharmacies” because they contract with our plan and have agreed to fill covered prescriptions for our plan members. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. You are not required to continue going to the same pharmacy to fill your prescription; you can go to any of our network pharmacies. For the most up-to-date list of our network pharmacies, contact Member Services or visit our website at www.ccama.org.

- **What are “covered drugs”?** “Covered drugs” is the general term we use to mean all of the prescription drugs that are covered by our plan. Covered drugs are listed in the plan’s List of Covered Drugs (Formulary). (See Section 9.6 **What drugs are covered by CCA Senior Care Options** to learn more about covered drugs and our formulary.)

Section 9.2: How do I fill a prescription at a network pharmacy?

To fill your prescription, you must show your CCA Senior Care Options member ID card at one of our network pharmacies. If you do not have your member ID card with you when you fill your prescription, you can ask the network pharmacist to call the toll-free Member Services number. Member Services staff can assist the pharmacist with identifying your correct member identification number so that they can fill your prescription. If the network pharmacist does not have access to your membership identification number, and requests that you pay the full cost of the prescription, you can ask us to reimburse you by submitting a claim to us. To learn how to submit a claim, please refer to the claims process described in Section 12: **How to ask the plan to pay you back or to pay a bill you have received**.

Section 9.3: The Provider and Pharmacy Directory gives you a list of CCA Senior Care Options network pharmacies

As a member of our plan, you have access to our **Provider and Pharmacy Directory,** which gives you a list of our network pharmacies. CCA Senior Care Options has a nationwide network of pharmacies. You can use the **Provider and Pharmacy Directory** to find a network pharmacy in your neighborhood. If you don’t have the **Provider and Pharmacy Directory**, you can get a copy from Member Services. They can also give you the most up-to-date information about changes in our plan’s pharmacy network. Contact information for Member Services is found in Section 2.1. You may also visit our website at www.ccama.org for the most up-to-date list of our network pharmacies.

- **What if a pharmacy is no longer a "network pharmacy"?** Sometimes a pharmacy might leave the plan's network. If this happens, you will have to get your prescriptions filled at another network pharmacy. Please refer to your Provider and Pharmacy Directory or call Member Services to find another network pharmacy in your area.

- **How do I fill a prescription through the CCA Senior Care Options network mail-order program?** You can use our plan's mail-order program to fill prescriptions for certain drugs. The only drugs available through our mail order service are those that you take on a regular basis for a long-term condition. When you order prescription drugs through our network mail-order program, you must order up to 90-day supply of the drug. Usually, a mail-order pharmacy order will get to you in no more than 14 days. If for any reason your mail order is delayed, please call our Member Services. We will assist you in obtaining the prescription(s) you need. For more information, please contact Member Services or speak with your PCP/care team.

If you use a mail-order pharmacy that is not in the plan's network, your prescription will not be covered.

Section 9.4: Filling prescriptions outside the network

Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. Before you fill a prescription at an out-of-network pharmacy, please call Member Services to see if there is a network pharmacy available.

- **What if I need a prescription because of a medical emergency?** We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. In this situation, you will have to pay the full cost when you fill your prescription. You can ask us to reimburse you the cost by submitting a claim to us. To learn how to submit a claim, please refer to the process described in Section 12: **How to ask the plan to pay you back or to pay a bill you have received.**

- **Getting coverage when you travel or are away from the plan's service area.** If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your

prescription drugs ahead of time through our mail-order pharmacy service or through our retail network pharmacies. If you become ill, lose or run out of our prescription drugs while traveling outside of our service area within the US, we will cover prescriptions. These prescriptions can be filled at an out-of-network pharmacy if you follow all other coverage rules identified within this document and a network pharmacy is not available.

- In this situation, you will have to pay the full cost when you fill your prescription. You can ask us to reimburse you the cost of the prescription by submitting a reimbursement form. To learn how to submit a claim, please refer to the claims process described in Section 12: **How to ask the plan to pay you back or to pay a bill you have received**.
- **Prior to filling your prescription at an out-of-network pharmacy, call Member Services to find out if there is a network pharmacy in the area where you are traveling.** If there are no network pharmacies in that area, Member Services may be able to arrange for you to get your prescriptions from an out-of-network pharmacy. Contact information for Member Services is found in Section 2.1.
- We will not pay for any prescriptions purchased outside the United States and its territories, even for a medical emergency**.**

We cannot pay for any prescriptions that are filled by pharmacies outside the United States and its territories.

Other times you can get your prescription covered if you go to an out-of-network pharmacy.

We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

- If you are unable to get a covered drug in a timely manner within our service area because there is no network pharmacy (within a reasonable driving distance) that provides 24-hour service.
- If you are trying to fill a covered prescription drug that is not regularly stocked at a network retail pharmacy or our mail-order pharmacy (these drugs include orphan drugs or other specialty pharmaceuticals).
- If you cannot use a network pharmacy during a declared disaster.

Before you fill your prescription in either of these situations, call Member Services to

see if there is a network pharmacy in your area where you can fill your prescription. If you go to an out-of-network pharmacy for the reasons listed above, you will have to pay the full cost when you fill your prescription. You can ask us to pay you back (reimburse you) for the cost. To learn how to request a reimbursement, please refer to Section 12: **How to ask the plan to pay you back or to pay a bill you have received**. Contact information for Member Services is found in Section 2.1.

Section 9.5: Types of Specialty Pharmacies

Some prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (**Note:** This scenario should happen rarely.)

Lumicera Health Services is the plan's preferred specialty pharmacy. They provide members of the CCA Senior Care Options with their specialty medications and offer personalized support. Contact Lumicera 24 hours a day, 7 days a week at 855-847-3553 with any questions about filling specialty medications.

Section 9.6: What drugs are covered by CCA Senior Care Options?

- **What is a formulary?** A formulary is a list of all the drugs we cover. It is also called the **List of Covered Drugs**. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy or through our network mail order pharmacy service, and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. The drugs on the formulary are selected by our plan with the help of a team of healthcare providers. We select the prescription therapies believed to be a necessary part of a quality treatment program and both brand-name drugs and generic drugs are

included on the formulary. A generic drug has the same active-ingredient formula as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the **F**ood and **D**rug **A**dministration (FDA) to be as safe and as effective as brand-name drugs. Not all drugs are included on the formulary. In some cases, the law prohibits coverage of certain types of drugs. (See **"Drug Exclusions,"** in Section 9.6 for more information about the types of drugs that cannot be covered under MassHealth (Medicaid).) In other cases, we have decided not to include a particular drug.

- **How do you find out what drugs are on the formulary?** You may call Member Services to find out if your drug is on the formulary or to request a copy of our formulary. You can also find the Drug List on our website at www.ccama.org. The formulary on the website is always the most current.

- **What if your drug is not on the formulary?** If your prescription is not listed on the formulary, you should first contact Member Services to be sure it is not covered. If Member Services confirms that we do not cover your drug, you have three options:

    - You can ask your healthcare provider if you can switch to another drug that is covered by us. If you would like to give your healthcare provider a list of covered drugs that are used to treat similar medical conditions, please contact Member Services.

    - You can ask us to make an exception to cover your drug. See section below for more information.

    - You can pay out-of-pocket for the drug and request that the plan reimburse you by means of an exceptions request. This does not obligate the plan to reimburse you if the exception request is not approved. See Section 13.2: **What is an appeal and how to request it?** for more information on how to request an appeal.

- **How can you request an exception to the plan's formulary?** You can ask us to make an exception to our coverage rules.

    - There are several types of exceptions that you can ask us to make, for example:

        - You can ask us to cover your drug even if it is not on our formulary.

        - You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask

us to waive the limit and cover more.

- Generally, we will only approve your request for an exception if the alternative drugs included on the plan's formulary would not be as effective in treating your condition and/or would cause you adverse medical effects.
- Please go to Section 13: **Member Complaints and Appeals about Medical Care or about Prescription Drugs Coverage** to learn more about requesting an exception. In order to help us make a decision more quickly, you should include supporting medical information from your healthcare provider when you submit your exception request. If we approve your exception request, our approval is valid for the remainder of the plan year, as long as: your healthcare provider continues to prescribe the drug for you, and the drug continues to be safe and effective for treating your condition. If we deny your exception request, you can appeal our decision. Please see Section 13.2: **What is an appeal and how to request it?** For more information about how to request an appeal.

- **Drug exclusions**

This section tells you what kinds of drugs are not covered by our plan.

The drugs or categories of drugs not covered by CCA Senior Care Options are called "exclusions" and include:

- Non-prescription drugs, unless they are part of an approved step therapy or are covered under over-the-counter (OTC) medication policy
- Drugs when used to promote fertility
- Drugs when used for cosmetic purposes or to promote hair growth
- Drugs when used for the treatment of sexual or erectile dysfunction
- Drugs when used for the treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs purchased outside the United States and its territories

Section 9.7: Programs on Drug Safety and Monitoring

Drug restrictions For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us to control drug plan costs. A team of healthcare providers and pharmacists developed these requirements and limits for CCA Senior Care Options to help us provide quality coverage to our members. Examples are described below:

- **Prior Authorization**: We require you to get prior authorization for certain drugs. This means that your healthcare provider will need to get approval from us before you fill your prescription. If they don't get approval, we may not cover the drug.
- **Quantity Limits**: For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time.
- **Step Therapy:** In some cases, we require you to first try one drug to treat your medical condition before we will cover another drug for that condition.
- **Generic Substitution:** When there is a generic version of a brand-name drug available, our network pharmacies will automatically give you the generic version.

You can find out if your drug is subject to these additional requirements or limits by looking in the formulary. If your drug has these additional restrictions or limits, you can ask us to make an exception to our coverage rules. For more information, see **How can you request an exception to the plan's formulary?** in Section 9.6.

Drug use reviews

We conduct drug use reviews for all of our members to make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one healthcare provider who prescribe their medications. We conduct drug use reviews each time you fill a prescription and on a regular basis by reviewing our records. During these reviews, we look for medication problems such as:

- Possible medication errors
- Drugs that are unnecessary because you are taking another drug to treat the same medical condition
- Drugs that are not safe or inappropriate because of your age or gender
- Possible harmful interactions between drugs you are taking

- Drug allergies
- Drug dosage errors

If we identify a medication problem during our drug use review, we will work with your healthcare provider to correct the problem.

SECTION 10: Service Exclusions

This section tells you what kinds of benefits are not covered by our plan.

- Services considered not reasonable or not medically necessary will not be covered unless these services are determined to be necessary based upon the signed Individualized Care Plan or are otherwise covered by the plan.
- Services that you get without prior authorization when prior authorization is required will not be covered. Failure to receive authorization may result in the services not being covered.
- Prescription drugs not supplied by a contracted pharmacy will not be covered unless required for an emergency or in an urgent situation.
- Cosmetic surgery or procedures will not be covered unless required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy.
- Experimental, medical, surgical, or other health procedures, equipment or medication, or procedures not generally accepted in the geographic area will not be covered.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance) will not be covered, except when medically necessary.
- Care in any hospital other than a contracted hospital will not be covered unless authorized in advance or except for emergency care.
- Non-emergent and non-urgent care rendered outside the United States and its territories will not be covered.
- Any medications purchased outside the United States and its territories will not be covered.

- Routine services received outside the plan's service area (except for emergency care, out of area urgent care and out of area dialysis) will not be covered.
- Personal comfort items provided in inpatient settings or in skilled facility such as private room (except when it is considered medically necessary) and any non-medical items for your use such as telephone charges or TV rental will not be covered.
- E-cigarettes will not be covered.

Other Coverage Provisions

If you are hospitalized when you are out of our service area, we request that you notify your PCP/care team within 48 hours or as soon as it is reasonably possible to do so.

SECTION 11: Access to After-Hours Care, Emergency, and Urgent Care

Nurse Advice Line

There may be times when you need to speak with a clinician to receive advice or treatment for a non-emergency injury or onset of an illness that simply can't wait until your PCP's regular office hours. If you need medical or behavioral health information and advice after hours, there is a clinician available 24 hours a day, 7 days a week. The clinician responding to your call will consult with you about your request. The clinician has access to your Individualized Care Plan, along with your most recent medical history, allergy, pharmacy, lab, and radiology information.

We encourage you to call Member Services line at 866-610-2273 (TTY 711) if you have urgent care needs 24 hours a day, 7 days a week. We will connect you with our Nurse Advice Line which is available 24 hours a day. We have registered nurses and behavioral health clinicians who will assist you with your medical, behavioral health, or substance use symptoms.

All urgent care and symptomatic office or home visits are available to you within 48 hours, so you will be evaluated either in an office or in your home. All non-symptomatic office visits are available to you within 30 calendar days.

CCA Senior Care Options provides you with around the clock access to medical information and advice through the Nurse Advice Line. Our on-call clinicians are available 24 hours a day, 7 days a week at 866-610-2273 (TTY 711).

Emergency Care and Post-Stabilization Care Services

In an emergency, you should call 911 or go to the nearest emergency room for care.

An emergency medical condition is one that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson**,** who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

Authorization is not required for CCA Senior Care Options to pay for emergency care. It is advised that you have someone notify your PCP/care team as soon as possible of an emergency admission. Your PCP/care team will want to know so that he/she can inform emergency care clinicians of your prior history and assist in coordinating your care.

Our plan also covers medically necessary **post-stabilization** care services following emergency services. After the emergency is over you are entitled to post-stabilization services and follow-up care to be sure your condition remains stable or to improve or resolve your condition. This may require additional care in an inpatient hospital, outpatient setting, a skilled nursing facility, or a rehabilitation center. We are required to respond to requests for approval for post stabilization care within an hour of the request. Appropriate follow-up care will be covered by our plan and we are available to consult with your treating providers and care teams to determine the appropriate next steps in treatment. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow. Our goal is to ensure that your care needs during the post-stabilization period are not disrupted by requirements for authorization.

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Emergency services, including emergency transportation, and urgently needed care outside the United States and its territories are covered by the plan up to one hundred thousand dollars ($100,000) per calendar year.

Urgently Needed Care

CCA Senior Care Options also covers care needed for an urgent medical condition. **Urgently needed care** is when you need medical attention right away for an unforeseen illness or injury and it is not reasonable, given the situation, for you to get the care you need from your PCP or other plan providers. If you are out of the plan's service area for a short time and cannot wait until you return home, our plan must pay for urgently needed care.

Emergency services, including emergency transportation, and urgently needed care outside the United States and its territories are covered by the plan up to one hundred thousand dollars ($100,000) per calendar year.

1. **In-Area Urgently Needed Care**

   By calling your PCP's office, you can make arrangements for an urgent care visit. You may also call Member Services at 866-610-2273 (TTY 711) to connect to our Nurse Advice Line. Urgent care visits to out-of-network providers in the service area will only be covered if the services are pre-approved by your PCP/care team or in situations when your PCP is temporarily unavailable or inaccessible.

2. **Out-of-Area Urgently Needed Care**

   Our program covers urgent care requests when you are temporarily out of the service area. Prior authorization is not needed when seeking out-of-area urgently needed services. Out-of-area urgent care coverage is only available to you when:

   - The care you receive is needed as a result of an unforeseen illness, injury, or condition
   - Your illness or injury requires medical attention to prevent serious deterioration in your health
   - You cannot delay necessary medical attention until you return to the service area

   We request that you call your PCP/care team when you need to receive urgent care services. If you are hospitalized when you are out of your service area, we ask that you notify your PCP/care team within 48 hours or as soon as it is reasonably possible to do so.

   Note: If you are out of the CCA Senior Care Options service area for more than six months, you will be automatically disenrolled from our plan. (Please see Section 16: **Termination of Enrollment from CCA Senior Care Options** for further clarification on involuntary Disenrollment)

3. **Reimbursement for emergency or urgent care**

   If you have paid for the emergency or urgent medical services you received and you believe that CCA Senior Care Options should pay the bill, you should request a receipt from the facility or provider. This receipt must show the provider's name, date(s) of treatment, and charges. Please send a copy of the receipt and any additional documentation to Member Services so that the claim can be processed.

For more information about our reimbursement process, our mailing address and fax number, please refer to the next section.

SECTION 12: How to ask the plan to pay you back or to pay a bill you have received

- There may be a situation when you need to pay for services or prescription drugs right away. Other times, you may receive a bill from a provider for covered services. In all these situations, you should ask us to pay you back (reimburse you) or send us the bill you have received so we can decide whether the services should be covered and pay for it. **Requests for reimbursement for fitness/wellness must be received by March 31, 2024.**

All other reimbursement requests must be submitted within 12 months of the date you received the service or item.

To make sure you are giving us all the information we need to make a decision, you can fill out our reimbursement form to make your request for payment. You don't have to use the form, but it will help us process the information faster. Your request must be written, and be signed by you, an authorized representative, or a licensed prescriber. You must include the following information with your request:

- First and Last Name
- Member ID
- Date of birth
- Service type:
    - Medical/Behavioral Health
    - Dental
    - Equipment/Supplies
    - Worldwide Emergency Services
    - Transportation
    - Healthy Savings
    - Fitness/Wellness
    - Delivered Meals
    - Vision
- The name of the service/supply provider

- Date(s) of service
- CPT/Diagnosis code
- You must include a copy of the receipt and an itemized bill of services or supplies. Receipts must show:
    - Place and date of purchase
    - Total amount paid and payment method
    - Items/services to be reimbursed
    - Service provider and date of service
- The receipt or bill should include diagnostic and procedure codes. If an itemized bill is not available, you can submit a statement from the provider/supplier on their letterhead. Both your receipt and your itemized bill must be easy to read. CCA will not honor reimbursement requests for items purchased with gift certificates, gift cards, or pre-paid debit cards. CCA will not reimburse for coupons.
- Either download a copy of the CCA reimbursement form from our website (www.ccama.org) or call Member Services and ask for the form.

Mail or fax your request for payment together with any bills or paid receipts to us at this address:

Commonwealth Care Alliance, Inc.
Member Services Department
30 Winter Street
Boston, MA 02108
Fax: 617-426-1311

Prescription reimbursement is different from medical services reimbursement. The plan works in partnership with its pharmacy benefit manager (PBM), Navitus Health Solutions (Navitus), to provide prescription reimbursements. **You must submit your claim to Navitus within 12 months of the date you received the drug.**

To make sure you are giving us all the information we need to make a decision, you can fill out our prescription reimbursement form to make your request for payment.

- You don’t have to use the prescription reimbursement form, but it will help us process the information faster. Your request must be written, and be signed and dated by you, an authorized representative, or a licensed prescriber. You must include the following information with your request:
    - First and last name

  - Telephone number
  - Date of birth
  - Gender
  - Member ID
  - Mailing address
  - The name, address, and telephone number of the pharmacy that filled your prescription
  - Date(s) the prescription was filled
  - Diagnosis code and description
  - Name of medication
  - Prescription number
  - For compound medications, the following information is needed
    - Final form of compound (cream, patches, suppository, suspension, etc.)
    - Time spent preparing drug
    - Compound ingredients
  - National Drug code
  - Quantity
  - Day supply
  - Total volume (grams, ml., each, etc.)
  - Proof of payment
  - Prescriber first and last name
  - Prescriber NPI
  - Original cost of drug
  - Amount primary insurance paid on the drug
  - Member paid amount
- Either download a copy of the prescription reimbursement form from our website (www.ccama.org) or call Member Services and ask for the form.

Mail or fax your request for payment together with any bills or paid receipts to Navitus at this address:

CCA Senior Care Options Manual Claims
PO Box 1039
Appleton, WI 54912-1039
Fax: 1-855-668-8550

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision. If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will reimburse you for the service. If we do not agree to pay your claim, please see Section 13.2: **What is an appeal and how to request it?** to learn how to request a coverage determination (service decision) and how to request an appeal regarding your prescription drug benefit.

Please contact Member Services if you have any questions, need help, or want to learn more about our reimbursement process.

SECTION 13: Member Complaints and Appeals about Medical Care or about Prescription Drugs Coverage

We are committed to ensuring that you are satisfied with the care you receive. Should you ever have a concern or a complaint about your care, your provider of care, your drug prescription program, or any aspect of our program, we have a complaint process for you to express your concern. You also have the right to appeal any decision about our failure to approve, furnish, arrange for, or continue providing any services or pay for services that you believe are necessary.

Section 13.1: What is a complaint and how to file it?

What is a complaint?

A complaint is a member's informal oral or written expression of dissatisfaction with any aspect of his or her care. Another term for "making a complaint" is "filing a grievance."

You have the right to file a complaint about anything that concerns you. Listed below are some examples of possible complaints:

- The quality of services you receive in your home, during an inpatient stay (hospital, skilled nursing facility, nursing home, etc.) or at an Adult Day Health Center

- Waiting times on the phone or in the waiting room or pharmacy
- Transportation services (e.g., waiting times for the van, driver is rude, etc.)
- Cleanliness of your healthcare provider's office
- Behavior of any of your care providers
- Disrespectful or rude behavior by pharmacists or other staff
- You disagree with our decision not to expedite your request for an expedited coverage determination or redetermination
- You believe our notices and other written materials are difficult to understand
- Failure to give you a decision within the required timeframe
- Mistakes you feel have been made

You or your representative may file a complaint with Member Services, either verbally or in writing, at any time. Information on how to reach Member Services is listed in Section 2.1.

Once you or your representative have filed a complaint, we must discuss it with you or your representative and provide the specific steps we are taking to resolve the complaint, including how long we expect to take to do so. During the complaint process, we must continue to provide you with all services as described in the current Individualized Care Plan.

How to file a complaint:

1. Call Member Services or put your complaint in writing and send it to us. When calling, discuss your complaint with our Member Services staff. Give complete information so that our Member Services staff can help resolve your complaint in a timely manner. Member Services staff may involve other appropriate staff to help investigate the complaint.
2. We will provide you acknowledgement within one day of receipt of your complaint.
3. If possible, the Member Services staff will try to resolve the complaint over the phone.
4. You, your designated family member, or an authorized representative may participate in the discussion and offer suggestions or ideas toward resolving the problem or issue.

5. If the complaint is not able to be resolved over the phone, then a more formal process will take place. Solutions to a complaint will be based on what is in the member's best interest.

6. The investigation will be completed as quickly as possible. Most complaints are answered within 30 calendar days. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.

7. You or your authorized representative will receive a phone call (or letter if requested) from our plan with a response to the complaint within 3 calendar days of the decision but not later than 30 days from receipt of the complaint.

8. If you are making a complaint because we denied your request for a "fast response" to a coverage decision or appeal, we will automatically give you a "fast" complaint. If you have a "fast" complaint, it means we will give you an answer within 24 hours.

9. If a solution is agreed to by you or your authorized representative within 30 calendar days, the complaint is resolved. Some complaints by basis of their nature are not able to be resolved (e.g.: food at Adult Day Health was served cold). Our plan tracks and logs these complaints and looks to identify any repeated offenses and uses this information to inform the Provider Network Management Department as well as the Clinical Department of unsatisfactory care.

10. If you are concerned about the quality of care that you receive, including care during a hospital stay, you may file a complaint to the plan, and it will be investigated by our Quality Department. To file a complaint to the plan, simply follow the steps described in this section. You may also file a complaint to KEPRO, the Quality Improvement Organization for Massachusetts. To find more information about the Quality Improvement Organization in Massachusetts, look in Section 2.5: **KEPRO/Quality Improvement Organization (QIO)**.

If you have any other concerns, you may also contact the MassHealth (Medicaid) Customer Service Center. Please call 1-800-841-2900 (TDD/TTY: 1-800-497-4648) to voice a concern or file a grievance (complaint) that you may have with our plan or MassHealth (Medicaid). MassHealth (Medicaid) Representatives are available Monday through Friday, between 8:00 a.m. and 5:00 p.m.

At the same time, you may also file a grievance (complaint) with our plan, in which case you should follow instructions for complaint process listed earlier in this section.

Complaints about Mental Health Parity

Federal and state laws require that all managed care organizations, including CCA Senior Care Options provide behavioral health services to MassHealth Standard (Medicaid) members in the same way they provide physical health services. This is what is referred to as “parity”. In general, this means that:

- CCA Senior Care Options must provide the same level of benefits for any behavioral health and substance use problems you may have as for other physical problems you may have;
- CCA Senior Care Options must have similar prior authorization requirements and treatment limitations for behavioral health and substance use services as it does for physical health services;
- CCA Senior Care Options must provide you or your provider with the medical necessity criteria used by the plan for prior authorization upon your or your provider’s request; and
- CCA Senior Care Options must also provide you within a reasonable time frame the reason for any denial of authorization for mental or substance use services.

If you think that CCA Senior Care Options is not providing parity as explained above, you have the right to file a grievance with Commonwealth Care Alliance Massachusetts. For more information about grievances and how to file them, please see Section 13.1 in this booklet.

You may also file a grievance with MassHealth (Medicaid). You can do this by calling the MassHealth (Medicaid) Customer Service Center at 1-800-841-2900 (TTY: 1-800-497- 4648) Monday—Friday 8:00 a.m. to 5:00 p.m.

Section 13.2: What is an appeal and how to request it?

What is an Appeal?

An appeal is defined as a member’s request for a formal reconsideration of a decision to deny, terminate, suspend, or reduce services or prescription drug coverage. An appeal also applies to a member’s request for a formal reconsideration of the plan’s decision not to provide payment for services or prescription drugs received by the member. If you disagree with our decision to deny, terminate, suspend, or reduce services or deny payments for services you received, you have the right to ask for an appeal. If you decide to appeal our decision, it means you are going on to level 1 of the appeals process with our plan.

How to request a level 1 appeal with the plan?

You or your representative may file a request with Commonwealth Care Alliance Massachusetts directly if we have denied, terminated, suspended, or reduced services; or if we delay providing or arranging for a covered service. If we deny a request for service or payment, we will give you a written denial notice along with your right to file an appeal. You can file your appeal, either verbally or in writing, with our Member Services within 60 calendar days from the date you received the written notice of denial. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.

If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.

- **Your healthcare provider can make a request for you.**
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, you are not required to hire a lawyer to ask for any kind of coverage decision or appeal a decision.
- **You can ask someone to act on your behalf.** There may be someone who is already legally authorized to act as your representative under State law. If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services and ask for the "Appointment of Representative" form. The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.

There are two types of appeal: standard and expedited (fast).

- **Standard appeal:** We will resolve the appeal as quickly as your health condition requires, and will notify you in writing of the decision, but no later than 30 calendar days from receipt of the appeal. However, if you ask for more time, or if we need to gather more information that may benefit you, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will tell you in writing. Our Member Services staff will help you to file your appeal.
- **Expedited (fast) appeal:** If you believe your life, health, or ability to regain maximum function would be seriously jeopardized if the disputed service were not provided, you may request an expedited appeal. In case of an expedited

appeal, our organization will make a decision on your appeal as quickly as your health requires, but no later than 72 hours after receiving your request for an appeal. We will contact you verbally and send something in writing. We may extend this time frame up to 14 days if you request the extension or if we justify to MassHealth (Medicaid) the need for additional information and how the extension will benefit you.

If you believe we should not take extra days or if we decide that your medical condition does not meet the requirements for an expedited appeal, you have the right to file an expedited (fast) complaint with our plan. For more information about the process for making the complaint, please go to Section 13.1: **What is a complaint and how to file it?** in this booklet.

Your CCA Senior Care Options appeal shall be dealt with according to the procedures listed below. If you do not speak English, an interpreter will be provided to facilitate the appeals process. All appeals related information will remain confidential.

- To pursue a CCA Senior Care Options appeal, contact Member Services by phone or the Appeals and Grievances department in writing. Contact us promptly.
    - You can submit a request to the following address:

        Commonwealth Care Alliance, Inc.
        Appeals and Grievances Department
        30 Winter Street
        Boston, MA 02108
        Fax: 857-453-4517

    - Or, you can call Member Services at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week, from October 1 to March 31. (April 1 to September 30: 8 am to 8 pm, Monday to Friday, and 8 am to 6 pm, Saturday and Sunday.)
- The Member Services representative will record your appeal in the company's appeal tracking database.
- We will provide you with a timely acknowledgement of receipt of your appeal.
- A member of the appeal reviewer team will contact you. The appeal reviewer will have had no involvement in the original action to deny coverage or payment of a service or have any personal financial stake in the outcome of the appeal.
- You and/or your representative will be notified in writing of the date and time of

the plan's reconsideration to have an opportunity to present evidence, in person or in writing, related to the appeal. If you have identified someone as your representative, our plan must have a signed assigned representative form on file. The form gives your representative permission to act on your behalf.

- We will resolve the appeal as expeditiously as your health condition requires, and will notify you in writing of the decision, but no later than 30 calendar days from receipt of the appeal. However, if you ask for more time, or if we need to gather more information that may benefit you, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will tell you in writing.

- In case of an expedited appeal, our organization will make a decision on your appeal as expeditiously as your health requires, but no later than 72 hours after receiving your request for an appeal. We may extend this time frame up to 14 days if you request the extension or if we justify the need for additional information and how the extension will benefit you. If we decide to take extra days to make the decision, we will tell you in writing.

- If you are currently receiving the disputed service: we will furnish the disputed service until a final determination is made and if the following conditions are met:

    - Our plan is proposing to terminate, reduce, deny, or suspend services that are currently being furnished to you.

    - You request continuation with the understanding that you may be liable for the costs of the contested services if the decision is not made in your favor.

- If our plan decides fully in your favor on either a standard or expedited appeal for a request for a service, we must arrange for you to get the service as quickly as your health conditions requires.

- If our plan decides fully in your favor on a request for payment, we must make the requested payment.

- If our plan does not decide in your favor on a standard or expedited appeal, either in whole or in part, on a request for payment or for services, you will be notified in writing about our decision and the right to pursue additional appeal rights with the MassHealth Board of Hearings.

How to request a level 2 appeal with the MassHealth Board of Hearings?

You may request a fair hearing through the MassHealth Board of Hearing appeal process

if you are dissatisfied with our decision. To pursue a MassHealth of Board of Hearing appeal, MassHealth (Medicaid) must receive your request for a fair hearing no later than 30 calendar days from the mailing date of the written notice of appeal denial from us.

If your appeal was expedited (reviewed quickly) during our plan's internal appeal process (level 1 appeal), the Board of Hearings must get your fair hearing request form within 20 calendar days of the mailing date of the Commonwealth Care Alliance Massachusetts written appeal denial notice to you for your appeal to be expedited at the Board of Hearings. However, if the Board of Hearings gets your fair hearing request form between 21 and 30 calendar days of the mailing date of the plan's final written notice to you, then the Board of Hearings will process your appeal using standard appeal times.

The request along with a copy of the plan's final denial notice must be sent to:

Executive Office of Health & Human Services
Board of Hearings Office of Medicaid
100 Hancock Street, 6th Floor
Quincy, MA 02171
Fax: 617-847-1204

Please keep one copy of the fair hearing request for your information.

To get the "Fair Hearing Request Form" or for more information about your appeal rights, you may contact the Board of Hearings at 617-847-1200 or 1-800-655-0338. The form is also available at: www.mass.gov/doc/fair-hearing-request-form-2/download.

You may also choose to continue receiving services you are appealing during the Board of Hearings appeal process. If you want the services to continue during the appeal, you must submit your appeal request to the Board of Hearings within ten (10) calendar days of the date of mailing of the appeal decision from CCA Senior Care Options. You must tell the Board of Hearings that you wish to continue to receive the service while you are appealing. If you continue to receive services during the Board of Hearings appeal process, you may be responsible for the costs of those services. You may also choose not to continue to receive services during your appeal.

The Board of Hearings will review your appeal case and notify you about its decision. If the Board of Hearings says "yes" to part or all of what you asked for, we must authorize or provide the service for you within 72 hours or as quickly as your health condition requires.

If the Board of Hearings says "no" to part or all of what you asked for, it means that they agree with our plan's appeal decision.

If the appeal decision **is not in your favor,** there may be further levels of appeal. You will be notified of those appeal rights if this happens. We will assist you with pursuing your appeal further as applicable. Some examples of further levels of appeal include:

- A hearing before an Administrative Law Judge
- Review by Departmental Appeals Board
- Judicial review

You may contact Member Services to ask for help with appeal process or for more information about your appeal rights.

If you have any other concerns, you may also contact the MassHealth (Medicaid) Customer Service Center. Please call 1-800-841-2900 (TDD/TTY: 1-800-497-4648) to voice a concern or file a grievance (complaint) that you may have with our plan or MassHealth (Medicaid). MassHealth (Medicaid) Representatives are available Monday through Friday, between 8:00 am and 5:00 pm.

SECTION 14: Your Rights

Our plan must honor your rights and cultural sensitivities as a member of the plan

Section 14.1	We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, in large print, or other alternate formats, etc.)

- Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.
- Our plan has free interpreter services available to answer questions. You can get this document and other printed materials in Spanish or other languages or speak with someone about this information in other languages, for free. We can also give you information in braille, in large print, or other alternate formats at no

cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services.

- Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive healthcare services.
- If providers in the plan's network for a specialty are not available, it is the plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. If you find yourself in a situation where there are no specialists in the plan's network that cover a service you need, call the plan for information on where to go to obtain this service.
- If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Services at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week, from October 1 to March 31. (April 1 to September 30: 8 am to 8 pm, Monday to Friday, and 8 am to 6 pm, Saturday and Sunday.).

Section 14.2 We must ensure that you are treated with respect and recognition of your dignity and your right to privacy

- Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's medical condition, health status, receipt of health services, claims experience, medical history, disability (including behavioral impairment), marital status, age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, public assistance, or place of residence.
- If you want more information or have concerns about discrimination or unfair treatment, please call the U.S. Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.
- If you have a disability and need help with access to care, please call us at Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.
- For more information on how we protect your right to privacy, refer to Section 14.1.

Section 14.3 We must ensure that you get timely access to your covered services and drugs

- You have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. We do not require you to get referrals to go to network providers.
- You have the right to get appointments and covered services from the plan's network of providers **within a reasonable amount of time**. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.
- All urgent care and symptomatic office or home visits are available to you within 48 hours. All non-symptomatic office visits are available to you within 14 calendar days.
- If you think that you are not getting your medical care or prescription drugs within a reasonable amount of time, you have the right to notify us.

Section 14.4 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that talks about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, **we are required to get written permission from you or someone you have given legal power to make decisions for you first.**

- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - We are required to release health information to government agencies that are checking on quality of care.

You can see the information in your records and know how it has been shared with others.

- You have the right to look at your medical records held at the plan, and to get a copy of your records. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.
- You have the right to know how your health information has been shared with others for any purposes that are not routine.
- If you have questions or concerns about the privacy of your personal health information, please call Member Services

Notice of Privacy Practices

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.

Effective Date: August 4, 2022

Commonwealth Care Alliance, Inc. is required by law (i) to protect the privacy of your **Medical Information (which includes behavioral health information)**; (ii) to provide you with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to Medical Information; and (iii) to notify you if your unencrypted Medical Information is affected by a breach.

We reserve the right to change this Notice and to make the changes effective for all Medical Information we maintain. If we make a material change to the Notice, we will (i) post the updated Notice on our website; (ii) post the updated Notice in each of Our Healthcare Providers' service locations; and (iii) make copies of the updated Notice available upon request. We will also send Our Health Plan Members information about the updated Notice and how to obtain the updated Notice (or a copy of the Notice) in the next annual mailing to Members. We are required to abide by the terms of the Notice that is currently in effect.

CONTACT INFORMATION: If you have questions about the information in this Notice, would like to exercise your rights, or file a complaint, please contact:

Commonwealth Care Alliance, Inc.
Attention: Privacy and Security Officer
30 Winter Street
Boston, MA 02108
Toll Free: 866-457-4953 (TTY 711)

SECTION 1: Companies to Which This Notice Applies

This Notice applies to Commonwealth Care Alliance, Inc. and its subsidiaries that are subject to the HIPAA Privacy Rule as "covered entities." Some of these subsidiaries are "**Our Health Plans**"—companies that provide or pay for Medicare Advantage benefits, Medicaid benefits, or other healthcare benefits, such a health insurer or HMO. Other subsidiaries are Our Healthcare Providers ("**Our Providers**") that furnish treatment to patients, such as primary care clinics.

This Notice describes how all of these entities use and disclose your Medical Information and your rights with respect to that information. In most cases, Our Health Plans use and disclose your Medical Information in the same ways as Our Providers and your rights to your Medical Information are the same. When there are differences, however, this Notice will explain those differences by describing how we treat Medical Information about a **Health Plan's Member** differently than Medical Information about a **Provider's Patient**.

The Health Plans and Providers to which this Notice applies include:

Our Health Plans

- Commonwealth Care Alliance Massachusetts, LLC
- Commonwealth Care Alliance Rhode Island, LLC
- CCA Health Michigan, Inc.
- CCA Health Plans of California, Inc.

Our Healthcare Providers

- Commonwealth Clinical Alliance, Inc.
- Boston's Community Medical Group, Inc. d/b/a CCA Primary Care
- Reliance PO of Michigan, Inc.
- instED™
- Marie's Place

SECTION 2: Information We Collect:

Individuals are responsible for providing correct and complete Medical Information for Commonwealth Care Alliance, Inc., and its subsidiaries (CCA) to provide quality services. CCA is committed to protecting the confidentiality of individuals' Medical Information that is collected or created as part of our operations and provision of services. When you interact with us through our services, we may collect Medical Information and other information from you, as further described below.

Medical Information may include personal information, but it is all considered Medical Information when you provide it through or in connection with the services:

- We collect information, such as email addresses, personal, financial, or demographic information from you when you voluntarily provide us with such information, such as (but not limited to) when you contact us with inquiries, fill out on-line forms, respond to one of our surveys, respond to advertising or promotional material, register for access to our services or use certain services.
- Wherever CCA collects Medical Information, we make access to this notice available. By providing us with Medical Information, you are consenting to our use of it in accordance with this notice. If you provide information to CCA, you acknowledge and agree that such information may be transferred from your current location to the facilities and servers of CCA and the authorized third parties with whom CCA does business.

SECTION 3: How We Use and Disclose Your Medical Information

This section of our Notice explains how we may use and disclose your Medical Information to provide healthcare, pay for healthcare, obtain payment for healthcare, and operate our business efficiently. This section also describes other circumstances in which we may use or disclose your Medical Information.

Our model of care requires that Our Health Plans and Our Healthcare Providers work together with other healthcare providers to provide medical services to you. Our professional staff, physicians, and other care providers (referred to as a "Care Team") have access to your Medical Information and share your information with each other as needed to perform treatment, payment, and healthcare operations as permitted by law.

Treatment: Our Providers may use a Patient's Medical Information and we may disclose Medical Information to provide, coordinate, or manage your healthcare and related services. This may include communicating with other healthcare providers regarding your treatment and coordinating and managing your healthcare with others.

Example: You are being discharged from a hospital. Our nurse practitioner may disclose your Medical Information to a home health agency to make sure you get the services you need after discharge from the hospital.

Payment: We may use and disclose your Medical Information to pay for healthcare services you have received and to obtain payment from others for those services.

Example: Your healthcare provider may send Our Health Plan a claim for healthcare services furnished to you. The Health Plan may use that information to pay your healthcare provider's claim and it may disclose the Medical Information to Medicare or Medicaid when the Health Plan seeks payment for the services.

Healthcare Operations: We may use and disclose your Medical Information to perform a variety of business activities that allow us to administer the benefits you are entitled to under Our Health Plan and the treatment furnished by Our Providers. For example, we may use or disclose your Medical Information to:

- Review and evaluate the skills, qualifications, and performance of healthcare providers treating you.
- Cooperate with other organizations that assess the quality of the care of others.
- Determine whether you are entitled to benefits under our coverage; but we are prohibited by law from using your genetic information for underwriting purposes.

Joint Activities. Commonwealth Care Alliance, Inc. and its subsidiaries have an arrangement to work together to improve health and reduce costs. We may engage in similar arrangements with other healthcare providers and health plans. We may exchange your Medical Information with other participants in these arrangements for treatment, payment, and healthcare operations related to the joint activities of these "organized healthcare arrangements."

Persons Involved in Your Care: We may disclose your Medical Information to a relative, close personal friend or any other person you identify as being involved in your care. For example, if you ask us to share your Medical Information with your spouse, we will disclose your Medical Information to your spouse. We may also disclose your Medical Information to these people if you are not available to agree and we determine it is in your best interests. In an emergency, we may use or disclose your Medical Information to a relative, another person involved in your care or a disaster relief organization (such as the Red Cross), if we need to notify someone about your location or condition.

Required by Law: We will use and disclose your Medical Information whenever we are required by law to do so. For example:

- We will disclose Medical Information in response to a court order or in response to a subpoena.
- We will use or disclose Medical Information to help with a product recall or to report adverse reactions to medications.
- We will disclose Medical Information to a health oversight agency, which is an agency responsible for overseeing health plans, healthcare providers, the healthcare system generally, or certain government programs (such as Medicare and Medicaid).
- We will disclose an individual's Medical Information to a person who qualifies as the individual's Personal Representative. A "Personal Representative" has legal authority to act on behalf of the individual, such as a child's parent or guardian, a person with a healthcare power of attorney, or a disabled individual's court-appointed guardian.

Threat to health or safety: We may use or disclose your Medical Information if we believe it is necessary to prevent or lessen a serious threat to health or safety.

Public health activities: We may use or disclose your Medical Information for public health activities, such as investigating diseases, reporting child or domestic abuse and neglect, and monitoring drugs or devices regulated by the Food and Drug Administration.

Law enforcement: We may disclose Medical Information to a law enforcement official for specific, limited law enforcement purposes, such as disclosures of Medical Information about the victim of a crime or in response to a grand jury subpoena. We may also disclose Medical Information about an inmate to a correctional institution.

Coroners and others: We may disclose Medical Information to a coroner, medical examiner, or funeral director or to organizations that help with organ, eye, and tissue transplants.

Worker's compensation: We may disclose Medical Information as authorized by and in compliance with workers' compensation laws.

Research organizations: We may use or disclose your Medical Information for research that satisfies certain conditions about protecting the privacy of the Medical Information.

Certain government functions: We may use or disclose your Medical Information for certain government functions, including but not limited to military and veterans' activities and national security and intelligence activities.

Business associates: We contract with vendors to perform functions on our behalf. We permit these "**business associates**" to collect, use, or disclose Medical Information on our behalf to perform these functions. We contractually obligate our business associates (and they are required by law) to provide the same privacy protections that we provide.

Fundraising Communications: We may use or disclose Medical Information for fundraising. If you receive a fundraising request from us (or on our behalf) you may opt out of future fundraising activities.

SECTION 4: Other Uses and Disclosures Require Your Prior Authorization

Except as described above, we will not use or disclose your Medical Information without your written permission ("**authorization**"). We may contact you to ask you to sign an authorization form for our uses and disclosures or you may contact us to disclose your Medical Information to another person and we will need to ask you to sign an authorization form.

If you sign a written authorization, you may later revoke (or cancel) your authorization. If you would like to revoke your authorization, you must do so in writing (send this to us using the **Contact Information** at the beginning of this Notice). If you revoke your authorization, we will stop using or disclosing your Medical Information based on the authorization except to the extent we have acted in reliance on the authorization. The following are uses or disclosures of your Medical Information for which we would need your written authorization:

- **Use or disclosure for "marketing" purposes:** We may only use or disclose your Medical Information for "marketing" purposes if we have your written authorization. We may, however, send you information about certain health-related products and services without your written authorization, as long as no one pays us to send the information.
- **Sale of your Medical Information:** Commonwealth Care Alliance, Inc. will not sell your Medical Information. If we did, we would need your written authorization.
- **Use and disclosure of psychotherapy notes**: Except for certain treatment, payment, and healthcare operations activities or as required by law, we may only use or disclose your psychotherapy notes if we have your written authorization.

SECTION 5: You Have Rights with Respect to Your Medical Information

You have certain rights with respect to your Medical Information. To exercise any of these rights, you may contact us using the **Contact Information** at the beginning of this Notice.

Right to a Copy of this Notice: You have a right to receive a paper copy of our Notice of Privacy Practices at any time, even if you agreed to receive the Notice electronically.

Right to Access to Inspect and Copy: You have the right to inspect (see or review) and receive a copy or summary of your Medical Information we maintain in a "designated record set." If we maintain this information in electronic form, you may obtain an electronic copy of these records. You may also instruct Our Healthcare Providers to send an electronic copy of information we maintain about you in an Electronic Medical Record to a third party. You must provide us with a request for this access in writing. We may charge you a reasonable, cost-based fee to cover the costs of a copy of your Medical Information. In accordance with the HIPAA Privacy Rule and in very limited circumstances, we may deny this request. We will provide a denial in writing to you no later than 30 calendar days after the request (or no more than 60 calendar days if we notified you of an extension).

Right to Request Medical Information be Amended: If you believe that Medical Information we have is either inaccurate or incomplete, you have the right to request that we amend, correct, or add to your Medical Information. Your request must be in writing and include an explanation of why our information needs to be changed. If we agree, we will change your information. If we do not agree, we will provide an explanation with future disclosures of the information.

Right to an Accounting of Disclosures: You have the right to receive a list of certain disclosures we make of your Medical Information ("**disclosure accounting**"). The list will not include disclosures for treatment, payment, and healthcare operations, disclosures made more than six years ago, or certain other disclosures. We will provide one accounting each year for free but may charge a reasonable, cost-based fee if you ask for another one within 12 months. You must make a request for disclosure accounting in writing.

Right to Request Restrictions on Uses and Disclosures: You have the right to request that we limit how we use and disclose your Medical Information (i) for treatment, payment, and healthcare operations or (ii) to persons involved in your care. Except as described below, we do not have to agree to your requested restriction. If we do agree

to your request, we will comply with your restrictions, unless the information is necessary for emergency treatment.

Our Healthcare Providers must agree to your request to restrict disclosures of Medical Information if (i) the disclosures are for payment or healthcare operations (and are not required by law) and (ii) the information pertains solely to healthcare items or services for which you, or another person on your behalf (other than Our Health Plans) has paid in full.

Right to Request an Alternative Method of Contact: You have the right to request in writing that we contact you at a different location or using a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address or e-mailed to you. Our Healthcare Providers will agree to any reasonable request for alternative methods of contact.

SECTION 6: You May File a Complaint About Our Privacy Practices

If you believe your privacy rights have been violated, you may file a written complaint either with Commonwealth Care Alliance, Inc. or the U.S. Department of Health and Human Services.

Commonwealth Care Alliance, Inc. will not take any action against you or change the way we treat you in any way if you file a complaint.

To file a written complaint with or request more information from Commonwealth Care Alliance, Inc., contact us using the **Contact Information** at the beginning of this Notice.

SECTION 7: State-Specific Requirements

Massachusetts Immunization Information Systems: Our Providers are required to report vaccinations you receive to the Massachusetts Immunization Information System (MIIS). The MIIS is a statewide system to keep track of vaccination records and is managed by the Massachusetts Department of Public Health (MDPH). If you do not want your MIIS records shared with other healthcare providers, you must submit an Objection to Data Sharing Form to:

Massachusetts Immunization Information System (MIIS)
Immunization Program
Massachusetts Department of Public Health
305 South Street
Jamaica Plain, MA 02130

Section 14.5 We must give you information about the plan, its network of providers, and your covered services

As a member of CCA Senior Care Options, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Member Services:

- **Information about our plan**. This includes, for example, information about the plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your covered services and the rules you must follow when using your coverage.** Your Evidence of Coverage provides information regarding medical services and prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Your Evidence of Coverage provides information on asking for a written explanation on why a medical service or prescription drug is not covered or if your coverage is restricted. It also provides information on asking us to change a decision, also called an appeal.
- **Information on your responsibilities as a member of our plan.** You have some responsibilities you must follow as a CCA Senior Care Options member.

Section 14.6 We must support your right to participate with practitioners and providers in making decisions about your care

- **You have the right to know your treatment options and participate in decisions about your healthcare.**
- You have the right to get full information from your doctors and other healthcare providers. Your providers must explain your medical condition and your treatment choices **in a way that you can understand.**
- You also have the right to participate fully in decisions about your healthcare. To help you make decisions with your healthcare providers about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** You have the right to have a discussion about the appropriate or medically necessary treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no.**" You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your healthcare provider advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To be free from any form of restraint.** You have the right to be free from restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

- You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself.
- Sometimes people become unable to make healthcare decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation.
- The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. In Massachusetts, the document is called the **health care proxy**. In other states, documents called "**living will**" and "**power of attorney for healthcare**" are examples of advance directives.
- This means that, if you want to, you can:
  - Fill out a health care proxy form in which you give someone (called your "health care agent") the legal authority to make healthcare decisions for you if your healthcare provider determines you have become unable to make or communicate healthcare decisions for yourself.
- If you want to use a health care proxy to give your instructions, here is what to do:

  - **Get the form.** You can contact Member Services to ask for a form this is provided by Honoring Choices Massachusetts. You can also download a copy of the form from the Honoring Choices Massachusetts website (www.honoringcoicesmass.com).
  - **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document.
  - **Give copies to appropriate people.** A copy of your health care proxy is as valid as the original. You should give a copy of the form to your healthcare provider and to your health care agents. You may want to give copies to close friends or family members. Keep a copy at home.

- If you know ahead of time that you are going to be hospitalized, and you have signed a health care proxy, take a copy with you to the hospital.
  - The hospital will ask you whether you have signed an advance directive form and whether you have it with you.
  - If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

- **Remember, it is your choice whether you want to fill out an advance** directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.
- **What if you object to the decision your health care agent is making?**
  - If you disagree with the decision your health care agent is making, you can say so, and your decision will prevail unless a court determines that you lack capacity to make healthcare decisions.
- **What if your physician determines that you have regained capacity to make healthcare decisions?**
  - The authority of your healthcare agent will end but can begin if you lose capacity again and your consent for treatment shall be required.
- **What if your instructions are not followed?**
  - If you have signed a health care proxy and your wishes were not followed, you may file a complaint with Massachusetts Department of Public Health, Division of Healthcare Quality's Complaint Unit by calling 1-800-462-5540. To file a complaint against an individual healthcare provider, please call the Board of Registration in Medicine at 781-876-8200.

Section 14.7 You have the right to make complaints or appeals about the organization or the care it provides

- If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly**.
- You may file an internal appeal directly with our plan. This Evidence of Coverage tells what you need to do to file an appeal directly with the plan. You may also file an internal appeal through the Social Security Administration or the Railroad Retirement Board, which will forward the appeal to our plan. For details about how to contact the Social Security Administration and the Railroad Retirement Board, go to Section 2.11.

Section 14.8 You have the right to make recommendations on our member rights and responsibilities policy

If you have any recommendations on our member rights and responsibilities policy, you can share your suggestion by calling Member Services.

Section 14.9 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, sexual orientation, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697 or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, **and** it's **not** about discrimination, you can get help dealing with the problem you are having:

- You can **call Member Services**.
- You can **call the SHIP**. For details, go to Section 2.8

- Or, **call MassHealth (Medicaid)** at 1-800-841-2900, Monday through Friday, 8 a.m. to 5 p.m. TTY users should call: 1-800-497-4648.
    - You can also **get help from My Ombudsman** by calling 1-855-781-9898 (or using MassRelay at 711 to call 1-855-781-9898 or Videophone (VP) 339-224-6831) or emailing info@myombudsman.org.

Section 14.10 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Member Services**.
- You can **call the SHIP**. For details, go to Section 2.8.

SECTION 15: Your Responsibilities

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services.

- **Get familiar with your covered services and the rules you must follow to get these covered services**. Use this Evidence of Coverage to learn what is covered for you and the rules you need to follow to get your covered services.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Please call Member Services to let us know.
- **Tell your doctor and other healthcare providers that you are enrolled in our plan.** Show your plan member ID card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
    - To help get the best care, tell your doctors and other healthcare providers about your health problems. Follow the mutually agreed upon treatment plans and instructions that you and your healthcare providers agree upon.
    - Make sure your healthcare providers know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.

  - If you have any questions, be sure to ask and get an answer you can understand.

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.

- **If you move <u>within</u> our service area, we need to know** so we can keep your membership record (centralized enrollee record) up to date and know how to contact you.

- **If you move <u>outside</u> of our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).
- **Estate Recovery Awareness:** MassHealth is required by federal law to recover money from the estates of certain MassHealth members who are age 55 years or older, and who are any age and are receiving long-term care in a nursing home or other medical institution. For more information about MassHealth estate recovery, please visit <u>www.mass.gov/estaterecovery</u>.

SECTION 16: Termination of Enrollment from CCA Senior Care Options

Your benefits under CCA Senior Care Options can be stopped if you choose to disenroll from our program (voluntarily) or if you no longer meet the conditions of enrollment (involuntarily by our plan). Disenrollment is effective on the first day of the month following the month in which we were notified about your disenrollment.

You are required to continue to use CCA Senior Care Options services and obtain all services through the plan and its network of providers and facilities until your disenrollment becomes effective.

If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged (even if you are discharged after your new health coverage begins).

Voluntary Disenrollment

If you wish to disenroll from CCA Senior Care Options, you can call the Member

Services Department at 866-610-2273 (TTY 711). Member Services will assist you with your disenrollment. Your disenrollment must be submitted to MassHealth (Medicaid) by our plan in order to become effective. You will receive a letter from Commonwealth Care Alliance Massachusetts indicating the reason for the termination, the date of termination and your complaint rights. Our Member Services representative can assist you with alternative options in the community following the termination of your CCA Senior Care Options benefits. You may re-enroll with our plan anytime as long as you still meet the eligibility requirements.

Involuntary Disenrollment

Commonwealth Care Alliance Massachusetts will do everything possible to avoid involuntary disenrollment. We will work with you and your care team to help ensure continued compliance with MassHealth Standard (Medicaid) eligibility requirements. However, Commonwealth Care Alliance Massachusetts **must end your membership in the plan** if any of the following happen:

- You lose MassHealth Standard (Medicaid) eligibility.
- You move permanently out of our service area.
- You remain outside the service area for more than six consecutive months.
    - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Member Services are printed in Section 2.1.)
- You become incarcerated (go to prison).
- If you are not lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from MassHealth (Medicaid) first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from MassHealth (Medicaid) first.)
- You commit fraud or allow another person to use your CCA Senior Care Options member ID card to obtain services. (We cannot make you leave our plan for this reason unless we get permission from MassHealth (Medicaid) first.)

- Our program agreement with the Commonwealth of Massachusetts/Executive Office of Health and Human Services (Medicaid) and Medicare is not renewed or is terminated.

You will receive a letter from Commonwealth Care Alliance Massachusetts indicating the reason for the termination, the date of termination and your complaint rights. Your membership cannot be canceled due to the status of your health.

SECTION 17: Coordination of Benefits

Commonwealth Care Alliance, Inc. shall be responsible for conducting all coordination of benefit activities on behalf of its members including but not limited to, billing and collecting payment for workers compensation, subrogation, private insurance, and government programs. Members are required to pay Commonwealth Care Alliance, Inc. any money recovered by a suit, settlement, or any third-party recovery up to the amount of the benefits provided by CCA Senior Care Options. Members will be required to provide our plan with information to help assist in the coordination of benefits effort.

SECTION 18: General Provisions

Access to Your Medical Records

It may be necessary for us to obtain your medical records and information from hospitals, skilled nursing facilities, intermediate care facilities, home health agencies, physicians or other practitioners who treat you. By accepting coverage under this contract, you agree to authorize us to obtain and use such records and information. This may include information and records concerning treatment and care you received before the effective date of this program by anyone who provided the treatment and/or care. You may be asked to sign a consent form for these purposes. Access to your own medical record, including your central enrollee record, is permitted in accordance with Massachusetts General Law Chapter III, Section 70E.

Authorization to Take and Use Photographs

As part of the routine administration of this program, photographs of participants may be taken for purposes of identification, publicity, education, or medical care. Before a picture of you can be taken for publicity purposes, we must first ask for your permission to take the picture and have you sign a consent form. (Your participation is voluntary.)

Changes to Contract

Changes to this contract may be made if they are approved by the US Department of

Health and Human Services, Centers for Medicare & Medicaid Services and the Commonwealth of Massachusetts/Executive Office of Health and Human Services. Commonwealth Care Alliance, Inc. will give you at least 30 days written notice of any significant change. No changes to the contract that decrease your benefit can be made except on an annual basis.

Continuation of Services upon Termination

If this health contract terminates for any reason, you will be advised of the availability of other services. If you are eligible, you will continue to be entitled to coverage under Medicare Parts A and/or B and MassHealth Standard (Medicaid).

In the event of Commonwealth Care Alliance, Inc. insolvency, you will not be held liable for the plan's debt.

Cooperation in Assessments

In order for us to determine the best services for you, your full cooperation is required in providing us with health, demographic and financial information.

Governing Law

CCA Senior Care Options is subject to the requirements of the Commonwealth of Massachusetts/Executive Office of Health and Human Services and the US Department of Health and Human Services, and Medicare (the Centers for Medicare and Medicaid Services). Any provision required to be in this contract shall bind Commonwealth Care Alliance, Inc. whether or not set forth herein.

Information upon request

As a CCA Senior Care Options member, you have the right to request information on the following:

- General coverage, and comparative plan information
- Utilization control procedures
- Quality improvement programs
- Statistical data on grievances and appeals
- The financial condition of Commonwealth Care Alliance, Inc., or one of its affiliates.

New Technology

We regularly review new procedures, devices, treatments, and drugs to determine if they are safe and effective for members. New technology that are found to be safe and

effective are eligible to become Covered Services. If the technology becomes a Covered Service, it will be subject to all other terms and conditions of the plan, including medical necessity. As a Senior Care Options member, you have no member cost share responsibilities.

Any device, medical treatment, drug, supply or procedure for which safety and efficacy has not been established and proven is considered experimental, investigational, or unproven. Investigational or unproven therapies are not medically necessary, and are excluded from coverage, unless they are explicitly covered by Medicare or by CCA's plan documents.

When we determine whether to cover new technologies for an individual member because of their unique clinical circumstances, or because all other treatment options have been exhausted, and there is reason to believe that the intervention requested will be successful, one of our Medical Directors makes a medical necessity determination based on individual member medical documentation, review of published scientific evidence, and, when appropriate, consultation with a professional with relevant specialty or professional expertise.

Notice of nondiscrimination

Our plan must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

Commonwealth Care Alliance, Inc.® complies with applicable Federal civil rights laws and does not discriminate on the basis of, or exclude people or treat them differently because of, medical condition, health status, receipt of health services, claims experience, medical history, disability (including behavioral impairment), marital status, age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, public assistance, or place of residence. Commonwealth Care Alliance, Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services.

If you believe that Commonwealth Care Alliance, Inc. has failed to provide these services or discriminated in another way based on medical condition, health status, receipt of health services, claims experience, medical history, disability (including behavioral impairment), marital status, age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, public assistance, or place of residence, you can file a grievance with:

Commonwealth Care Alliance, Inc.
Civil Rights Coordinator
30 Winter Street
Boston, MA 02108
Phone: 617-960-0474, ext. 3932 (TTY 711) Fax: 857-453-4517
Email: civilrightscoordinator@commonwealthcare.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

If you have a disability and need help with access to care, please call us at Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Notification

Any notice that we give you under this contract will be mailed to you at your address as it appears in our records. You should notify us promptly of any change of address. If you choose to notify us in writing, please send to: Commonwealth Care Alliance Massachusetts, Member Services Department, 30 Winter Street, Boston, MA 02108 or you can call us directly at 866-610-2273 (TTY 711).

Notice of Certain Events

We will notify you if we have to terminate a contract with or can no longer use a provider or facility from which you receive services. This includes hospitals, physicians or any other person with whom we have a contract to provide services or benefits. We will arrange for you to receive services from another provider.

Our Relationship to CCA Senior Care Options Providers

CCA Senior Care Options providers are generally independent providers, suppliers, or organizations related to us by contract only. These providers are not our employees or agents. CCA Senior Care Options and its contracted providers maintain a relationship with you and are responsible for acts of omissions, including malpractice or negligence.

Renewal Provisions

CCA Senior Care Options has an agreement with the Commonwealth of Massachusetts/Executive Office of Health and Human Services (Medicaid) and Medicare (the Centers for Medicare & Medicaid Services) that is subject to renewal every year. If the agreement is not renewed, the CCA Senior Care Options will be terminated.

Time Limitation on Claims

Commonwealth Care Alliance, Inc. pays clean claims submitted within specified contractual timeframes for covered services provided to eligible members. In most cases, Commonwealth Care Alliance, Inc. pays clean claims within 30 days of receipt. CCA Senior Care Options is under no obligation to pay a complete claim that has not been received within 90 days for contracted providers and within 365 days for non-contracted providers. However, the member will not be liable for payment on such claims and the provider is prohibited from billing you. If you receive a bill, please call Member Services.

Waiver of Conditions for Care

If you do not meet a certain criterion established by the care team and CCA Senior Care Options as a condition of receiving a particular service, we reserve the right to waive such a

criterion if we, in our judgment, determine that you could medically benefit from receiving that service. However, if we waive a criterion for you in one instance, this does not mean

that we are obligated to waive that condition or any other criterion for you on any other occasion.

Who Receives Payment under this Contract?

CCA Senior Care Options or its third-party administrator will make payment for services provided and authorized by your PCP/care team under this contract directly to the plan's provider. You are not required to pay anything that is owed by the plan.

SECTION 19: Definitions

Appeal: An appeal is something you do if you disagree with our decision to deny a request for coverage of healthcare services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive.

Brand Name Drug: A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Care Team: A team that may consist of a primary care provider, a care partner, a geriatric support services coordinator (GSSC), and/or other healthcare professionals who are responsible to coordinate all your medical care. "Coordinating" your services includes checking or consulting with you and other plan providers about your care and how it is going. To assure effective coordination and delivery of care, the care team may be enlarged at the discretion of the team members to include other professional and support disciplines.

Centers for Medicare & Medicaid Services (CMS): The federal agency under the Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

Complex Care Needs: Any condition or situation that demonstrates the member's need for intensive coordination of multiple services including but not limited to clinical

eligibility for institutional long-term care, medical illness, psychiatric illness or cognitive impairment.

Covered Services: The health and health-related services we provide through this contract. This is made possible through a special arrangement between Commonwealth Care Alliance, Inc., Medicare, and the Commonwealth of Massachusetts/Executive Office of Health and Human Services (Medicaid). This contract gives you the services and benefits you would receive under MassHealth Standard (Medicaid) plus additional benefits and flexibility. To receive services and benefits under this program, you must meet the conditions described in this contract.

Commonwealth Care Alliance, Inc.: A not-for-profit healthcare delivery system providing health and health-related care on a prepaid basis for persons 65 and older who reside in the service area and who meet eligibility requirements. The words "we," "our" and "us" used in this Handbook refer to Commonwealth Care Alliance, Inc.

Community Health Worker: Community Health Workers assists members managing their social determinants of health (SDOH) by identifying and connecting members to services and resources within their own communities; with a member-centered-approach that aims to both improve members' health and empower their independence. SDOH includes, but it is not limited to, housing, public assistance [SNAP, SSI Cash Assistance], day programs, fuel assistance, and MassHealth (Medicaid).

Contracted (Network) Provider: A health facility, healthcare professional or service agency, which has contracted with our plan to provide health-related services or other services to participants necessary in the functioning of CCA Senior Care Options.

Custodial Care: Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care, provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops.

Disenroll or Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Durable Medical Equipment: Certain medical equipment that is ordered by your doctor or other provider for use at home. Examples are walkers, wheelchairs, or hospital beds.

Emergency Condition: An emergency condition is one that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

Exception: A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Generic Drug: A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

Geriatric Support Services Coordinator (GSSC): A GSSC is an employee of an Aging Services Access Point (ASAP), who is a social worker and works within a care team structure to assist with coordinating and managing the support services in relation to the member's healthcare needs.

Health Services: Health Services are identified as medical care, diagnostic tests, medical equipment, appliances, drugs, prosthetic and orthotic devices, nutritional counseling, nursing, social services, therapies, dentistry, optometry, podiatry, and audiology. Health services may be provided at contracted adult day health/primary care centers, in your home, hospitals, in professional offices of specialists or nursing homes under contract with CCA Senior Care Options.

Health-related services: Health-related services are those services, which support the provision of health services and help you maintain your independence. Such services include personal care attendant services, homemaker/chore services, escort, transportation, home-delivered meals, help in handling your money and paying your bills, and assistance with housing problems.

Hospital services: These are services that are generally provided by acute general hospitals.

Individualized Care Plan: An individualized care plan is a detailed written description of the scope, frequency, and duration of all covered services to be provided by our plan to a member as determined by the PCP/care team and the member.

Initial Assessment: A comprehensive assessment of a potential member that may include:

- An evaluation of clinical status, functional status, nutritional status and physical well-being;
- Medical History of the member, including relevant family members and illnesses;
- Screenings for mental health status and tobacco, alcohol and drug use;
- An evaluation of the member's need for long term care services, including the availability of informal support.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA): A Federal law that requires health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the requirements or limitations plans apply to all other medical, surgical, community and support benefits.

Member: A person who meets the eligibility criteria and who voluntarily signs a contract with CCA Senior Care Options and whose enrollment has been approved by MassHealth (Medicaid). The words you, your, or yours refer to member and or the enrollee.

Ongoing assessment: Re-evaluation of a member's health status by the care team.

Out-of-Area: An area outside the plan's Service Area. See the definition of Service Area in Section 19: **Definitions** and the enclosure that is included in this Evidence of Coverage in Section 20: **Service Area**.

Primary Care Provider (PCP): Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and healthcare providers about your care and refer you to them. See Section 4.1: **Primary Care Provider (PCP)** for information about primary care providers.

Senior Care Options: A program implemented by CMS and MassHealth (Medicaid) in partnership for the purpose of delivering and coordinating all Medicare and MassHealth Standard (Medicaid) covered service benefits for eligible Massachusetts seniors.

Skilled Nursing Facility: A health facility providing short and long-term nursing and rehabilitative care in a residential setting licensed as such by the Massachusetts Department of Public Health.

Service Area: The specific geographical area of Massachusetts for which CCA Senior Care Options has contracted with Medicare and the Commonwealth of Massachusetts/Executive Office of Health and Human Services (Medicaid) to provide covered services to all members who select the plan. Please see the enclosure included

in this Evidence of Coverage in Section 20: **Service Area** that identifies the CCA Senior Care Options Service Area.

Service Decision (coverage decision or organization determination): A decision by the plan, or one of its providers, about what services should be covered for you.

Urgent Care: Urgently needed care is when you need medical attention right away for an unforeseen illness or injury and it is not reasonable, given the situation for you to get the care you need from your PCP or other plan providers. If you are out of your plan's service area for a short time and cannot wait until you return home, our plan must pay for urgently needed care.

SECTION 20: Service Area

What is the geographic Service Area for CCA Senior Care Options?

Our plan is available only to individuals who live in our plan's service area. To stay a member of our plan, you must keep living in this service area described below.

Our service area includes **ALL CITIES AND TOWNS** in these counties in Massachusetts: Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester.