Senior Care Options Program (HMO SNP) offered by Commonwealth Care Alliance

Annual Notice of Changes for 2021

You are currently enrolled as a member of Senior Care Options Program. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.1 and 1.5 for information about benefit and cost changes for our plan. You pay $0 as a member of Senior Care Options Program.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy? You pay $0 as a member of Senior Care Options Program.
- Review the 2021 Drug List and look in Section 1.6 for information about changes to our drug coverage.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our Provider Directory.

☐ Think about your overall health care costs.

- How do your total plan costs compare to other Medicare coverage options? You pay $0 as a member of Senior Care Options Program.

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 2.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website. You pay $0 as a member of Senior Care Options Program.

3. CHOOSE: Decide whether you want to change your plan

- If you don't join another plan by December 7, 2020, you will be enrolled in Senior Care Options Program (HMO SNP).
- If you want to **change to a different plan** that may better meet your needs, you can switch plans between October 15 and December 7. Look in section 2.2, page 12 to learn more about your choices.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2020**

- If you don't join another plan by **December 7, 2020**, you will be enrolled in Senior Care Options Program (HMO SNP).
- If you join another plan between **October 15** and **December 7, 2020**, your new coverage will start on **January 1, 2021**.

Additional Resources

- Please contact our Member Services number at 1-866-610-2273 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., 7 days a week from October 1st through March 31st. (April 1st through September 30th, Monday – Friday, 8 a.m. – 8 p.m. and Saturday and Sunday, 8 a.m. – 6 p.m.)..
- This information is available in a different format. Please call Member Services at the numbers provided above for more information on materials in another format.
- Member Services has free language interpreter services available for non-English speakers.
- ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-866-619-2273 (TTY: call MassRelay at 711).

- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-610-2273 (TTY: llamar a MassRelay al 711).
- You can get this document for free in other formats, such as large print, formats that work with screen reader technology, braille, or audio. Call 1-866-610-2273 (TTY: call MassRelay at 711), 8 a.m. – 8 p.m., 7 days a week from October 1st through March 31st. (April 1st through September 30th, Monday – Friday, 8 a.m. – 8 p.m. and Saturday and Sunday, 8 a.m. – 6 p.m.). The call is free.
- You can get this document for free in other formats, such as large print, formats that work with screen reader technology, braille, or audio. Call 1-866-610-2273 (TTY: call MassRelay at 711), 8 a.m. – 8 p.m., 7 days a week from October 1st through March 31st. (April 1st through September 30th, Monday – Friday, 8 a.m. – 8 p.m. and Saturday and Sunday, 8 a.m. – 6 p.m.). The call is free.
- **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 https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Senior Care Options Program

- Senior Care Options Program (HMO SNP) is a Special Needs Plan with a Medicare contract and a contract with the Commonwealth of Massachusetts/Executive Office of Health and Human Services Medicaid program. Enrollment in Senior Care Options Program depends on contract renewal. Enrollment is voluntary.
- When this booklet says "we," "us," or "our," it means Commonwealth Care Alliance. When it says "plan" or "our plan," it means Senior Care Options Program.

Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for Senior Care Options Program in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2020 (this year)	2021 (next year)
Monthly plan premium* * See Section 1.1 for details.	$0	$0
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $0 per visit	Primary care visits: $0 per visit Specialist visits: $0 per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day**.**	$0	$0
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copays: $0	Deductible: $0 Copay: $0

Annual Notice of Changes for 2021
Table of Contents

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2020 (this year)	2021 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by MassHealth (Medicaid).)	$0	$0

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

Because you get assistance from MassHealth (Medicaid), you do not have "out-of-pocket" costs for covered services. You pay nothing for medical services covered by Senior Care Options Program.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at www.CommonwealthCareSco.org. Starting in 2021, Senior Care Options Program will work directly with hospice providers. Please look in the Provider Directory for our contracted hospice providers. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2021 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors, specialists (providers), and hospice providers that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.

- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and to manage your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.CommonwealthCareSco.org. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2021 Pharmacy Directory to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare and MassHealth (Medicaid) benefits and costs.

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Benefits Chart (what is covered),* in your *2021 Evidence of Coverage.* A copy of the *Evidence of Coverage* is available on our website at www.CommonwealthCareSco.org.You may also call Member Services to ask us to mail you a copy of the *Evidence of Coverage*.

Cost	2020 (this year)	2021 (next year)
Acupuncture for chronic low back pain (continued on the next page)	Our plan covers acupuncture under the MassHealth (Medicaid) benefit. *The plan covers 36 visits per calendar year unless authorized differently in your Individualized Care Plan.*	Covered services include: acupuncture for low back pain, and for other conditions as covered by MassHealth (see "Acupuncture" below in this same section). Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: it is medically necessary For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Our plan covers acupuncture under the MassHealth (Medicaid) benefit in addition to the Medicare covered services above.

Cost	2020 (this year)	2021 (next year)
Acupuncture for chronic low back pain (continued from prior page)		The plan covers up to 36 visits total per calendar year through MassHealth unless authorized differently in your Individualized Care Plan. The 36 sessions are not in addition to the 20 covered sessions above if it is for lower back pain. It is a total of 36 sessions between both Medicare and MassHealth if medically necessary.
Durable Medical Equipment (DME)	Prior authorization may be required.	Limits may apply to certain DME. Prior authorization may be required.

Cost	2020 (this year)	2021 (next year)
Healthy Savings Card to purchase certain Medicare approved Over-the-Counter (OTC) items	You receive a card with an allowance of $110 every quarter (every three months) to purchase Medicare-approved items such as first aid supplies, dental care, cold symptoms supplies, and others, without a prescription	You receive a card with an allowance of $125 every calendar quarter (every three months) to purchase Medicare-approved items such as first aid supplies, dental care, cold symptoms supplies, and others, without a prescription. For members with chronic illnesses, you may use the OTC card to purchase healthy and nutritious food products similar to the Supplemental Nutrition Assistance Program (SNAP) benefit offering Members without chronic illness can only use the OTC Card towards the purchase of Medicare-approved items. Please see “Help with Chronic Conditions” within the benefits chart for more information. Prior authorization is not required for members with chronic illnesses to use the OTC card towards the purchase of healthy and nutritious foods. 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.

Cost	2020 (this year)	2021 (next year)
Help with Chronic Conditions	N/A	Commonwealth Care Alliance 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 $125 at contracted retailers. Chronic conditions include: Chronic alcohol and other drug dependence, autoimmune disorders, cancer, neurologic disorders, chronic and disabling mental 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 and more. 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.

Cost	2020 (this year)	2021 (next year)
Home Infusion Therapy	N/A	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.*
Hospice	For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your Hospice services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.	For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Senior Care Options Program will pay for your Hospice services related to your terminal prognosis.

Cost	2020 (this year)	2021 (next year)
Medicare Part B prescription drugs	N/A for Part B Step Therapy Drugs	Part B Step Therapy Drug Categories: (Note: drugs classes listed below are usually not self-administered by the patient) • Anti-inflammatory • Anti-neoplastic agents (cancer) • Biologics • Colony-stimulating factors • Immunomodulators The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: http://www.commonwealthcarealliance.org/members/pharmacy-program/formulary-2020/2020-senior-care-options-formulary
Outpatient mental health care	Prior authorization is not required except for neuropsychological testing, electroconvulsive therapy and transcranial magnetic stimulation.	Prior authorization is not required except for neuropsychological testing, psychological testing, electroconvulsive therapy and transcranial magnetic stimulation.

Cost	2020 (this year)	2021 (next year)
Palliative Care (Life Choices Program)	N/A	Life Choices is Senior Care Options Program's palliative care program. Palliative care is care that aims to improve the quality of life for people living with a serious illness. This type of care is focused on relief from the symptoms and stress of a serious illness. When receiving palliative care, you can still receive treatment and therapies mean 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 Senior Care Option Program's Life Choices program or from a contracted provider.

Physician/ Practitioner services, including doctor's office visits	Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment • Second opinion by another network provider or out-of-network provider for any care, including surgery prior to receiving the service. Your PCP/care team will help you to arrange to receive a second opinion services from out-of-network provider if a network provider is not available. • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer	Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment • You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. • Virtual check-ins (for example by phone or video chat) with your doctor for 5-10 minutes **if**: o You are not a new patient **and** o The check-in is not related to an office visit in the past 7 days and o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor • Consultation your doctor has with other doctors by phone, internet, or electronic health record **if** you're not a new patient • Telehealth services for monthly end-stage renal disease- related visits for home dialysis members in a hospital-based or critical access hospital-based renal

Cost	2020 (this year)	2021 (next year)
	disease, or services that would be covered when provided by a physician). For more information on dental services, including prior authorization requirements, please go to the *Dental services* section listed earlier in this Benefits Chart.	dialysis center. renal dialysis facility. or the member's home • Telehealth services to diagnose. evaluate, or treat symptoms of a stroke • Second opinion by another network provider or out-of-network provider for any care, including surgery prior to receiving the service. Your PCP/care team will help you to arrange to receive a second opinion services from out-of-network provider if a network provider is not available. • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician). For more information on dental services, including prior authorization requirements, please go to the *Dental services* section listed earlier in this Benefits Chart.

Wellness Allowance	N/A	• Membership in a qualified health club or fitness facility. A qualified health club or fitness facility provides cardiovascular and strength-training exercise equipment onsite. This benefit does not cover membership fees you pay to non-qualified health clubs or fitness facilities, including but not limited to martial arts centers; gymnastics facilities; country clubs, sports clubs and social clubs; and for sports activities such as golf and tennis. • Participation in group and/or instructional fitness classes such as Tai Chi and health programs including those at a YMCA (for classes and programs associated with an additional fee) • Activity tracker (limit of one per member per year) To obtain this reimbursement, you must submit a completed Wellness Allowance reimbursement form along with **proof of payment** and any additional information outlined on the form. Call Member Services to request a reimbursement form or go to http://www.commonwealthcarealliance.org/members/sco/sco-member-forms Send the completed form with any required documents to the address shown on the form. If you have any questions, call Member Services. The plan reimburses you up to $250 each calendar year toward your cost for membership in a qualified health club or fitness facility, covered instructional fitness classes, participation in wellness programs, memory fitness activities, an activity tracker (e.g. Fitbit, Apple watch,

Cost	2020 (this year)	2021 (next year)
		etc.). You pay all charges over $250 per calendar year. Reimbursement requests for a prior year must be received by Commonwealth Care Alliance Senior Care Options no later than March 31 of the following year. No referral is required for this benefit

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically. **You can get the *complete* Drug List** by calling Member Services (see the back cover) or visiting our website (www.CommonwealthCareSco.org).

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug.
    - To learn what you must do to ask for an exception, see Chapter 8 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Member Services.
- **Work with your doctor (or prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. For 2021, members in long term care (LTC) facilities will now receive a temporary supply that is the same amount of temporary days supply provided in all other cases: 31 days of medication rather than the amount provided in 2020, which was a 98-day supply of medication). (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug,

you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Formulary exceptions are usually valid for 12 months from the approval date unless the prescription is written for a shorter amount of time and/or shorter approval duration is noted in the approval letter.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

Starting in 2021, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost sharing tier and with the same or fewer restrictions. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

Also, starting in 2021, before we make other changes during the year to our Drug List that require us to provide you with advance notice if you are taking a drug, we will provide you with notice 30, rather than 60, days before we make the change. Or we will give you a 31 day, rather than a 60-day, refill of your brand name drug at a network pharmacy.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about the changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: Because you are eligible for MassHealth (Medicaid), you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you didn't receive this insert with this packet, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are in Section 6.1 of this booklet.

Because you get assistance from MassHealth (Medicaid), you do not have "out-of-pocket" costs for covered prescription drugs. You pay nothing for prescription drugs covered by Senior Care Options Program.

Cost	2020 (this year)	2021 (next year)
Part D Prescription Drug Coverage	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: $0	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: $0

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Senior Care Options Program

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare, you will automatically stay enrolled as a member of our plan for 2021.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2021 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan at any time,
- -- *OR*-- You can change to Original Medicare at any time.

If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2021*, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Senior Care Options Program.

- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Senior Care Options Program.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 6.1 of this booklet).
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

  If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 3 Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from now until December 7. The change will take effect on January 1, 2021.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year.

Note: Effective January 1, 2021, if you're in a drug management program, you may not be able to change plans.

If you enrolled in a Medicare Advantage plan for January 1, 2021, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2021. For more information, see Chapter 9, Section 2.3 of the *Evidence of Coverage*.

SECTION 4 Programs That Offer Free Counseling about Medicare and MassHealth (Medicaid)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Massachusetts, the SHIP is called Serving the Health Information Needs of Elders (SHINE).

SHINE is independent (not connected with any insurance company or health plan). It is a 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 with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer

questions about switching plans. You can call SHINE at 1-800-AGE-INFO (1-800-243-4636). You can learn more about SHINE by visiting their website (www.800ageinfo.com).

For questions about your MassHealth (Medicaid) benefits, contact MassHealth (Medicaid) 1-800-841-2900 (TTY: 1-800-497-4648), Monday - Friday, 8 a.m. - 8 p.m. Ask how joining another plan or returning to Original Medicare affects how you get your MassHealth (Medicaid) coverage.

SECTION 5 Programs That Help Pay for Prescription Drugs

Because you have MassHealth (Medicaid), you are already enrolled in 'Extra Help,' also called the Low Income Subsidy. Extra Help pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
- The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
- Your State MassHealth (Medicaid) Office (applications).

SECTION 6 Questions?

Section 6.1 – Getting Help from Senior Care Options Program

Questions? We're here to help. Please call Member Services at 1-866-610-2273 (TTY only, call MassRelay, 711). We are available for phone calls 8 a.m. – 8 p.m., 7 days a week from October 1st through March 31st. (April 1st through September 30th, Monday – Friday, 8 a.m. – 8 p.m. and Saturday and Sunday, 8 a.m. – 6 p.m.).. Calls to these numbers are free.

Read your 2021 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2021. For details, look in the 2021 *Evidence of Coverage* for Senior Care Options Plan. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.CommonwealthCareSco.org. You may also call Member Services to ask us to mail you an Evidence of Coverage.

Visit our Website

You can also visit our website at www.CommonwealthCareSco.org. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare).

Read *Medicare & You 2021*

You can read *Medicare & You 2021* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 6.3 – Getting Help from MassHealth (Medicaid)

To get information from Medicaid you can call MassHealth (Medicaid) at 1-800-841-2900. TTY users should call 1-800-497-4648.