



January 1 – December 31, 2021

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Senior Care Options Program (HMO SNP)

This booklet gives you the details about your Medicare and MassHealth (Medicaid) health care, long-term care, home & community based services and prescription drug coverage from January 1 – December 31, 2021. It explains how to get coverage for the health care services and prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

This plan, Senior Care Options Program, 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 Senior Care Options Program.)

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OMB Approval 0938-1051 (Expires: December 31, 2021)

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CHAPTER 1

Getting started as a member

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SECTION 1 Introduction

Section 1.1	You are enrolled in Senior Care Options Program, which is a specialized Medicare Advantage Plan (Special Needs Plan)
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You are covered by both Medicare and MassHealth (Medicaid):

- **Medicare** is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (kidney failure).
- **MassHealth (Medicaid)** is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. MassHealth (Medicaid) coverage varies depending on the state and the type of MassHealth (Medicaid) you have. Some people with MassHealth (Medicaid) get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that are not covered by Medicare.

You have chosen to get your Medicare and MassHealth (Medicaid) health care and your prescription drug coverage through our plan, Senior Care Options Program.

There are different types of Medicare health plans. Senior Care Options Program is a specialized Medicare Advantage Plan (a Medicare “Special Needs Plan”), which means its benefits are designed for people with special health care needs. Senior Care Options Program is designed specifically for people who have Medicare and who are also entitled to assistance from MassHealth (Medicaid).

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.

Because you get assistance from MassHealth (Medicaid), you will have no out-of-pocket expenses for your Medicare and MassHealth (Medicaid) health care services. MassHealth (Medicaid) also provides other benefits to you by covering health care services, including long term care, home and community based services, and some prescription drugs, that are not usually covered under Medicare. You will also receive “Extra Help” from Medicare to pay for the costs of your Medicare prescription drugs. Senior Care Options Program will help manage all of these benefits for you, so that you get the health care services and payment assistance that you are entitled to. You will have no out-of-pocket expenses for covered health care services or medications.

Senior Care Options Program is run by a non-profit organization. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. The plan also has a contract with the Commonwealth of Massachusetts/Executive Office of Health and Human Services MassHealth (Medicaid) program to coordinate your MassHealth (Medicaid) benefits. We are pleased to be providing your Medicare and MassHealth (Medicaid) health care coverage, including your prescription drug coverage long term care, home and community based services.

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Section 1.2 What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare and MassHealth (Medicaid) medical care, long term care, home and community based services as applicable, and prescription drugs covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The word “coverage” and “covered services” refers to the medical care, long term care, home and community based services as applicable, and services and the prescription drugs available to you as a member of Senior Care Options Program.

It’s important for you to learn what the plan’s rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact our plan’s Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the *Evidence of Coverage***It’s part of our contract with you**

This *Evidence of Coverage* is part of our contract with you about how Senior Care Options Program covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called “riders” or “amendments.”

The contract is in effect for months in which you are enrolled in Senior Care Options Program between January 1, 2021, and December 31, 2021.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Senior Care Options Program after December 31, 2021. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2021.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve Senior Care Options Program each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

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MassHealth (Medicaid) must approve our plan each year

The Commonwealth of Massachusetts/Executive Office of Health and Human Services MassHealth (Medicaid) must approve our plan each year. You can continue to get MassHealth (Medicaid) coverage as a member of our plan only as long as we choose to offer the plan for the year in question and the Commonwealth of Massachusetts/Executive Office of Health and Human Services MassHealth (Medicaid) renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1	Your eligibility requirements
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You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- -- *and* -- You live in our geographic service area (Section 2.4 below describes our service area).
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- You meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who receive certain MassHealth (Medicaid) benefits. (MassHealth (Medicaid) is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must meet the following criteria:

- be 65 years of age or older
- be enrolled in MassHealth Standard
- not be subject to a six-month deductible period
- not be a resident of an intermediate care facility for the developmentally disabled
- not be inpatient in a chronic or rehabilitation hospital.

Please note: If you lose your eligibility but can reasonably be expected to regain eligibility within one (1) month, then you are still eligible for membership in our plan (Chapter 4, Section 2.1 tells you about coverage and cost-sharing during a period of deemed continued eligibility).

Section 2.2	What are Medicare Part A and Medicare Part B?
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When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services, skilled nursing facilities, or home health agencies).

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- Medicare Part B is for most other medical services (such as physician's services, home infusion therapy and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3	What is MassHealth (Medicaid)?
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MassHealth (Medicaid) is a joint Federal and state government program that helps with medical and long-term care costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who is eligible, what services are covered, and the cost for services. States also can decide how to run their program as long as they follow the Federal guidelines.

In addition, there are programs offered through MassHealth (Medicaid) that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)

Section 2.4	Here is the plan service area for Senior Care Options Program
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Although Medicare is a Federal program, Senior Care Options Program is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

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

We do not currently service Barnstable, Berkshire, or Dukes counties.

If you plan to move out of the service area, please contact Member Services (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location. If you move to a part of the state not in our covered service area, you can retain MassHealth (Medicaid).

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Section 2.5 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Senior Care Options Program if you are not eligible to remain a member on this basis. Senior Care Options Program must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered care and prescription drugs

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. You should also show the provider your MassHealth (Medicaid) card. Here's a sample membership card to show you what yours will look like:



Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your Senior Care Options Program membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in routine research studies.

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Here's why this is so important: If you get covered services using your new red, white, and blue Medicare card instead of using your Senior Care Options Program membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Section 3.2	The <i>Provider & Pharmacy Directory</i>: Your guide to all providers in the plan's network
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The *Provider & Pharmacy Directory* lists our network providers and durable medical equipment suppliers, as well as our network pharmacies. The directory also includes the list of the participating MassHealth (Medicaid) Providers.

What are “network providers”?

Network providers are the doctors, dentists and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, long term care providers and facilities, home and community based providers and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers is available on our website at www.CommonwealthCareSCO.org.

Why do you need to know which providers are part of our network?

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed services when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which Senior Care Options Program authorizes use of out-of-network providers. See Chapter 3 (*Using the plan's coverage for your medical and other covered services*) for more specific information about emergency, out-of-network, and out-of-area coverage.

If you don't have your copy of the *Provider & Pharmacy Directory*, you can request a copy from Member Services (phone numbers are printed on the back cover of this booklet). You may ask Member Services for more information about our network providers, including their qualifications. You can also see the *Provider & Pharmacy Directory* at www.CommonwealthCareSCO.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.

What are “network pharmacies”?

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

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Why do you need to know about network pharmacies?

You can use the *Provider & Pharmacy Directory* to find the network pharmacy you want to use. 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.**

If you don't have the *Provider & Pharmacy Directory*, you can get a copy from Member Services (phone numbers are printed on the back cover of this booklet). At any time, you can call Member Services to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at www.CommonwealthCareSCO.org.

Section 3.3	The Plan's <i>List of Covered Drugs (Formulary)</i>
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The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in Senior Care Options Program. In addition to the drugs covered by Part D, some prescription drugs are covered for you under your MassHealth (Medicaid) benefits. The Drug List tells you how to find out which drugs are covered under MassHealth (Medicaid).

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the Senior Care Options Program Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

To get the most complete and current information about which drugs are covered, you can visit the plan's website (www.CommonwealthCareSCO.org) or call Member Services (phone numbers are printed on the back cover of this booklet). You may also ask us to mail you a copy of the *List of Covered Drugs (Formulary)*.

Section 3.4	The <i>Part D Explanation of Benefits</i> (the "Part D EOB"): Reports with a summary of payments made for your Part D prescription drugs
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When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Part D Explanation of Benefits* (or the "Part D EOB").

The *Part D Explanation of Benefits* tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. The Part D EOB provides more information about the drugs you take, such as increases in price and other drugs with lower cost- sharing that may be available. You should consult with your prescriber about these lower cost options. Chapter 5 (*Using the plan's*

Chapter 1. Getting started as a member

coverage for your Part D prescription drugs) gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

A *Part D Explanation of Benefits* summary is also available upon request. To get a copy, please contact Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 4 Your monthly premium for Senior Care Options Program

Section 4.1 How much is your plan premium?
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You do not pay a separate monthly plan premium for Senior Care Options Program. You must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by MassHealth (Medicaid) or another third party).

In some situations, your plan premium could be more

In some situations, your plan premium could be more than the amount listed above in Section 4.1. This situation is described below.

- Some members are required to pay a Part D **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) For these members, the Part D late enrollment penalty is added to the plan's monthly premium. Their premium amount will be the monthly plan premium plus the amount of their Part D late enrollment penalty.
 - If you receive "Extra Help" from Medicare to pay for your prescription drugs, you will not pay a late enrollment penalty.
 - If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.
 - If you are required to pay the Part D late enrollment penalty, the cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage.
- Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA, because, 2 years ago, they had a modified adjusted gross income, above a certain amount, on their IRS tax return. Members subject to an IRMAA will have to pay the standard premium amount and this extra charge, which will be added to their premium.

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Some members are required to pay other Medicare premiums

Some members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must maintain your eligibility for MassHealth (Medicaid) as well as be entitled to Medicare Part A and enrolled in Medicare Part B. For most Senior Care Options Program members, MassHealth (Medicaid) pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium. If MassHealth (Medicaid) is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.

- If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. If you have to pay an extra amount, Social Security, **not your Medicare plan**, will send you a letter telling you what that extra amount will be. If you had a life-changing event that caused your income to go down, you can ask Social Security to reconsider their decision.
- **If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan.**
- You can also visit www.medicare.gov on the Web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of *Medicare & You 2021* gives information about these premiums in the section called "2021 Medicare Costs." Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2021* from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.2 If you pay a Part D late enrollment penalty, there are several ways you can pay your penalty

If you are required to pay a Part D late enrollment penalty, there are two ways you can pay the penalty. Contact Member Services for more information on how to pay your monthly penalty. (Phone numbers for Member Services are printed on the back cover of this booklet.)

If you decide to change the way you pay your Part D late enrollment penalty, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your Part D late enrollment penalty is paid on time.

Option 1: You can pay by check

Penalties will generally not apply to you because you are covered by both Medicare and MassHealth (Medicaid). Contact Member Services for more information on whether any penalties

Chapter 1. Getting started as a member

apply to you and if required, how to pay your monthly penalty. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Option 2: You can have the late enrollment penalty taken out of your monthly Social Security check

You can have the Part D late enrollment penalty taken out of your monthly Social Security check. Contact Member Services for more information on how to pay your monthly penalty this way. We will be happy to help you set this up. (Phone numbers for Member Services are printed on the back cover of this booklet.)

What to do if you are having trouble paying your Part D late enrollment penalty

If you are having trouble paying your Part D late enrollment penalty on time, please contact Member Services to see if we can direct you to programs that will help with your penalty. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Section 4.3	Can we change your monthly plan premium during the year?
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No. We are not allowed to begin charging a monthly plan premium during the year. If the monthly plan premium changes for next year, we will tell you in September and the change will take effect on January 1.

SECTION 5	Please keep your plan membership record (centralized enrollee record) up to date
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Section 5.1	How to help make sure that we have accurate information about you
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Your membership record (centralized enrollee record) has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider.

The doctors, hospitals, pharmacists, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record (centralized enrollee record) to know what services and drugs are covered and the cost-sharing amounts for you.** Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or MassHealth (Medicaid))

Chapter 1. Getting started as a member

- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Member Services (phone numbers are printed on the back cover of this booklet).

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 Chapter 2, Section 5.

It is very important to contact the MassHealth (Medicaid) office if there are changes to your name, address or other information. This agency needs to have correct information about you in order to keep sufficient communication about your rights and other important things that may have an impact on your eligibility with our plan. Phone numbers are included in Chapter 2, Section 6 of this booklet.

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected
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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.

For more information about how we protect your personal health information, please go to Chapter 7, Section 1.4 of this booklet.

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?
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When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the “primary payer” and pays up to the limits of its coverage. The one that pays second, called the “secondary payer,” only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member’s current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
 - If you’re under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
 - If you’re over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers’ compensation

MassHealth (Medicaid) and TRICARE never pay first for Medicare-covered services. They only pay after Medicare and/or employer group health plans have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

CHAPTER 2

*Important phone numbers
and resources*

Chapter 2. Important phone numbers and resources

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SECTION 1 Senior Care Options Program contacts (how to contact us, including how to reach Member Services at the plan)

How to contact our plan's Member Services

For assistance with claims, billing, or member card questions, please call or write to Senior Care Options Program Member Services. We will be happy to help you.

Method	Member Services – Contact Information
CALL	1-866-610-2273 Calls to this number are free. October 1 st through March 31 st : 8 a.m. to 8 p.m., 7 days a week. April 1 st through September 30 th : 8 a.m. to 8 p.m., Monday through Friday, and 8 a.m. to 6 p.m. on Saturday and Sunday. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. October 1 st through March 31 st : 8 a.m. to 8 p.m., 7 days a week. April 1 st through September 30 th : 8 a.m. to 8 p.m., Monday through Friday, and 8 a.m. to 6 p.m. on Saturday and Sunday.
FAX	617-426-1311
WRITE	Commonwealth Care Alliance, 30 Winter Street Boston, MA 02108
WEBSITE	www.CommonwealthCareSCO.org

How to contact us when you are asking for coverage decisions, appeals, or making complaints about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

You may call us if you have questions about our coverage decision process, appeals or complaints about medical care.

Method	Coverage Decisions, Appeals, and Complaints about Medical Care – Contact Information
CALL	1-866-610-2273 Calls to this number are free. October 1 st through March 31 st : 8 a.m. to 8 p.m., 7 days a week. April 1 st through September 30 th : 8 a.m. to 8 p.m., Monday through Friday, and 8 a.m. to 6 p.m. on Saturday and Sunday. Please call this number provided above to contact our clinician on call for after-hours inquiries.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	857-453-4517
WRITE	Commonwealth Care Alliance, 30 Winter Street Boston, MA 02108
WEBSITE	www.CommonwealthCareSCO.org
MEDICARE WEBSITE	You can submit a complaint about Senior Care Options Program directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx

How to contact us when you are asking for a coverage decision or making a complaint about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs covered under the Part D benefit included in your plan. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your Part D prescription drugs, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Coverage Decisions and Complaints about Part D Prescription Drugs Contact Information
CALL	1-866-610-2273 Calls to this number are free. October 1 st through March 31 st : 8 a.m. to 8 p.m., 7 days a week. April 1 st through September 30 th : 8 a.m. to 8 p.m., Monday through Friday, and 8 a.m. to 6 p.m. on Saturday and Sunday. Please call the number provided above to contact our clinician on call for after-hours inquiries.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. October 1 st through March 31 st : 8 a.m. to 8 p.m., 7 days a week. April 1 st through September 30 th : 8 a.m. to 8 p.m., Monday through Friday, and 8 a.m. to 6 p.m. on Saturday and Sunday. Please call the number provided above to contact our clinician on call for after-hour inquiries.
FAX	1-857-453-4517
WRITE	Commonwealth Care Alliance, 30 Winter Street, Boston, MA 02108
WEBSITE	www.CommonwealthCareSCO.org
MEDICARE WEBSITE	You can submit a complaint about Senior Care Options Program directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx .

How to contact us when you are making an appeal about your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)*).

Method	Appeals for Part D Prescription Drugs – Contact Information
CALL	1-866-610-2273 Calls to this number are free. October 1 st through March 31 st : 8 a.m. to 8 p.m., 7 days a week. April 1 st through September 30 th : 8 a.m. to 8 p.m., Monday through Friday, and 8 a.m. to 6 p.m. on Saturday and Sunday. Please call the number provided above to contact our clinician on call for after-hours inquiries.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8 a.m. to 8 p.m., 7 days a week. Please call the number provided above to contact our clinician on call for after-hours inquiries.
FAX	1-857-453-4517
WRITE	Commonwealth Care Alliance, Attn.: Pharmacy Department, 30 Winter Street, Boston, MA 02108
WEBSITE	www.CommonwealthCareSCO.org

Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 6 (*Asking us to pay a bill you have received for covered medical services or drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Method	Payment Request – Contact Information
CALL	1-866-610-2273 Calls to this number are free. October 1 st through March 31 st : 8 a.m. to 8 p.m., 7 days a week. April 1 st through September 30 th : 8 a.m. to 8 p.m., Monday through Friday, and 8 a.m. to 6 p.m. on Saturday and Sunday.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. October 1 st through March 31 st : 8 a.m. to 8 p.m., 7 days a week. April 1 st through September 30 th : 8 a.m. to 8 p.m., Monday through Friday, and 8 a.m. to 6 p.m. on Saturday and Sunday.
FAX	617-426-1311
WRITE	Commonwealth Care Alliance, 30 Winter Street Boston, MA 02108
WEBSITE	www.CommonwealthCareSCO.org

SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and 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”). This agency contracts with Medicare Advantage organizations including us.

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.

Method	Medicare – Contact Information
TTY	<p>1-877-486-2048</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p>
WEBSITE	<p>www.medicare.gov</p> <p>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 your state.</p> <p>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul style="list-style-type: none">• 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.
WEBSITE (continued)	<p>You can also use the website to tell Medicare about any complaints you have about Senior Care Options Program:</p> <ul style="list-style-type: none">• Tell Medicare about your complaint: You can submit a complaint about Senior Care Options Program directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. <p>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.)</p>

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

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

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 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 understand your Medicare plan choices and answer questions about switching plans.

Method	SHINE (Massachusetts's SHIP) – Contact Information
CALL	1-800-AGE-INFO (1-800-243-4636)
TTY	MassRelay 711 or (800) 439-0183 (voice) TTY/ASCII (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 town or region.
WEBSITE	www.mass.gov/health-insurance-counseling

SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Massachusetts, the Quality Improvement Organization is called KEPRO.

KEPRO has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. KEPRO is an independent organization. It is not connected with our plan.

You should contact KEPRO in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	KEPRO (Massachusetts's Quality Improvement Organization) – Contact Information
CALL	888-319-8452
TTY	855-843-4776 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131
WEBSITE	www.keproqio.com/

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents 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.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

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

Method	Social Security – Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use Social Security’s 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 7:00 am to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 MassHealth (Medicaid) (a joint Federal and state program that helps with medical costs for some people with limited income and resources)

MassHealth is the name of the Massachusetts Medicaid program. MassHealth (Medicaid) is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.

In addition, there are programs offered through MassHealth (Medicaid) that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These “Medicare Savings Programs” help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)

Our plan is designed to meet the needs of people who receive certain MassHealth (Medicaid) benefits. To be eligible for our plan, you must have MassHealth (Medicaid) Standard in addition to meeting other eligibility requirements. For more information about eligibility requirements, please see Section 2.1 *Your eligibility requirements* in Chapter 1.

Because you get assistance from MassHealth (Medicaid), you will have no out-of-pocket expenses for your Medicare and MassHealth (Medicaid) health care services. MassHealth (Medicaid) also provides other benefits to you by covering health care services, including long term care, home

and community based services, and some prescription drugs, that are not usually covered under Medicare. Senior Care Options Program will help manage all of these benefits for you so that you can get the health care services and payment assistance that you are entitled to.

If you have questions about the assistance you get from MassHealth (Medicaid), contact

Method	MassHealth (Medicaid) agency (Massachusetts's Medicaid program) – Contact Information
CALL	1-800-841-2900
TTY	1-800-497-4648 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	55 Summer Street, Boston, MA 02110
WEBSITE	www.mass.gov/masshealth

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.

Method	My Ombudsman Program – Contact Information
CALL	1-855-781-9898
TTY	Use MassRelay at 711 to call the number above This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	11 Dartmouth Street, Suite 301, Malden, MA 02148
EMAIL	info@myombudsman.org
WEBSITE	www.myombudsman.org

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. MassOptions helps individuals avoid the frustration of calling multiple agencies and navigating various networks.

Method	MassOptions
CALL	1-844-422-6277 or 1-844-422-MASS (toll-free)
TTY	MassOptions works with telephonic interpreter for the deaf, heard of hearing and speech impaired who wants to communicate with us.

WEBSITE	massoptions.org/massoptions/contact-us/
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Online chat available at the link above.

SECTION 7 Information about programs to help people pay for their prescription drugs

Medicare’s “Extra Help” Program

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. You do not need to do anything further to get this “Extra Help.”

If you have questions about “Extra Help,” call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 (applications), 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State MassHealth (Medicaid) Office (applications) (See Section 6 of this chapter for contact information).

If you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- Call Member Services for more information or help (phone numbers are printed on the back cover of this booklet)
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn’t collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions (phone numbers are printed on the back cover of this booklet).

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?

What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are

also covered by ADAP qualify for prescription cost-sharing assistance from the ADAP in Massachusetts. Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. Massachusetts' ADAP is called the HIV Drug Assistance Program (HDAP).

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call or write:

Community Research Initiative of New England/HDAP
38 Chauncy Street, Suite 500
Boston, MA 02111
Fax: 617-502-1703
Phone: 1-800-228-2714

What if you get “Extra Help” from Medicare to help pay your prescription drug costs? Can you get the discounts?

Most of our members get “Extra Help” from Medicare to pay for their prescription drug plan costs. If you get “Extra Help,” the Medicare Coverage Gap Discount Program does not apply to you. If you get “Extra Help,” you already have coverage for your prescription drug costs during the coverage gap.

What if you don’t get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next *Part D Explanation of Benefits* (Part D EOB) notice. If the discount doesn’t appear on your *Part D Explanation of Benefits*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don’t agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) called Serving Health Insurance Needs of Everyone (SHINE) (telephone numbers are in Section 3 of this Chapter) 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 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation’s railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board – Contact Information
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 <i>not</i> free.
WEBSITE	rrb.gov/

SECTION 9 Do you have “group insurance” or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse’s) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse’s) employer or retiree health benefits or premiums. (Phone numbers for Member Services are printed on the back cover of this booklet.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan or enrollment periods to make a change.

If you have other prescription drug coverage through your (or your spouse’s) employer or retiree group, please contact **that group’s benefits administrator**. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

SECTION 10 You can get assistance from the Nurse Advice Call Line

Senior Care Options Program provides you with around the clock access to an on-call skilled health care professional if you need medical information and advice. When you call, our Clinician, a Registered Nurse, a Behavioral Health Specialist or equivalent, will answer your general health and wellness-related questions. Our Clinician who has access to your Individualized Plan of Care will also 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 Call Line 24 hours a day, 7 days a week for medical and behavioral health clinical questions.

Method	Nurse Advice Call Line – Contact Information
CALL	1-866-610-2273 Calls to this number are free. Available 24 hours a day, 7 days a week. Free interpreter services are available for non-English speakers.
TTY	711 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 24 hours a day, 7 days a week.

CHAPTER 3

*Using the plan's coverage for your
medical and other covered services*

Chapter 3. Using the plan's coverage for your medical and other covered services

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SECTION 1 Things to know about getting your medical care and other services covered as a member of our plan

This chapter explains what you need to know about using the plan to get your medical care and other services covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by the plan.

For the details on what medical care and other services are covered by our plan, use the Benefits Chart in the next chapter, Chapter 4 (*Benefits Chart, what is covered*).

Section 1.1	What are “network providers” and “covered services”?
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Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **“Providers”** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **“Network providers”** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay nothing for covered services.
- **“Covered services”** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the Benefits Chart in Chapter 4.

Chapter 3. Using the plan's coverage for your medical and other covered services

Section 1.2 Basic rules for getting your medical care and other services covered by the plan

As a Medicare and MassHealth (Medicaid) health plan, Senior Care Options Program must cover all services covered by Original Medicare and other services.

Senior Care Options Program will generally cover your medical care as long as:

- **The care you receive is included in the plan's Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary.** "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) and a care team who are providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
 - In most situations, your network PCP/ your care team, or our plan must give you approval in advance (prior authorization or approval) before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. Your PCP/care team works closely with our plan to arrange for services when necessary. For more information about this, see Section 2.3 of this chapter and the Benefits Chart in Chapter 4.
 - Prior authorization from your PCP is not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having a prior authorization from your PCP/care team, or the plan (for more information about this, see Section 2.2 of this chapter and the Benefits Chart in Chapter 4).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. Here are three exceptions:
 - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
 - If you need medical care that Medicare or MassHealth (Medicaid) requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. Your PCP/care team or the plan must authorize care you receive from an out-of-network provider before you seek care. Your PCP/care team works closely with our plan to arrange for services when necessary. In this situation, we will cover these services at no cost to you.

Chapter 3. Using the plan's coverage for your medical and other covered services

For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.

- The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

SECTION 2 Use providers in the plan's network to get your medical care and other services

Section 2.1	You must choose a Primary Care Provider (PCP) to provide and oversee your care
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What is a "PCP" and what does the PCP do for you?

Your primary care provider is the provider you see first for most health problems. Your PCP 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 comprehensive general medical care.

When you become a member of our plan, you must choose a plan provider to be your PCP. Senior Care Options Program contracts with primary care providers who know your community and who have developed working relationships with specialists, hospitals, community based homecare providers and skilled nursing facilities in your area.

Your PCP, along with the other members of your care team, is responsible for coordinating all your medical care. Your care team may include your PCP, Care Partner, and/or a Geriatric Support Services Coordinator (GSSC), and others as appropriate. "Coordinating" your services includes checking or consulting with you and other plan providers about your care and how it is going.

Prior authorization (approval in advance) from your PCP/care team or the plan is required for a certain number of services before you receive them. Your PCP/care team works closely with the plan to arrange for these services when necessary. These services are identified in the Benefits Chart in the next chapter (*Benefits Chart, what is covered*). While some services do not require a prior authorization, we always encourage you to speak with your PCP/care team to make sure you receive all appropriate services.

Once you are enrolled, your 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. To ensure that you are receiving the most appropriate care, your care team will review, and authorize changes to your plan of care. With your active participation, your care team will reassess your needs at least every 6 months, but more frequently, if necessary.

Chapter 3. Using the plan's coverage for your medical and other covered services

How do you choose your PCP?

Each of our members is required to have a primary care provider (PCP) who is contracted with our plan. The PCP that you choose may be a licensed primary care physician, a nurse practitioner or a physician assistant. During the enrollment process, our Marketing and Outreach representative will work with you to choose a PCP. If you do not choose a PCP, we will assign one for you. You may also call our Member Services at the number printed on the back cover of this booklet if you need more information or help.

If there are specific specialists you want to use, you should ask your PCP if they work with those specialists. Each PCP has certain specialists to whom they could refer you, although you are covered for any specialist who is part of our network.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP.

If the PCP change is to a different medical group practice, it will become effective the first day of the following month after the request is made; however, if your PCP change is within the same primary care practice/office, your change may take effect more quickly. If your PCP leaves our plan network, we will let you know by mail and help you choose another PCP so that you may continue to get covered services. For more information or help, please call our Member Services at the number printed on the back cover of this booklet.

Section 2.2 What kinds of medical care and other services can you get without getting approval in advance from your PCP?

You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots, Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible, e.g., when you are temporarily outside of the plan's service area.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Member Services before you leave the service area, so we can help arrange for you to have maintenance dialysis while you are away. Phone numbers for Member Services are printed on the back cover of

Chapter 3. Using the plan's coverage for your medical and other covered services

this booklet.)

- For more information about services that do not require a prior authorization (approval in advance), see the Benefits Chart in Chapter 4, *Benefits Chart (what is covered)*.

Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer
- Cardiologists care for patients with heart conditions
- Orthopedists care for patients with certain bone, joint, or muscle conditions

You have a primary care provider (PCP) and a care team who are providing and overseeing your care. Your PCP/care team will work with you and your specialists to make sure you receive the services you need.

Plan PCPs and dentists have certain specialists they use for referrals, although, you are covered for any specialist who is part of our network. If there are specific specialists you want to see, you should ask your PCP if they work with those specialists. You may change your PCP if you want to see a specialist to whom your current PCP cannot refer you. For more information about changing your PCP, see Section 2.1 in this chapter. You may also call Member Services if you need more information or help.

Our plan contracts with certain facilities that provide acute, chronic and rehabilitative care. As a member of Senior Care Options Program, you will be referred to contracted hospitals at which your PCP has admitting privileges. These facilities should be familiar to you and are often located in your community. Please refer to the *Provider Directory* to locate facilities in the plan's network. The most up-to-date *Provider Directory* is located on our website at www.CommonwealthCareSCO.org.

If you recently received a diagnosis for a serious or terminal illness, your Care Partner, primary care provider or specialist may recommend the Life Choices palliative care program or the hospice program. Palliative care can support you during a serious illness, such as finding services to meet your needs including hospice care. Hospice care is an option for members with a terminal illness. You should discuss your options with your care team.

Prior authorization from your PCP/care team or the plan is required for a certain number of services before you receive them. Your PCP/care team works closely with our plan to arrange for these services when necessary. For a full list of services that require prior authorization, please see the Benefits Chart in Chapter 4. We encourage you to speak with your PCP/care team before you get services that do not require a prior authorization to make sure you receive all appropriate services unless it is an emergency or urgent situation.

Our plan also covers a second opinion from a specialist or any other qualified health care professional for any covered services within the network. You may also obtain a second opinion

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from an 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 an out-of-network provider. Your PCP/care team must authorize this 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.

What if a specialist or another network provider leaves our plan?

We may make changes to the hospitals, doctors, and specialists (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 that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we 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 to manage your care.

Please call Member Services at the number printed on the back cover of this booklet for more information or help.

Section 2.4	How to get care from out-of-network providers
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You must receive your care from a network provider (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. **There are a few exceptions to note:**

- The plan covers emergency care or out-of-area urgently needed care that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed care means, see Section 3 in this chapter.
- If you need medical care that Medicare or MassHealth (Medicaid) requires our plan to cover and the providers in our network cannot provide this care, you can get this care,

Chapter 3. Using the plan's coverage for your medical and other covered services

including family planning services, from an out-of-network provider. Your PCP/care team or the plan must authorize care you receive from an out-of-network provider prior to seeking care. Your PCP/care team works closely with the plan to arrange for these services when necessary. In this situation, we will cover these authorized services at no cost to you. If you do not get authorization for seeing an out-of-network provider in advance, you will have to pay for the service.

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.
- The plan covers out-of-network care in unusual circumstances. You must receive authorization for the care you receive from an out-of-network provider 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 have a unique medical condition and the services are not available from network providers.
 - Services are available in network but are not available in a timely manner as warranted by your medical condition.
 - 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 an out-of-network provider.
 - Your PCP/care team determines that a non-network provider can best provide the service.

SECTION 3 How to get covered services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency
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What is a “medical emergency” and what should you do if you have one?

A “**medical emergency**” is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

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- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. All you need to do is call the toll free number listed on the back of the membership card and the Member Service staff will be sure to relay the information to your care team. Senior Care Options Program's Member Services are available 8 a.m. to 8 p.m., 7 days a week from October 1st through March 31st. From April 1st through September 30th, Member Services is available 8 a.m. to 8 p.m., Monday through Friday, and 8 a.m. to 6 p.m. on Saturday and Sunday.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan also covers emergency services, including emergency transportation, and urgently needed care outside the United States and its territories up to one thousand dollars (\$1,000) per calendar year. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Benefits Chart in Chapter 4 of this booklet.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable, and the medical emergency is over.

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.

Medicare does not cover emergency services or any other services if you receive the services outside of the United States.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

Chapter 3. Using the plan's coverage for your medical and other covered services

However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- – *or* – The additional care you get is considered “urgently needed services” and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

Section 3.2	Getting care when you have an urgent need for services
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What are “urgently needed services”?

“Urgently needed services” are non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan's service area when you have an urgent need for care?

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible and it is not reasonable to wait to obtain care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

We encourage you to call the Member Services line at 1-866-610-2273 (TTY: call MassRelay at 711) if you have urgent care needs 24 hours a day, 7 days a week. We will connect you with our Clinical Response Department which is available 24 hours a day. We have Registered Nurses and Behavioral Health Clinicians who will assist you with your medical or behavioral health urgent care needs.

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.

What if you are outside the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider.

Our plan also covers emergency services, including emergency transportation, and urgently needed care outside the United States and its territories up to one thousand dollars (\$1,000) per calendar year. For more information, see the Benefits Chart in Chapter 4 of this booklet.

Chapter 3. Using the plan's coverage for your medical and other covered services

Medicare does not cover urgently needed services or any other care if you receive the care outside of the United States.

Section 3.3 Getting care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from your plan.

Please visit the following website: www.CommonwealthCareSCO.org for information on how to obtain needed care during a disaster.

Generally, if you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

SECTION 4 What if you are billed directly for the full cost of your covered services?

Section 4.1 You can ask us to pay for covered services

If you have paid for your covered services, or if you have received a bill for covered medical services, go to Chapter 6 (*Asking us to pay a bill you have received for covered medical services or drugs*) for information about what to do.

Section 4.2 What should you do if services are not covered by our plan?

Senior Care Options Program covers all medical services that are medically necessary, these services are listed in the plan's Benefits Chart (this chart is in Chapter 4 of this booklet) and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or they were obtained out-of-network and were not authorized.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or

Chapter 3. Using the plan's coverage for your medical and other covered services

want to appeal a decision we have already made. You may also call Member Services to get more information (phone numbers are printed on the back cover of this booklet).

As a Senior Care Options Program member, you pay \$0 for covered services. Please reference Chapter 4, Section 2, Benefits Chart to see covered services.

SECTION 5 How are your medical services covered when you are in a “clinical research study”?

Section 5.1	What is a “clinical research study”?
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A clinical research study (also called a “clinical trial”) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study.*

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.**

If you plan on participating in a clinical research study, contact Member Services (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what your plan will pay.

Chapter 3. Using the plan's coverage for your medical and other covered services

Section 5.2	When you participate in a clinical research study, who pays for what?
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Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study
- An operation or other medical procedure if it is part of the research study
- Treatment of side effects and complications of the new care

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will pay the rest. Like for all covered services, you will pay nothing for the covered services you get in the clinical research study.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study. Please see Chapter 6 for more information about submitting requests for payment.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items and services the study gives you or any participant for free
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (www.medicare.gov). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Chapter 3. Using the plan's coverage for your medical and other covered services

SECTION 6 Rules for getting care covered in a “religious non-medical health care institution”

Section 6.1 What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 6.2 Receiving Care From a Religious Non-Medical Health Care Institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is “non-excepted.”

- “Non-excepted” medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- “Excepted” medical treatment is medical care or treatment that you get that is *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
 - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
 - – *and* – You must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

As with the Senior Care Options Program inpatient hospital coverage, there is no coverage limit to this benefit. You pay nothing for your authorized services. For more information, please see the Benefits Chart in Chapter 4 of this *Evidence of Coverage*.

Chapter 3. Using the plan's coverage for your medical and other covered services

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1	Will you own the durable medical equipment after making a certain number of payments under our plan?
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Your care team plays an important role in determining what equipment is best for you. Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. Certain items, such as prosthetics, are always owned by the member, while other items may be rented to meet a specific length of need for a medical condition and then returned to the providing vendor. There are some types of rental equipment (Capped Rental) that only rent up to 13 months; after 13 months of rental, the item is then considered owned by the member.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months.

When you enroll in Senior Care Options Program, your care team, together with you and anyone else you choose to have involved, such as a family member, will develop an individualized Care Plan designed just for you. With your active participation, your care team will reassess your needs at least every 6 months, but more frequently, if necessary. If your need for durable medical equipment is temporary, Commonwealth Care Alliance can rent certain durable medical equipment for short term use. However, you may acquire ownership of rented durable medical equipment item as long as the item is medically necessary, you have a long-term need for the item and it is authorized. You pay nothing for your covered services, including durable medical equipment. Authorizations rules may apply. Please refer to the Benefits Chart in Chapter 4, Section 2 for information on durable medical equipment.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. Payments you made while in our plan do not count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare *before* you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

Chapter 3. Using the plan's coverage for your medical and other covered services

SECTION 8 Rules for Oxygen Equipment, Supplies, and Maintenance

Section 8.1 What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, then for as long as you are enrolled, Senior Care Options Program will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave Senior Care Options Program or no longer medically require oxygen equipment, then the oxygen equipment must be returned to the DME provider.

Section 8.2 What happens if you leave your plan and return to Original Medicare?

If you return to Original Medicare, then you start a new 36-month cycle which renews every five years. For example, if you had paid rentals for oxygen equipment for 36 months prior to joining Senior Care Options Program for 12 months, and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

CHAPTER 4

Benefits Chart (what is covered)

Chapter 4. Benefits Chart (what is covered)

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SECTION 1 Understanding covered services

This chapter focuses on what services are covered. It includes a Benefits Chart that lists your covered services as a member of Senior Care Options Program. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 You pay nothing for your covered services

Because you get assistance from MassHealth (Medicaid), you pay nothing for your covered services as long as you follow the plans' rules for getting your care. (See Chapter 3 for more information about the plans' rules for getting your care.)

SECTION 2 Use the *Benefits Chart* to find out what is covered for you

Section 2.1 Your medical long-term care, home and community-based services benefits as a member of the plan

The Benefits Chart on the following pages lists the services Senior Care Options Program covers. The services listed in the Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare and MassHealth (Medicaid) covered services must be provided according to the coverage guidelines established by Medicare and MassHealth (Medicaid).
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care.
- Some of the services listed in the Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called “prior authorization”) from us. Covered services that need approval in advance are marked in the Benefits Chart in italics.

Chapter 4. Benefits Chart (what is covered)

Other important things to know about our coverage:

- You are covered by both Medicare and MassHealth (Medicaid). Medicare covers health care and prescription drugs. MassHealth (Medicaid) covers your cost-sharing for Medicare services, including any co-pays for services and drugs that you may otherwise have to pay for. MassHealth (Medicaid) also covers services Medicare does not cover, like long-term care, home and community-based services, dental services, over-the-counter drugs and other.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2021 Handbook*. View it online at www.medicare.gov or ask for a copy 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.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2021, either Medicare or our plan will cover those services.
- Because you get assistance from MassHealth (Medicaid), you pay nothing for your covered services as long as you follow the plans' rules for getting your care. (See Chapter 3 for more information about the plans' rules for getting your care.) Under our agreement with MassHealth (Medicaid), our plan also provides additional benefits to you as approved in your Individualized Care Plan. Our plan covers health care services, including but not limited to long-term care, home and community-based services, dental care and some prescription drugs that are not usually covered under Medicare. Senior Care Options Program will help manage all of these benefits for you, so that you get the health care services and payment assistance that you are entitled to. All these benefits are listed in the Benefits Chart below.
- If you are within our plan's 1-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, we will not continue to cover MassHealth (Medicaid) benefits that are included under the MassHealth (Medicaid) State Plan, nor will we pay the Medicare premiums or cost-sharing for which the state would otherwise be liable. During this time, please work with the MassHealth (Medicaid) office to ensure your continued eligibility in MassHealth. Medicare cost-sharing amounts for Medicare basic and supplemental benefits do not change during this period.

You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described above.

Important Benefit Information for Enrollees with Certain Chronic Conditions

- If you are diagnosed by a plan provider with the following chronic condition(s) identified below and meet certain medical criteria, you may be eligible for other targeted supplemental benefits and/or targeted reduced cost sharing:


- 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
 - Other chronic conditions. Speak with your Care Partner if you have questions about your eligibility.
- **Important Benefit Information for all Enrollees Participating in Wellness and Health Care Planning (WHP) Services**
- Because Senior Care Options Program participates in the Hospice program and Life Choices Palliative Care Program, you will be eligible for the following WHP services, including advance care planning (ACP) services:
 - All Senior Care Options Program members have access to the following WHP services, regardless of participation in Life Choices or hospice:
 - Annual Wellness visit
 - Medicare Health Risk Assessment
 - Care Management Program
 - In-Home Assessment
 - Advanced Care Planning (ACP)
 - WHP and ACP are voluntary, and enrollees are free to decline the offers of WHP and ACP.

You have access to the WHP services as an enrollee in Senior Care Options Program's Hospice, and Life Choices Palliative Care Programs.






You will see this apple next to the preventive services in the Benefits Chart. The plan covers Medicare preventive services.




Benefits Chart


Services that are covered for you	What you must pay when you get these services
 Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors. <i>Prior authorization is not required for services provided by a contracted provider.</i>	You pay \$0. There is no coinsurance, copayment, or deductible for beneficiaries eligible for this preventive screening.

Services that are covered for you	What you must pay when you get these services
<p>Acupuncture for chronic low back pain</p> <p>Covered services include: acupuncture for low back pain, and for other conditions as covered by MassHealth (see “Acupuncture” below in this same section).</p> <p>Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: it is medically necessary</p> <p>For the purpose of this benefit, chronic low back pain is defined as:</p> <ul style="list-style-type: none"> • 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. <p>An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.</p> <p>Treatment must be discontinued if the patient is not improving or is regressing.</p> <p>Acupuncture</p> <p>Our plan covers acupuncture under the MassHealth (Medicaid) benefit in addition to the Medicare covered services above.</p> <p>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.</p>	<p>You pay \$0.</p>
<p>Adult day health</p> <p>A day program for those who are eligible where an organized program of nursing services and supervision, assistance with activities of daily living (such as eating, toileting, exercising, and taking medication) maintenance-therapy services, and socialization are provided. Adult day health is covered by our plan under the MassHealth (Medicaid) benefit.</p> <p><i>Prior authorization is required.</i></p>	<p>You pay \$0.</p>

Services that are covered for you	What you must pay when you get these services
<p>Adult foster care Services delivered to a member in a home setting by a care provider qualified by the AFC provider agency; services include assistance with activities of daily living (such as bathing, dressing, eating, shopping, meal preparation), other personal care as needed and supervision. Medical oversight, teaching and training for the care provider, and care management is provided by the nurse or nurse practitioner from the care team. Adult foster care is covered by our plan under the MassHealth (Medicaid) benefit. <i>Prior authorization is required.</i></p>	<p>You pay \$0.</p>
<p>Alzheimer's coaching Service that supports members and their caregivers to create and maintain a positive experience for the person living with Alzheimer's disease and related disorders. <i>Prior authorization is required.</i></p>	<p>You pay \$0.</p>
<p>Ambulance services</p> <ul style="list-style-type: none"> • 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. <p><i>Prior authorization is required for non-emergency ambulance services.</i></p> <p>Our plan also covers emergency services, including emergency transportation, and urgently needed care outside the United States and its territories up to one thousand dollars (\$1,000) per calendar year. See <i>Emergency</i> and <i>Urgent Care</i> sections later in this chart for more information.</p> <p>For more information about non-emergency transportation services covered by the plan under the MassHealth (Medicaid) benefit, see <i>Transportation</i> section listed later in this chart.</p>	<p>You pay \$0.</p>

Services that are covered for you	What you must pay when you get these services
<p> Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.</p> <p>Note: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.</p> <p><i>Prior authorization is not required for services provided by a contracted provider.</i></p>	<p>You pay \$0.</p> <p>There is no coinsurance, copayment, or deductible for the annual wellness visit.</p>
<p> Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.</p> <p><i>Prior authorization is not required for services provided by a contracted provider.</i></p>	<p>You pay \$0.</p> <p>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.</p>
<p> Breast cancer screening (mammograms) Covered services include:</p> <ul style="list-style-type: none"> • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months <p>The plan may also cover additional screenings and clinical exams when medically necessary under the MassHealth (Medicaid) benefit.</p> <p><i>Prior authorization is not required for services provided by a contracted provider.</i></p>	<p>You pay \$0.</p> <p>There is no coinsurance, copayment, or deductible for covered screening mammograms.</p>
<p>Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p> <p><i>Prior authorization is required.</i></p>	<p>You pay \$0.</p>

Services that are covered for you	What you must pay when you get these services
 Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating well. <i>Prior authorization is not required for services provided by a contracted provider.</i>	You pay \$0. There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
 Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months). The plan also covers additional blood tests when medically necessary under the MassHealth (Medicaid) benefit. <i>Prior authorization is not required for services provided by a contracted provider.</i>	You pay \$0. There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
 Cervical and vaginal cancer screening Covered services include: <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months The plan may also cover additional pap tests and pelvic exams when medically necessary under the MassHealth (Medicaid) benefit. <i>Prior authorization is not required for services provided by a contracted provider.</i>	You pay \$0. There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services The plan covers manual manipulation of the spine to correct subluxation under the Medicare benefit. The plan also covers routine care, office visits and radiology services under the MassHealth (Medicaid) benefit. <i>The plan covers 36 visits per calendar year unless authorized differently in your Individualized Care Plan.</i>	You pay \$0.

Services that are covered for you	What you must pay when you get these services
<p>Chore services Include activities that assist members to maintain their homes and/or to correct or prevent environmental defects that may be hazardous to a member's health and safety. Chore services are covered by our plan under the MassHealth (Medicaid) benefit. <i>Prior authorization is required.</i></p>	<p>You pay \$0.</p>
<p> Colorectal cancer screening For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months <p>One of the following every 12 months:</p> <ul style="list-style-type: none"> • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) <p>DNA based colorectal screening every 3 years.</p> <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy (or screening barium enema as an alternative) every 24 months <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy <p><i>Prior authorization is not required for services provided by a contracted provider.</i></p>	<p>You pay \$0.</p> <p>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.</p>
<p>Companion services Companion services allow healthy individuals to remain at home by providing assistance. Activities related to socialization and recreation, assistance with preparation of light snacks, help with shopping and errands and escort to medical appointments, nutrition sites and walks. Companion services are covered by our plan under the MassHealth (Medicaid) benefit. <i>Prior authorization is required.</i></p>	<p>You pay \$0.</p>
<p>Continuous nursing services/private duty nursing Continuous, specialized skilled nursing services. These services are covered by our plan under the MassHealth (Medicaid) benefit. <i>Prior authorization is required.</i></p>	<p>You pay \$0.</p>

Services that are covered for you	What you must pay when you get these services
<p>Custodial care (long term nursing home care) Care provided in a nursing home. The Senior Care Options Program does not pay for personal services such as TV, etc. The plan also helps transition to community. Custodial care is covered by our plan under the MassHealth (Medicaid) benefit. <i>Prior authorization is required.</i></p>	<p>You pay \$0. If MassHealth (Medicaid) determines you have a monthly Patient Paid Amount (PPA) for your custodial care, you are responsible for these payments to MassHealth (Medicaid).</p>
<p>Day habilitation A structured, goal-oriented, active treatment program of medically oriented, therapeutic and habilitation services for developmentally disabled individuals who need active treatment. Day habilitation is covered by our plan under the MassHealth (Medicaid) benefit. <i>Prior authorization is required.</i></p>	<p>You pay \$0.</p>

Dental services

In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare.

You pay \$0.

Services must be performed by a network dentist.

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

Preventive/Diagnostic:

- Preventive 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:



- Limited to 4 implants when needed to support complete dentures*

Oral and Maxillofacial Surgery:


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

These services are covered without prior authorization:

- Routine exams and x-rays
- Preventive services including cleanings
- Restorative fillings
- Complete dentures and relines
- Non-surgical extractions
- Emergency Care

Services that are covered for you	What you must pay when you get these services
<p>Preventive cleanings and routine exams & x-rays are covered twice per calendar year.</p> <p>Complete and partial, and crowns dentures are covered once every five years. Other limitations may apply.</p> <p>In the event that clinical input is necessary to determine whether a course of treatment is appropriate, Commonwealth Care Alliance Senior Care Options Program reserves the right to have a dental expert review the treatment plan your dentist has proposed.</p> <p>Services requiring authorization must be sent directly by your treating network dental provider for review.</p> <p><i>* Prior authorization may be required for services listed and additional services.</i></p> <p>For a detailed list, please call Member Services at the number printed on the back cover of this booklet.</p>	
 Depression screening The plan covers one screening for depression per year under the Medicare benefit. The plan also covers additional services and screening under the MassHealth (Medicaid) benefit. <i>Prior authorization is not required for services provided by a contracted provider.</i>	<p>You pay \$0.</p> <p>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</p>
 Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months. <i>Prior authorization is not required for services provided by a contracted provider.</i>	<p>You pay \$0.</p> <p>There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.</p>

Chapter 4. Benefits Chart (what is covered)

Services that are covered for you	What you must pay when you get these services
<p> Diabetes self-management training, diabetic services and supplies</p> <p>For all people who have diabetes (insulin and non-insulin users), the plan covers the following services under the Medicare benefit:</p> <ul style="list-style-type: none"> • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain condition. <p>The plan may also cover additional services under the MassHealth (Medicaid) benefit.</p> <p>Our plan contracts with Abbott Diabetes Care, a preferred vendor, to supply glucometers and test strips to our diabetic members. These products include: FreeStyle Lite® meters, FreeStyle Freedom Lite® meters, Precision Xtra® meters, FreeStyle Lite® test strips, Precision Xtra® test strips, Precision Xtra® Beta Ketone test strips.</p> <p>You can obtain a new glucometer and test strips by requesting a new prescription from your provider to fill at your local pharmacy or by calling Abbott Diabetes Care at 1-800-522-5226 or online at www.AbbottDiabetesCare.com</p> <p><i>Prior authorization is not required for these select products received from Abbott Diabetes Care. Prior authorization is required for glucometers, therapeutic continuous glucose monitors (CGMs), and test strips received from other manufacturers.</i></p> <p><i>Prior authorization is not required for diabetes self-management training, diabetic services and other diabetic supplies provided by a contracted provider.</i></p> <p>For more information, please call Member Services at the number printed on the back cover of this booklet.</p>	<p>You pay \$0.</p>

Services that are covered for you	What you must pay when you get these services
<p>Diversionary behavioral health services Community-based behavioral health care services that you may be able to use instead of going to the hospital or a facility for some behavioral health needs. Your primary care provider/care team will work with you to decide if these services are right for you and will be in your Individualized Care Plan. Services include but are not limited to:</p> <ul style="list-style-type: none"> • Medically Monitored Inpatient Withdrawal Management • Behavioral Emergency Services, including Emergency Screening Services Program, Short-Term Crisis Counseling, Medication Management Crisis and Specializing Services • Community Crisis Stabilization • Community Support Program (CSP) • Community Support Program (CSP) for Chronically Homeless Individuals • Clinical Support Services for Substance Abuse 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) • Telehealth 	<p>You pay \$0.</p>
<p><i>Prior authorization is not required.</i></p> <p>See <i>Outpatient mental health care</i> section listed later in this chart for more information about additional mental health services.</p>	

Services that are covered for you	What you must pay when you get these services
<p>Durable medical equipment and related supplies (For a definition of “durable medical equipment,” see Chapter 11 of this booklet.)</p> <p>Items that are covered by the plan under the Medicare benefit include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.</p> <p>The plan also covers certain additional supplies and equipment under the MassHealth (Medicaid) benefit. Covered supplies include but are not limited to the following:</p> <ul style="list-style-type: none">• Adult diapers• Urinary catheters• Personal Emergency Response Systems (PERS)• Wander Response System - Communication alert system/device for members who are at risk of wandering• Tub and shower grab bars• Environmental accessibility adaptations and aids, including services related to the provision of minor housing adaptations, minor home modifications, or adaptive equipment for members who require this service in order to remain safely and independently in the community• Assistive/adaptive technology• Augmentative and alternative communication devices• Repairs and modifications <p>We cover all medically necessary durable medical equipment covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you.</p> <p><i>Limits may apply to certain DME. Prior authorization may be required.</i> For a detailed list, please call Member Services at the number printed on the back cover of this booklet.</p>	You pay \$0.

Services that are covered for you	What you must pay when you get these services
<p>Emergency care Emergency care refers to services that are:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p> <p>Emergency services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.</p> <p>You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories.</p> <p>Our plan also covers emergency services, including emergency transportation, and urgently needed care outside the United States and its territories up to one thousand dollars (\$1,000) per calendar year. This is a supplemental benefit covered under our plan.</p> <p>See Chapter 3 for more information about emergency care.</p> <p><i>Prior authorization is not required.</i></p>	<p>You pay \$0.</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered <i>or</i> you must have your inpatient care at the out-of-network hospital authorized by the plan.</p>
<p>Gender reassignment/affirmation The plan covers gender reassignment services. Services may include the following: mastectomy, breast augmentation, hysterectomy, salpingectomy, oophorectomy, or genital reconstructive surgery.</p> <p><i>Prior authorization is required. Your medical provider will be required to submit your medical records for review.</i></p> <p>Services and procedures that are consider cosmetic and reversal of gender reassignment surgery are not covered.</p> <p>For more information or help, please contact your care team.</p>	<p>You pay \$0.</p>
<p>Grocery shopping and delivery These services are covered by our plan under the MassHealth (Medicaid) benefit.</p> <p><i>Prior authorization is required.</i></p>	<p>You pay \$0.</p>

Services that are covered for you	What you must pay when you get these services
<p>Group adult foster care Personal care in either an assisted living community or an elder/public housing complex for members at imminent risk of institutionalization. Daily assistance in personal care, managing medication, homemaking, and laundry is provided. Group adult foster care is covered by our plan under the MassHealth (Medicaid) benefit.</p> <p><i>Prior authorization is required.</i></p>	You pay \$0.

Chapter 4. Benefits Chart (what is covered)**Health and wellness education programs**

You pay \$0.

The plan covers Medicare preventive services. These services are listed separately within this Benefits Chart and are marked with an apple. Other health and wellness programs are not covered under the Medicare benefit.

Our plan also covers additional services and programs under the MassHealth (Medicaid) benefit, including but not limited to:

- Health education resources
- Chronic Self-Management Program
- Diabetes Self-Management Program
- Healthy Eating Program
- Cardiovascular Disease Program
- Motivational Interviewing
- Access to 24/7 Nurse Advice Call Line (see Chapter 2, for more information on accessing Nurse Advice Call Line)

Your care team will work with you and recommend which programs may be right for you based on your needs. For more information or help, please contact your care team or call Member Services at the number printed on the back cover of this booklet.

Prior authorization is not required for services provided by Commonwealth Care Alliance or a contracted provider.

Wellness Allowance

- 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)

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, 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.

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

No referral is required for this benefit


Services that are covered for you	What you must pay when you get these services
<p data-bbox="207 352 1039 422">www.commonwealthcarealliance.org/members/sco/sco-member-forms</p> <p data-bbox="207 464 987 569">Send the completed form with any required documents to the address shown on the form. If you have any questions, call Member Services.</p>	

Chapter 4. Benefits Chart (what is covered)

Services that are covered for you	What you must pay when you get these services
<p>Healthy Savings Card to purchase certain Medicare approved Over-the-Counter (OTC) items and healthy nutritious food: You receive a card with an allowance of \$125 that is applied at the beginning of each calendar quarter (every three months) to purchase Medicare-approved items such as hand sanitizer, masks, first aid supplies, dental care, cold symptoms supplies, and others, without a prescription.</p> <p><i>Prior authorization is not required for covered Medicare approved items purchased from a contracted retailer.</i></p>	<p>You pay \$0 for covered items up to \$125 per quarter.</p> <p>If the cost of the Medicare approved OTC items exceeds the quarterly benefit limitation of \$125 per quarter, you are responsible for additional costs.</p>
<p>For members with chronic illnesses, you may use the OTC card to for the purchase of 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. Members without chronic illness can only use the OTC Card towards the purchase of Medicare-approved items.</p>	
<p>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.</p>	
<p>Contact Member Services for questions regarding Medicare approved OTC items or visit www.otcnetwork.com/member with your OTC card number.</p>	
<p>For more information about OTC drugs covered under the MassHealth (Medicaid) benefit, see <i>Outpatient drugs</i> section listed later in this chart.</p>	

Services that are covered for you	What you must pay when you get these services
<p>Hearing services</p> <p>Under the Medicare benefit, the plan covers diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment. These services are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</p> <p>The plan also covers the following hearing services under the MassHealth (Medicaid):</p> <ul style="list-style-type: none">• Routine hearing exams• Hearing aids, including evaluations for fitting hearing aids, repairs and replacements <p><i>Prior authorization is not required for routine hearing exams, evaluations, repairs and replacements provided by a contracted provider. Prior authorization is required for hearing aids costing more than \$500.</i></p> <p>For a detailed list, please call Member Services at the number printed on the back cover of this booklet.</p>	<p>You pay \$0.</p>

Chapter 4. Benefits Chart (what is covered)

Services that are covered for you	What you must pay when you get these services
<p>Help with Chronic Conditions</p> <p>Commonwealth Care Alliance Senior Care Options benefits include the following additional services.</p> <ul style="list-style-type: none"> 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. <p>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.</p> <p>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.</p>	<p>You pay \$0.</p>
<p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> One screening exam every 12 months <p><i>Prior authorization is not required for services provided by a contracted provider.</i></p>	<p>You pay \$0.</p> <p>There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered preventive HIV screening.</p>
<p>Homemaker</p> <p>Includes assistance with shopping, menu planning, meal preparation, laundry, and light housekeeping including but not limited to vacuuming, dusting, dry mopping, dish washing, cleaning the kitchen and bathroom, and changing bed linens. Homemaker services are covered by our plan under the MassHealth (Medicaid) benefit.</p> <p><i>Prior authorization is required.</i></p>	<p>You pay \$0.</p>

Chapter 4. Benefits Chart (what is covered)


Services that are covered for you	What you must pay when you get these services
<p>Home delivered meals Service includes preparing, packaging and delivering meals to member homes. These services are covered by our plan under the MassHealth (Medicaid) benefit. <i>Prior authorization is required.</i></p>	<p>You pay \$0.</p>
<p>Home health agency care Prior to receiving home health services, a doctor 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. Services covered by the plan under the Medicare benefit include, but are not limited to:</p> <ul style="list-style-type: none"> • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care 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 <p>The plan may cover additional hours of care, including your skilled nursing and home health aide services, beyond the Medicare limit under the MassHealth (Medicaid) benefit. <i>Prior authorization is required.</i></p>	<p>You pay \$0.</p>

Chapter 4. Benefits Chart (what is covered)

Services that are covered for you	What you must pay when you get these services
<p>Home Infusion Therapy</p> <p>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)</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • 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 <p><i>Prior authorization is required.</i></p>	<p>You pay \$0.</p> <p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid by Senior Care Options Program.</p>
<p>Hospice care</p> <p>You may receive care from any Medicare-certified hospice program in the CCA service area. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you are terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care <p><u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Senior Care Options Program (our plan) will pay for your Hospice services related to your terminal prognosis.</p> <ul style="list-style-type: none"> • <u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, Senior Care Options Program will pay for your care. If you obtain the covered services from a 	



Chapter 4. Benefits Chart (what is covered)

Services that are covered for you	What you must pay when you get these services
<p>network provider, Senior Care Options Program will pay for your care.</p> <ul style="list-style-type: none"> If you obtain the covered services from an out-of-network provider, you pay the cost-sharing according to the plan's rules described in Chapter 3, Section 1.2, "Basic rules for getting your medical care covered by the plan." <p><u>For services that are covered by Senior Care Options Program but are not covered by Medicare Part A or B:</u> Senior Care Options Program will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay nothing for these services.</p> <p><u>For drugs that may be covered by the plan's Part D benefit:</u> Drugs are never covered by both the hospice organization and our plan at the same time. For more information, please see Chapter 5, Section 9.4 (<i>What if you're in Medicare-certified hospice</i>)</p> <p>Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.</p> <p>Our plan covers hospice consultation services for a terminally ill person who hasn't elected the hospice benefit.</p>	
Hospice care (continued)	
<p>The plan also covers hospice, including room and board in a facility, under the MassHealth (Medicaid) benefit. For all members who do not elect Medicare hospice, we offer palliative care services under our Life Choices program as well as end of life care. Life Choices is a palliative care program focused on relieving pain, stress, and other uncomfortable symptoms for people living with chronic or serious illness. The program is designed for our members, their families, and health care providers with active involvement of the care teams. For more information, please contact your care team.</p> <p><i>Prior authorization is not required for services provided by a contracted provider or the member's elected hospice organization.</i></p>	

Services that are covered for you	What you must pay when you get these services
 Immunizations Covered Medicare Part B services include: <ul style="list-style-type: none">• Pneumonia vaccine• Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B• Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit.	<p>You pay \$0.</p> <p>There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.</p>

Services that are covered for you	What you must pay when you get these services
<p>Inpatient hospital care 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. The plan covers your inpatient stay in a hospital beyond the Medicare limit under the MassHealth (Medicaid) benefit.</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • 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 abuse 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/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-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 Original Medicare rate. If Senior Care Options Program provides transplant services at a location outside the pattern of care for transplants in your community and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. 	<p>You pay \$0.</p>

Services that are covered for you	What you must pay when you get these services
<p>Inpatient hospital care (continued)</p> <ul style="list-style-type: none"> Blood - including storage and administration. The plan covers the first 3 pints of whole blood and packed red cells under the MassHealth (Medicaid) benefit. Medicare coverage of whole blood and packed red cells begins with the fourth pint of blood that you need. The plan covers all other components of blood beginning with the first pint used under the Medicare benefit. Physician services <p>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.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p> <p><i>Prior authorization is required, except for inpatient substance abuse and emergency admissions.</i></p>	<p>If you get <i>authorized</i> inpatient care at an out-of-network hospital after your emergency condition is stabilized, you pay nothing.</p>
<p>Inpatient mental health care</p> <p>Covered services include mental health care services that require a hospital stay. Medicare has a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to mental health services provided in a psychiatric unit of a general hospital under Medicare.</p> <p>The plan covers your inpatient stay in a psychiatric hospital beyond the Medicare limit under the MassHealth (Medicaid) benefit.</p> <p><i>Prior authorization is required, except for inpatient substance abuse and emergency admissions.</i></p>	<p>You pay \$0.</p>
<p>Laundry</p> <p>Our plan covers laundry services under the MassHealth (Medicaid) benefit.</p> <p><i>Prior authorization is required.</i></p>	<p>You pay \$0.</p>

Services that are covered for you	What you must pay when you get these services
<p> Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.</p> <p>The plan covers 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.</p> <p>The plan may cover medical nutrition therapy for members who do not meet the Medicare benefit criteria under the MassHealth (Medicaid) benefit.</p> <p><i>Prior authorization is not required for services provided by a contracted provider.</i></p>	<p>You pay \$0.</p> <p>There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered medical nutrition therapy services.</p>
<p> Medicare Diabetes Prevention Program (MDPP)</p> <p>MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.</p> <p>MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.</p> <p><i>Prior authorization is not required for services provided by a contracted provider.</i></p>	<p>You pay \$0.</p> <p>There is no coinsurance, copayment, or deductible for the MDPP benefit.</p>

Chapter 4. Benefits Chart (what is covered)

Medicare Part B prescription drugs

You pay \$0.

These drugs are covered under Part B of Original Medicare.

Members of our plan receive coverage for these drugs through our plan. Covered drugs include:

- Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services
- Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan
- Clotting factors you give yourself by injection if you have hemophilia
- Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug
- Antigens
- Certain oral anti-cancer drugs and anti-nausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases

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:

www.commonwealthcarealliance.org/members/pharmacy-program/formulary-2020/2020-senior-care-options-formulary

Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. You pay

Services that are covered for you	What you must pay when you get these services
<p>nothing for your Part D prescription drugs covered by our plan. Most specialty drugs are limited to a 30-day supply. <i>Prior authorization may be required for Medicare Part B drugs.</i> For a detailed list, please call Member Services at the number printed on the back cover of this booklet</p>	
<p> Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more. <i>Prior authorization is not required for services provided by a contracted provider.</i></p>	<p>You pay \$0.</p> <p>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</p>
<p>Opioid treatment program services Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include:</p> <ul style="list-style-type: none">• 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 <p><i>Prior authorization is not required.</i></p>	<p>You pay \$0.</p>

Services that are covered for you	What you must pay when you get these services
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none">• X-rays• Radiation (radium and isotope) therapy including technician materials and supplies• Surgical supplies, such as dressings• Splints, casts and other devices used to reduce fractures and dislocations• Laboratory tests• Blood - including storage and administration. The plan covers the first 3 pints of whole blood and packed red cells under the MassHealth (Medicaid) benefit. Medicare coverage of whole blood and packed red cells begins with the fourth pint of blood that you need. Medicare covers all other components of blood are covered beginning with the first pint used.• Other outpatient diagnostic tests• Genetic testing – services provided accordingly with Medicare and MassHealth (Medicaid) guidance <p><i>Prior authorization may be required for outpatient diagnostic tests and therapeutic services and supplies. For example, specialized imaging and specialized screening tests (i.e. genetic testing) may require a prior authorization.</i></p> <p>For more information, please call Member Services at the number printed on the back cover of this booklet.</p> <p>In the event that clinical input is necessary to determine whether a course of treatment is appropriate, Commonwealth Care Alliance reserves the right to have an expert review the proposed treatment plan or request.</p>	You pay \$0.

Services that are covered for you	What you must pay when you get these services
<p>Outpatient drugs</p> <p>Our plan covers prescription drugs under Medicare Part D. See Chapter 5 for more information on Medicare Part D drug benefit.</p> <p>Our plan also covers outpatient drugs, including home delivery of pre-packaged medications, under the MassHealth (Medicaid) benefit. Categories of drugs covered under the MassHealth (Medicaid) benefit:</p> <ul style="list-style-type: none">• Certain over-the-counter medications (OTC) with a prescription from a licensed prescriber. Generally, only generic OTCs are covered. Please refer to our complete MassHealth (Medicaid) Drug List. For more information, call Member Services (phone numbers are on the back cover of this booklet or visit our website www.CommonwealthCareSCO.org). <p>Additionally, our plan covers Healthy Savings Card to purchase certain Medicare-approved over-the-counter items. For more information about the OTC card allowance, see <i>Healthy Savings Card to purchase certain Medicare approved over-the-counter (OTC) items</i> section listed earlier in this chart.</p>	<p>You pay \$0.</p>

Chapter 4. Benefits Chart (what is covered)

Services that are covered for you	What you must pay when you get these services
<p>Outpatient hospital services</p> <p>Our plan covers medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain screenings and preventive services • Certain drugs and biologicals that you can't give yourself <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p> <p><i>Prior authorization is required for outpatient surgery. Prior authorization may be required for outpatient diagnostic tests and therapeutic services and supplies. For example, specialized imaging and specialized screening tests may require a prior authorization.</i></p> <p>For more information, please contact your care team or Member Services at the number printed on the back cover of this booklet.</p> <p>In the event that clinical input is necessary to determine whether a course of treatment is appropriate, Commonwealth Care Alliance reserves the right to have an expert review the proposed treatment plan or request.</p>	<p>You pay \$0.</p>

Services that are covered for you	What you must pay when you get these services
<p>Outpatient mental health care</p> <p>We provide mental health care and substance abuse benefits that are no more restrictive than the requirements or limitations that we apply to medical, surgical, and community support benefits. This required under the Mental Health Parity and Addiction Equity law.</p> <p>The plan covers the following services under the Medicare benefit:</p> <p>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p> <p>Under the MassHealth (Medicaid) benefit, the plan covers additional outpatient care provided by licensed mental health counselors and licensed independent clinical social workers.</p> <p>Services include but are not limited to...</p> <ul style="list-style-type: none"> • Diagnostic services • Family consultation • Case consultation • Behavioral therapy • Individual group, and couples/family treatment • Psychiatric consultation on an inpatient medical unit • Medication visit • Inpatient-outpatient bridge visit • Psychological testing. <p><i>Prior authorization is not required except for neuropsychological testing, psychological testing, electroconvulsive therapy and transcranial magnetic stimulation.</i></p> <p>The plan also covers community-based behavioral health care services (“diversionary behavioral health services”) under the MassHealth (Medicaid) benefit. These are services that you may be able to use instead of going to the hospital or a facility for some behavioral health needs. For more information on these services, including prior authorization requirements, please go to the <i>Diversionary behavioral health services</i> section listed earlier in this chart.</p>	<p>You pay \$0.</p>

Services that are covered for you	What you must pay when you get these services
<p>Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p> <p><i>Prior Authorization is required for physical therapy, occupational therapy, and speech therapy.</i></p> <p>For more information, please contact your care team or Member Services at the number printed on the back cover of this booklet.</p>	<p>You pay \$0.</p>
<p>Outpatient substance abuse services Under the Mental Health Parity and Addiction Equity law, we provide mental health care and substance abuse benefits that are no more restrictive than the requirements or limitations that we apply to medical, surgical, community and support benefits.</p> <p>The plan covers additional services under the MassHealth (Medicaid) benefit including but not limited to:</p> <ul style="list-style-type: none"> • Ambulatory detoxification (Level II. d) • Acupuncture Treatment • Methadone Maintenance/Opioid Replacement Therapy <p><i>Prior authorization is not required for services received from a contracted provider, except for acupuncture treatment after 36 sessions.</i></p>	<p>You pay \$0.</p>
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”</p> <p><i>Prior authorization is required.</i></p> <p>For more information, please contact your care team or Member Services at the number printed on the back cover of this booklet.</p>	<p>You pay \$0.</p>


Services that are covered for you	What you must pay when you get these services
<p>Over-the-counter (OTC) Medications Please see Outpatient drugs section of the Benefits Chart.</p>	
<p>Palliative Care Program (Life Choices) 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.</p> <p>When receiving palliative care, you can still receive treatment and therapies meant to improve, or even cure, your medical problems.</p> <p>The program can help you:</p> <ul style="list-style-type: none"> • 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 <p>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.</p>	<p>You pay \$0.</p>
<p>Partial hospitalization services “Partial hospitalization” is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p> <p><i>Prior authorization is not required for services provided by a contracted provider.</i></p>	<p>You pay \$0.</p>

Services that are covered for you	What you must pay when you get these services
<p>Personal Care Attendant (PCA) Consumer-directed care delivery. A caregiver employed by the member to provide assistance with activities of daily living (such as bathing, dressing, eating), as well as other activities performed under the direction of the member or Surrogate, such as assistance with medication or other health- related needs. These services are covered by our plan under the MassHealth (Medicaid) benefit.</p> <p><i>Prior authorization is required.</i></p>	<p>You pay \$0.</p>
<p>Personal Care Homemaker In addition to the services listed above under Homemaker, includes assistance with: bathing, dressing, shampoo/hair combing, foot care (excluding nail cutting), denture care, shaving, toileting, eating, ambulating and transfers. These services are covered by our plan under the MassHealth (Medicaid) benefit.</p> <p><i>Prior authorization is required.</i></p>	<p>You pay \$0.</p>

Physician/Practitioner services, including doctor's office visits You pay \$0.



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**:
 - You are not a new patient **and**
 - The check-in is not related to an office visit in the past 7 days and
 - 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 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



Services that are covered for you	What you must pay when you get these services
<p><i>Dental services</i> section listed earlier in this Benefits Chart.</p> <p><i>Prior authorization is not required for services provided by a contracted provider, except for certified ambulatory surgical centers, non-routine dental care, and services provided by out-of-network providers.</i></p>	
<p>Podiatry services</p> <p>The plan covers the following services under the Medicare benefit:</p> <ul style="list-style-type: none"> • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs <p>The plan also covers podiatric care, including routine foot care, not covered by Medicare under the MassHealth (Medicaid) benefit.</p> <p><i>Prior authorization is not required for services provided by a contracted provider, except for podiatric surgery and podiatry services provided in a nursing home.</i></p>	<p>You pay \$0.</p>
<p> Prostate cancer screening exams</p> <p>For men age 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test <p><i>Prior authorization is not required for services provided by a contracted provider.</i></p>	<p>You pay \$0.</p> <p>There is no coinsurance, copayment, or deductible for an annual PSA test.</p>

Services that are covered for you	What you must pay when you get these services
<p>Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p> <p>The plan also covers prosthetic care not covered by Medicare under the MassHealth (Medicaid) benefit.</p> <p><i>Prior authorization may be required.</i></p> <p>For a detailed list, please call your care team or Member Services at the number printed on the back cover of this booklet.</p>	<p>You pay \$0.</p>
<p>Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</p> <p><i>Prior authorization is required.</i></p>	<p>You pay \$0.</p>
<p>Respite Care Includes the provision of up to 24 hour/7 days per week residential care services to relieve caregivers from the daily stresses and demands of caring for a member to strengthen and support the informal support system. These services may be provided in an emergency or in a planned for a specified time period. These services are covered by our plan under the MassHealth (Medicaid) benefit.</p> <p><i>Prior authorization is not required for services provided by a contracted provider.</i></p>	<p>You pay \$0.</p>

Chapter 4. Benefits Chart (what is covered)

Services that are covered for you	What you must pay when you get these services
<p> Screening and counseling to reduce alcohol misuse</p> <p>The plan covers one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent under the Medicare benefit.</p> <p>If you screen positive for alcohol misuse, under the Medicare benefit, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p> <p>The plan covers additional services under the MassHealth (Medicaid) benefit.</p> <p><i>Prior authorization is not required for services provided by a contracted provider.</i></p>	<p>You pay \$0.</p> <p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>
<p> Screening for lung cancer with low dose computed tomography (LDCT)</p> <p>For qualified individuals, a LDCT is covered every 12 months.</p> <p>Eligible enrollees are: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years or who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.</p> <p>For LDCT lung cancer screenings after the initial LDCT screening: the enrollee must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p> <p><i>Prior authorization is required.</i></p>	<p>You pay \$0.</p> <p>There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT.</p>


Chapter 4. Benefits Chart (what is covered)

Services that are covered for you	What you must pay when you get these services
 Screening for Hepatitis C Virus (HCV) We cover screening for HCV when ordered by the primary care provider within the context of a primary care setting and performed by an eligible provider for these services. The plan covers HCV screening for adults who meet either of the following conditions: <ul style="list-style-type: none"> • Those at high risk for Hepatitis C Virus infection • Those who do not meet the high risk as defined above, but who were born from 1945 through 1965 or had a blood transfusion before 1992 <p><i>Prior authorization is not required for services provided by a contracted provider.</i></p>	You pay \$0.
 for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office. <p><i>Prior authorization is not required for services provided by a contracted provider.</i></p>	You pay \$0. There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling to prevent STIs preventive benefit.

Services that are covered for you	What you must pay when you get these services
<p>Services to treat kidney disease and conditions</p> <p>Covered services include:</p> <ul style="list-style-type: none">• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3)• Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)• Home dialysis equipment and supplies• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) <p><i>Prior authorization is not required for services provided by a contracted provider or for dialysis provided by an out-of-network provider when you are temporarily out of the service area.</i></p> <p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, <i>Medicare Part B prescription drugs</i>.</p>	You pay \$0.

Services that are covered for you	What you must pay when you get these services
<p>Skilled nursing facility (SNF) care (For a definition of “skilled nursing facility care,” see Chapter 11 of this booklet. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p>You are covered for up to 100 days for skilled nursing each benefit period. Your stay is unlimited for long-term care. No prior hospital stay is required. Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • 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. The plan covers the first 3 pints of whole blood and packed red cells under the MassHealth (Medicaid) benefit. Medicare coverage of whole blood and packed red cells begins with the fourth pint of blood that you need. The plan covers all other components of blood beginning with the first pint used under the Medicare benefit. • 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 <p>Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to get your care from a facility that isn’t a network provider for your Medicare covered care, if the facility accepts our plan’s amounts for payment.</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse is living at the time you leave the hospital. 	<p>You pay \$0.</p> <p>If MassHealth (Medicaid) determines you have a monthly Patient Paid Amount (PPA) for your custodial care, you are responsible for these payments to MassHealth (Medicaid).</p>
<p><i>Prior authorization is required.</i></p>	

Chapter 4. Benefits Chart (what is covered)

Services that are covered for you	What you must pay when you get these services
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p><u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> Under the Medicare benefit, the plan covers two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.</p> <p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> Under the Medicare benefit, the plan covers cessation counseling services. We cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.</p> <p>The plan also covers additional 8 cessation counseling sessions under the MassHealth (Medicaid) benefit.</p> <p><i>Prior authorization is not required for services provided by a contracted provider.</i></p>	<p>You pay \$0.</p> <p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>
<p>Social and Dementia Day Care</p> <p>Include the provision of support services in a group setting to help members recover from an acute illness or manage a chronic illness. Services provided include care planning, social services, therapeutic activities, nutrition and transportation; services focus on the member's strengths and abilities while maintaining connection to the community. These services are covered by our plan under the MassHealth (Medicaid) benefit.</p> <p><i>Prior authorization is required.</i></p>	<p>You pay \$0.</p>

Services that are covered for you	What you must pay when you get these services
<p>Supervised Exercise Therapy (SET)</p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment.</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p> <p>The SET program must:</p> <ul style="list-style-type: none"> • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques <p>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 health care provider.</p> <p><i>Prior authorization is required.</i></p>	<p>You pay \$0.</p>
<p>Transportation (medical)</p> <p>The plan covers transportation you need for medical reasons other than emergencies to approved destinations. This Non-emergency transportation is covered by our plan under the MassHealth (Medicaid) benefit.</p>	<p>You pay \$0.</p>
<p>Transportation (non-medical purposes)</p> <p>Eight one-way trips per month are provided for non-medical purposes, such as grocery shopping. Mile limitation applicable. This benefit is covered by the plan under the MassHealth (Medicaid) benefit.</p> <p><i>Prior authorization is required.</i></p>	<p>You pay \$0.</p>

Services that are covered for you	What you must pay when you get these services
<p>Urgently needed services</p> <p>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.</p> <p>Our plan also covers urgently needed care and emergency services, including emergency transportation, outside the United States and its territories up to one thousand dollars (\$1,000) per calendar year. This is a supplemental benefit covered under our plan. For more information about urgently needed care, see Chapter 3.</p> <p><i>Prior authorization is not required.</i> You should inform your PCP/care team whenever possible if you received such care.</p>	You pay \$0.



Vision care

The plan covers additional vision services that are typically not covered under the Medicare and (MassHealth) benefit. The plan pays up to \$200 per calendar year for prescription eyewear without prior authorization, including:

- Contact lenses
- Eyeglasses, including frames and lenses purchased separately or together
- Upgrades

The plan covers the following services under the Medicare benefit:

- Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams for eyeglasses/contacts.
- For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year.
- For people 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.)


The plan also covers vision services under the MassHealth (Medicaid) benefit. Covered services include but are not limited to:

- Routine vision exams
- Glasses, including certain lenses, and contact lenses for members with certain conditions. Eyeglasses and other visual aids, including 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.

You pay \$0 for plan, Medicare and MassHealth (Medicaid) covered services.

You pay \$0 for your eyewear up to \$200 per calendar year under the supplemental plan benefit without prior authorization.

The plan covers eyewear beyond \$200 with prior authorization from a contracted provider.

Services that are covered for you	What you must pay when you get these services
<p><i>Prior authorization is not required for prescription eyewear up to \$200. Prior authorization is required for any eyewear beyond the \$200 limit. Services must be provided by a contracted provider.</i></p> <p>Designer frames, or contact lenses used for cosmetic purposes, such as colored lenses, are not covered.</p>	
<p> “Welcome to Medicare” preventive visit</p> <p>The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p>Important: We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” preventive visit.</p>	<p>You pay \$0.</p> <p>There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.</p>

SECTION 3 What services are not covered by the plan?

Section 3.1 Services *not* covered by the plan (exclusions)

This section tells you what services are “excluded.” Excluded means that the plan doesn’t cover these services. In some cases, we cover items or services that are excluded by Medicare under our plan’s MassHealth (Medicaid) benefits. For more information about MassHealth (Medicaid) benefits, call Member Services (phone numbers are printed on the back cover of this booklet).

The chart below describes some services and items that aren’t covered by the plan under any conditions or are covered by the plan only under specific conditions. The chart also tells you if the services or item is covered by the plan under MassHealth (Medicaid).

We won’t pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found

Chapter 4. Benefits Chart (what is covered)

upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 8, Section 5.3 in this booklet.)

All exclusions or limitations on services are described in the Benefits Chart or in the chart below.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to the standards of Original Medicare		✓ Services considered to be unreasonable or unnecessary, according to the standards of Original Medicare are not covered, unless these services are listed by our plan as covered services or are covered by the plan under the MassHealth (Medicaid) benefit or determined to be necessary based upon the signed individualized care plan.
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Private room in a hospital		✓ Covered only when medically necessary.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	✓	
Full-time nursing care in your home		✓ May be covered by the plan under the MassHealth (Medicaid) benefit only when there are no other alternative modes of care available. Prior authorization is required.
*Custodial care is care provided in a nursing home, hospice, or other facility setting when you		✓ Covered by the plan under the MassHealth (Medicaid) benefit. Prior

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
do not require skilled medical care or skilled nursing care.		authorization is required. (See Chapter 4, Section 2.1 for more information on custodial care.)
Homemaker services include basic household assistance, including light housekeeping or light meal preparation		✓ Covered by the plan under the MassHealth (Medicaid) benefit. Prior authorization is required. (See Chapter 4, Section 2.1 for more information.)
Fees charged for care by your immediate relatives or members of your household		✓ May be covered by the plan under your MassHealth (Medicaid) benefit and when approved in advance. For example, if you participate in the Personal Care Attendant (PCA) program and your primary care provider/care team authorizes a certain family member to act as your PCA. (See Chapter 4, Section 2.1 for more information on custodial care.)
Cosmetic surgery or procedures		✓ Covered for reconstructive procedures in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Routine dental care, such as cleanings, fillings or dentures		✓ Routine dental care is covered by the plan under the MassHealth (Medicaid) benefit. Prior authorization may be required. (See Chapter 4, Section 2.1 for more information on dental care.)
Non-routine dental care		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care. Prior authorization may be required. (See Chapter 4, Section 2.1 for more information on dental care.)
Routine chiropractic care		✓

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		Manual manipulation of the spine to correct a subluxation is covered under the Medicare benefit. The plan covers problem-oriented issues under the MassHealth (Medicaid) benefit. (See Chapter 4, Section 2.1 for more information on chiropractic care.)
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes. Additional services are covered by the plan under the MassHealth (Medicaid) benefit. Prior authorization may be required. (See Chapter 4, Section 2.1 for more information.)
Home-delivered meals		✓ Services are covered by the plan under the MassHealth (Medicaid) benefit. Prior authorization is required. (See Chapter 4, Section 2.1 for more information on home-delivered meals.)
Orthopedic shoes		✓ Covered if shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease. Additional items may be covered under the MassHealth (Medicaid) benefit. Prior authorization may be required. (See Chapter 4, Section 2.1 for more information.)
Supportive devices for the feet		✓ Orthopedic or therapeutic shoes for people with diabetic foot disease. Additional items may be covered under the MassHealth (Medicaid) benefit. Prior authorization may be required. (See Chapter 4, Section 2.1 for more information.)

Chapter 4. Benefits Chart (what is covered)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine hearing exams, hearing aids, or exams to fit hearing aids		✓ Covered by the plan under the MassHealth (Medicaid) benefit. Prior authorization may be required. (See Chapter 4, Section 2.1 for more information.)
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, vision therapy and other low vision aids		✓ Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery under the Medicare benefit. The plan covers additional services including routine care under the MassHealth (Medicaid) benefit. Prior authorization may be required. (See Chapter 4, Section 2.1 for more information on vision care and eyeglasses.)
Reversal of sterilization procedures and or non-prescription contraceptive supplies.		✓ Covered only if these services or supplies are covered under the MassHealth (Medicaid) benefit.
Acupuncture		✓ Covered by the plan under the MassHealth (Medicaid) benefit. (See Chapter 4, Section 2.1 for more information.)
Naturopath services (uses natural or alternative treatments)	✓	
E-cigarettes	✓	
Routine services provided outside of the service area are not covered.	✓	
Services provided outside the United States and 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 thousand dollars (\$1,000) per calendar year. (See Chapter 4, Section 2.1 for more information.)

Chapter 4. Benefits Chart (what is covered)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services that you get without prior authorization when prior authorization is required. (The Benefits Chart earlier in this chapter tells which services require prior authorization.)	✓	

*Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.

CHAPTER 5

*Using the plan's coverage for your
Part D prescription drugs*

Chapter 5. Using the plan's coverage for your Part D prescription drugs

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**How can you get information about your drug costs?**

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. Because you are in the “Extra Help” program, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs does not apply to you.** We have sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “LIS Rider.” (Phone numbers for Member Services are printed on the back cover of this booklet.)

SECTION 1 Introduction

Section 1.1	This chapter describes your coverage for Part D drugs
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This chapter **explains rules for using your coverage for Part D drugs.**

In addition to your coverage for Part D drugs, Senior Care Options Program also covers some drugs under the plan’s medical benefits. Through its coverage of Medicare Part A benefits, our plan generally covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Through its coverage of Medicare Part B benefits, our plan covers drugs including certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. Chapter 4 (*Benefits Chart, what is covered*) tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay, as well as your benefits and costs for Part B drugs.

Your drugs will be covered by Senior Care Options Program if you are in Medicare hospice. Our plan will also cover Medicare Parts A, B, and D services and drugs that are unrelated to your terminal prognosis and related conditions. For more information, please see Section 9.4 (*What if you’re in Medicare-certified hospice*). For information on hospice coverage, see the hospice section of Chapter 4 (*Benefits Chart, what is covered*).

The following sections discuss coverage of your drugs under the plan’s Part D benefit rules. Section 9, *Part D drug coverage in special situations* includes more information on your Part D coverage and Original Medicare.

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your MassHealth (Medicaid) benefits. We send you the MassHealth (Medicaid) Drug List. For more information, call Member Services (phone numbers are printed on the back cover of this booklet). You can also visit our website www.CommonwealthCareSCO.org to find out what drugs are covered by MassHealth (Medicaid).

Chapter 5. Using the plan's coverage for your Part D prescription drugs

Section 1.2 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist or other prescriber) write your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service.*)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List."*)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

Section 2.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on the plan's Drug List.

Section 2.2 Finding network pharmacies**How do you find a network pharmacy in your area?**

To find a network pharmacy, you can look in your Pharmacy Directory, visit our website (www.CommonwealthCareSCO.org), or call Member Services (phone numbers are printed on the back cover of this booklet).

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new

Chapter 5. Using the plan's coverage for your Part D prescription drugs

prescription written by a provider or to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Member Services (phone numbers are printed on the back cover of this booklet) or use the *Pharmacy Directory*. You can also find information on our website at www.CommonwealthCareSCO.org.

What if you need a specialized pharmacy?

Sometimes 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 long-term care facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. 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.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Member Services (phone numbers are printed on the back cover of this booklet).

Section 2.3	Using the plan's mail-order services
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Our plan's mail-order service allows you to order **up to a 90-day supply**.

To get information about filling your prescriptions by mail you can choose one of the two options:

1. Call our Member Services at the number printed on the back cover.
2. Visit our website www.CommonwealthCareSCO.org and view 'Mail-Order Options'
3. Speak with your primary care provider/care team.

Usually a mail-order pharmacy prescription will get to you in no more than 14 days. If for any reason your mail order is delayed, please call our Member Services (phone numbers are printed on

Chapter 5. Using the plan's coverage for your Part D prescription drugs

the back cover of this booklet). We will assist you in obtaining the prescription (s) you need.

New prescriptions the pharmacy receives directly from your doctor's office.

After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop or delay the order before you are billed, and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

Refills on mail-order prescriptions. For refills, please contact your pharmacy 14-21 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. Please call your pharmacy to confirm your contact information.

Section 2.4	How can you get a long-term supply of drugs?
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The plan offers two ways to get a long-term supply also called an “extended supply” of “maintenance” drugs on our plan’s Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.) You may order this supply through mail order (see Section 2.3) or you may go to a retail pharmacy.

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services for more information (phone numbers are printed on the back cover of this booklet).
2. You can use the plan’s network **mail-order services**. Our plan’s mail-order service allows you to order up to a 90-day supply. See Section 2.3 for more information about using our mail-order services.

Section 2.5	When can you use a pharmacy that is not in the plan's network?
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Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. If you cannot use a network pharmacy, here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

Chapter 5. Using the plan's coverage for your Part D prescription drugs

- If you are traveling within the United States and territories, but outside of the plan's service area, and become ill, lose, or run out of your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy. Prior to filling your prescription at an out-of-network pharmacy, call our toll-free Member Services number printed on the back cover of this booklet, 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 make arrangements for you to get your prescriptions from an out-of-network pharmacy. Otherwise you may have to pay the full cost when you fill your prescription. You can ask us to reimburse you for the cost by submitting a claim to us. To learn how to submit a paper claim, please refer to the paper claims process described in Chapter 6. We cannot pay for any prescriptions that are filled by pharmacies outside of the United States and territories, even for a medical emergency.
- 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 network retail 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.

In these cases, we will cover a 31-day supply of covered prescription drugs that are filled in an out-of-network pharmacy.

In these situations, **please check first with Member Services** to see if there is a network pharmacy nearby. (Phone numbers for Member Services are printed on the back cover of this booklet.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost at the time you fill your prescription. You can ask us to reimburse you. (Chapter 6, Section 2.1 explains how to ask the plan to pay you back.)

SECTION 3 Your drugs need to be on the plan's "Drug List"

Section 3.1 The "Drug List" tells which Part D drugs are covered
--

The plan has a "*List of Covered Drugs (Formulary)*." In this *Evidence of Coverage*, we call it the "**Drug List**" for short.

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

Chapter 5. Using the plan's coverage for your Part D prescription drugs

The Drug List includes the drugs covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs). In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your MassHealth (Medicaid) benefits. We send you the MassHealth (Medicaid) over-the-counter (OTC) Drug List. For more information, call Member Services (phone numbers are printed on the back cover of this booklet). You can also visit our website www.CommonwealthCareSCO.org to find out what drugs are covered by MassHealth (Medicaid).

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either*:

- Approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- -- or -- Supported by certain references, such as books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.; the USPDI or its successor; and, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology or their successors.)

The Drug List includes both brand name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

Over-the-Counter Drugs

Our plan also covers certain over-the-counter drugs. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. For more information, call Member Services (phone numbers are printed on the back cover of this booklet).

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our Drug List.
- MassHealth (Medicaid)-covered drugs are not included on the Medicare Drug List (Formulary). We send you MassHealth (Medicaid) MassHealth over-the-counter (OTC) Drug List. For more information, call Member Services (phone numbers are printed on the back cover of this booklet). You can also visit the plan's website (www.CommonwealthCareSCO.org) to find out what drugs are covered by MassHealth (Medicaid).

Section 3.2 How can you find out if a specific drug is on the Drug List?

You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail. (Please note: The Drug List we send includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Member Services to find out if we cover it.)
2. Visit the plan's website (www.CommonwealthCareSCO.org) The Drug List on the website is always the most current.
3. Call Member Services to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. (Phone numbers for Member Services are printed on the back cover of this booklet.)

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost-sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 8, Section 7.2 for information about asking for exceptions.)

Please note that sometimes a drug may appear more than once in our drug list. This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount, or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Restricting brand name drugs when a generic version is available

Generally, a “generic” drug works the same as a brand name drug and usually costs less. **When a generic version of a brand name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug.

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called “**prior authorization.**” Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition and Drug A is less costly, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called “**step therapy.**”

Quantity limits

For certain drugs, we limit the amount of the drug that you can have by limiting how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Section 4.3 Do any of these restrictions apply to your drugs?

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services (phone numbers are printed on the back cover of this booklet) or check our website (www.CommonwealthCareSCO.org).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Member Services to learn what you or your provider would

Chapter 5. Using the plan's coverage for your Part D prescription drugs

need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 8, Section 7.2 for information about asking for exceptions.)

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered
--

We hope that your drug coverage will work well for you. But it's possible that there could be a prescription drug you are currently taking, or one that you and your provider think you should be taking, that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug. As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you.

There are things you can do if your drug is not covered in the way that you'd like it to be covered.

- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.

Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?
--

If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

Chapter 5. Using the plan's coverage for your Part D prescription drugs

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **no longer on the plan's Drug List**.
- -- or -- the drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

2. You must be in one of the situations described below:

- **For those members who are new or who were in the plan last year and aren't in a long-term care (LTC) facility:**

We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you were new and during the first 90 days of the calendar year if you were in the plan last year**. This temporary supply will be for a maximum of 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 30-day supply of medication. The prescription must be filled at a network pharmacy.

- **For those members who are new or who were in the plan last year and reside in a long-term care (LTC) facility:**

We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you are new and during the first 90 days of the calendar year if you were in the plan last year**. The total supply will be for a maximum of a 98-day supply depending on the dispensing increment. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 98-day supply of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **For those members who have been in the plan for more than 90 and reside in a long-term care (LTC) facility and need a supply right away:**

We will cover one 31-day supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

- **For those who have a level of care transition:**

For current enrollees with level-of-care changes, we will provide an emergency supply of at least 31-days (unless the prescription is written for fewer days) for all non-formulary medications including those that may have step therapy or prior authorization

Chapter 5. Using the plan's coverage for your Part D prescription drugs

requirements. An unplanned level of care transition could be any of the following:

- a discharge or admission to a Long Term Care facility
- a discharge or admission to a hospital, or
- a nursing facility skilled level change

To ask for a temporary supply, call Member Services (phone numbers are printed on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider 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. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Member Services are printed on the back cover of this booklet.)

You can ask for an exception

You and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your drug for next year. You can ask for an exception before next year and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we will authorize the coverage before the change takes effect.

If you and your provider want to ask for an exception, Chapter 8, Section 7.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year
--

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List.** New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 4 in this chapter).
- **Replace a brand name drug with a generic drug.**

We must follow Medicare requirements before we change the plan's Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the Drug List occur during the year, we post information on our website about those changes. We will update our online Drug List on a regularly scheduled basis to include any changes that have occurred after the last update. Below we point out the times that you would get direct notice if changes are made to a drug that you are then taking. You can also call Member Services for more information (phone numbers are printed on the back cover of this booklet).

Do changes to your drug coverage affect you right away?

Changes that can affect you this year: In the below cases, you will be affected by the coverage changes during the current year:

- **A new generic drug replaces a brand name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand name drug or both)**
 - We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

Chapter 5. Using the plan's coverage for your Part D prescription drugs

- We may not tell you in advance before we make that change—even if you are currently taking the brand name drug.
- You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).
- If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s) we made. This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.
- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
 - Once in a while, a drug may be suddenly withdrawn because it has been found to be unsafe or removed from the market for another reason. If this happens, we will immediately remove the drug from the Drug List. If you are taking that drug, we will let you know of this change right away.
 - Your prescriber will also know about this change and can work with you to find another drug for your condition.
- **Other changes to drugs on the Drug List**
 - We may make other changes once the year has started that affect drugs you are taking. For instance, we might add a generic drug that is not new to the market to replace a brand name drug or change the cost-sharing tier or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare. We must give you at least 30 days' notice or give you a 30-day refill of the drug you are taking at a network pharmacy.
 - During this 30-day period, you should be working with your prescriber to switch to a different drug that we cover.
 - Or you or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Changes to drugs on the Drug List that will not affect people currently taking the drug: For changes to the Drug List that are not described above, if you are currently taking the drug the following types of changes will not affect you until January 1 of the next year if you stay in the plan:

- If we put a new restriction on your use of the drug
- If we remove your drug from the Drug List

Chapter 5. Using the plan's coverage for your Part D prescription drugs

If any of these changes happen for a drug you are taking (but not because of a market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, the changes will affect you, and it is important to check the Drug List in the new benefit year for any changes to drugs.

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover
--

This section tells you what kinds of prescription drugs are “excluded.” This means neither Medicare nor MassHealth (Medicaid) pays for these drugs.

We won't pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 8, Section 5 in this booklet.) If the drug excluded by our plan is also excluded by MassHealth (Medicaid), you must pay for it yourself.

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. “Off-label use” is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
 - Generally, coverage for “off-label use” is allowed only when the use is supported by certain references, such as books. These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System; and for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology or their successors. If the use is not supported by any of these reference books, then our plan cannot cover its “off-label use.”

Also, by law, the categories of drugs listed below are not covered by Medicare or MassHealth (Medicaid):

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth

Chapter 5. Using the plan's coverage for your Part D prescription drugs

- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction
- Drugs when used for 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

SECTION 8 Show your plan membership card when you fill a prescription

Section 8.1 Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for your covered prescription drug.

Section 8.2 What if you don't have your membership card with you?

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then **ask us to reimburse you.** See Chapter 6, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage.

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your *Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Member Services (phone numbers are printed on the back cover of this booklet).

What if you're a resident in a long-term care (LTC) facility and become a new member of the plan?

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The total supply will be for a maximum of a 98-day supply, or less if your prescription is written for fewer days. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.) If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 8 Section 7.4 tells what to do.

Section 9.3 What if you're also getting drug coverage from an employer or retiree group plan?

Do you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group? If so, please contact **that group's benefits administrator**. He or she can help you determine how your current prescription drug coverage will work with our plan.

In general, if you are currently employed, the prescription drug coverage you get from us will be *secondary* to your employer or retiree group coverage. That means your group coverage would pay first.

Special note about 'creditable coverage':

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is "creditable" and the choices you have for drug coverage.

Chapter 5. Using the plan's coverage for your Part D prescription drugs

If the coverage from the group plan is “**creditable**,” it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.

Keep these notices about creditable coverage, because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn’t get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from your employer or retiree plan’s benefits administrator or the employer or union.

Section 9.4	What if you’re in Medicare-certified hospice?
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Drugs are never covered by the hospice organization and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice, our plan will cover all your drugs. See the previous parts of this section that tell about the rules for getting drug coverage under Part D. This chapter gives more information about drug coverage and what you pay.

SECTION 10	Programs on drug safety and managing medications
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Section 10.1	Programs to help members use drugs safely
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We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time

Chapter 5. Using the plan's coverage for your Part D prescription drugs

- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2	Drug Management Program (DMP) to help members safely use their opioid medications
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We have a program that can help make sure our members safely use their prescription opioid medications, and other medications that are frequently abused. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. The limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain doctor
- Limiting the amount of opioid or benzodiazepine medications we will cover for you
- Prescribing durable medical equipment (DME) to provide medication management via a pill dispenser

If we think that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the limitations that will apply to you. You will also have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake, or you disagree with our determination that you are at-risk for prescription drug misuse or with the limitation, you and your prescriber have the right to ask us for an appeal. If you choose to appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 8 for information about how to ask for an appeal.

The DMP may not apply to you if you have certain medical conditions, such as cancer, or you are receiving hospice care or live in a long-term care facility.

Section 10.3	Medication Therapy Management (MTM) program to help members manage their medications
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Chapter 5. Using the plan's coverage for your Part D prescription drugs

We have a program that can help our members with complex health needs.

This program is voluntary and free to members. A team of pharmacists and doctors developed the program for us. This program can help make sure that our members get the most benefit from the drugs they take. Our program is called a Medication Therapy Management (MTM) program. Some members who take several medications and who also have specific medical conditions and have high drug costs may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to have your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 11 We send you reports that explain payments for your drugs and which payment stage you are in

Section 11.1 We send you a monthly report called the "Part D Explanation of Benefits" (the "Part D EOB")
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Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you or others on your behalf have paid. This is called your **"out-of-pocket"** cost. With Senior Care Options Program, you do not have to pay anything for your prescription drugs, as long as you follow the rules described in this chapter.
- We keep track of your **"total drug costs."** This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan. Senior Care Options Program members are responsible for \$0 costs for covered drugs.

Chapter 5. Using the plan's coverage for your Part D prescription drugs

Our plan will prepare a written report called the *Part D Explanation of Benefits* (it is sometimes called the “Part D EOB”) when you have had one or more prescriptions filled through the plan during the previous month. It includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called “year-to-date” information. It shows you the total drug costs and total payments for your drugs since the year began.

Section 11.2	Help us keep our information about your drug payments up to date
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To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled. Senior Care Options Program members are responsible for \$0 costs for covered drugs.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay for the drug. For instructions on how to do this, go to Chapter 6, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
 - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
 - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
 - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us, so we can track your costs.
- **Check the written report we send you.** When you receive a *Part D Explanation of Benefits* (a Part D EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Member Services (phone numbers are printed on the back cover of this booklet).

Chapter 5. Using the plan's coverage for your Part D prescription drugs

Be sure to keep these reports. They are an important record of your drug expenses.

CHAPTER 6

*Asking us to pay a bill you have
received for covered medical
services or drugs*

Chapter 6. Asking us to pay a bill you have received for covered medical services or drugs

Chapter 6. Asking us to pay a bill you have received for covered medical services or drugs

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Chapter 6. Asking us to pay a bill you have received for covered medical services or drugs

SECTION 1 Situations in which you should ask us to pay for your covered services or drugs

Section 1.1	If you pay for your covered services or drugs, or if you receive a bill, you can ask us for payment
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Our network providers bill the plan directly for your covered services and drugs – you should not receive a bill for covered services or drugs. If you get a bill for medical care or drugs you have received, you should send this bill to us so that we can pay it. When you send us the bill, we will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

If you have already paid for a Medicaid service or items covered by the plan, you can ask our plan to pay you back (paying you back is often called “reimbursing” you). It is your right to be paid back by our plan whenever you’ve paid for medical services or drugs that are covered by our plan. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

If you have already paid for a Medicare service or item covered by the plan, you can ask our plan to pay you back (paying you back is often called “reimbursing” you). It is your right to be paid back by our plan whenever you’ve paid for medical services or drugs that are covered by our plan. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received.

1. When you’ve received emergency or urgently needed medical care from a provider who is not in our plan’s network

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed services from a provider who is not part of our network, you should ask the provider to bill the plan.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
 - If the provider is owed anything, we will pay the provider directly.
 - If you have already paid for the service, we will pay you back.

Chapter 6. Asking us to pay a bill you have received for covered medical services or drugs

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill the plan directly. But sometimes they make mistakes, and ask you to pay for your services.

- Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, send us the bill along with documentation of any payment you have made. You should ask us to pay you back for your covered services.

3. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back. You will need to submit paperwork for us to handle the reimbursement. Please contact Member Services for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Member Services are printed on the back cover of this booklet.)

4. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Section 2.5 to learn more.) Save your receipt and send a copy when you ask us to pay you back.

5. When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself. Save your receipt and send a copy when you ask us to pay you back.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think

Chapter 6. Asking us to pay a bill you have received for covered medical services or drugs

should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.

- Save your receipt and send a copy when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for the drug.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a “coverage decision.” If we decide it should be covered, we will pay for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 8 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or to pay a bill you have received

Section 2.1 How and where to send us your request for payment

Send Member Services your request for payment in writing, along with your bill and documentation of any payment you have made within 12 months of the date you received the service, item or drug. It’s a good idea to make a copy of your bill and receipts for your records.

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

- You don’t have to use the specific form, but it will help us process the information faster. The request must be written, and be signed by you, an authorized representative, or a licensed prescriber.
- Either download a copy of the form from our website www.CommonwealthCareSCO.org or call Member Services and ask for the form. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Please use the form when you are asking to pay you back for over-the-counter (OTC) drugs and items.

Mail your request for payment together with any bills or receipts to Member Services at this address:

Commonwealth Care Alliance
Attention: Member Services Department
30 Winter Street
Boston, MA 02108
Or fax to Member Services: (617) 426-1311

Chapter 6. Asking us to pay a bill you have received for covered medical services or drugs

You must submit your bill or receipt to Member Services within 12 months of the date you got the service or item.

Prescription (Part D) Reimbursement

Prescription reimbursement differs from medical services reimbursement. CCA works in partnership with its Pharmacy Benefit Manager (PBM), Navitus Health Solutions, to provide Part D prescription reimbursements.

To submit a claim for reimbursement of medications, please fill out the Navitus form, found on the CCA Pharmacy Program website under ‘Reimbursement’ and follow the provided steps within the document.

Forms can be mailed OR faxed to Navitus Health Solutions, using the contact information below:

Navitus Health Solutions, LLC
P.O. Box 999
Appleton, WI 54912-0999
Fax: 920-735-5315
Toll Free: 855-668-8550

You must submit your claim to us within 12 months of the date you received the service, item, or drug.

Contact Member Services if you have any questions (phone numbers are printed on the back cover of this booklet). If you receive bills and you don’t know what to do about those bills, we can help. You can also call if you want to give Member Services more information about a request for payment you have already sent to us.

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the service or drug

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 pay for the service. If you have already paid for the service or drug, we will mail your reimbursement to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains

Chapter 6. Asking us to pay a bill you have received for covered medical services or drugs

the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)

- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for the care or drug. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2	If we tell you that we will not pay for the medical care or drug, you can make an appeal
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If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 8 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 5 of Chapter 8. Section 5 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as “appeal.” Then after you have read Section 5, you can go to the section in Chapter 8 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 6.3 in Chapter 8.
- If you want to make an appeal about getting paid back for a drug, go to Section 7.5 of Chapter 8.

SECTION 4	Other situations in which you should save your receipts and send copies to us
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Section 4.1	In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs
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There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Below is an example of a situation when you should send us copies of receipts to let us know about payments you have made for your drugs:

Chapter 6. Asking us to pay a bill you have received for covered medical services or drugs

When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the case described above, this situation is not considered a coverage decision. Therefore, you cannot make an appeal if you disagree with our decision.

CHAPTER 7

Your rights and responsibilities

Chapter 7. Your rights and responsibilities

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SECTION 1 Our plan must honor your rights as a member of the plan

Section 1.1	We must provide information in a way that works for you (in languages other than English, in braille, in large print, or other alternate formats, etc.)
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To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. You can get this document and other printed materials in Spanish 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 (phone numbers are printed on the back cover of this booklet).

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 our Member Services (phone numbers are printed on the back cover of this booklet). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486- 2048) or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact our Member Services for additional information.

Section 1.2	We must treat you with fairness and respect at all times
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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 mental impairment), marital status, age, sex (including sex stereotypes and gender identity) sexual orientation, national origin, race, color, religion, creed, or public assistance.

If you want more information or have concerns about discrimination or unfair treatment, please call the 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 (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Chapter 7. Your rights and responsibilities

Section 1.3	We must ensure that you get timely access to your covered services and drugs
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As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). We do not require you to get referrals to go to network providers.

As a plan member, 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 30 calendar days.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 8, Section 11 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 8, Section 5 tells what you can do.)

Section 1.4	We must protect the privacy of your personal health information
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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.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a “Notice of Privacy Practice,” that tells 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.
- In most situations, if we 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 first*. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.

Chapter 7. Your rights and responsibilities

- For example, we are required to release health information to government agencies that are checking on quality of care.
- Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

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. We are allowed to charge you a fee for making copies. 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 health care 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 (phone numbers are printed on the back cover of this booklet).

NOTICE OF PRIVACY PRACTICES

Effective Date: August 14, 2020

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**PLEASE READ IT CAREFULLY****COMMONWEALTH CARE ALLIANCE IS REQUIRED BY LAW TO PROTECT YOUR MEDICAL INFORMATION**

We are committed to protecting your medical information. This medical information may be information about health care provided to you and or payment for health care provided to you.

We are required by law to provide you with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to medical information. We are only allowed to use and disclose medical information in the manner that is described in this Notice.

We reserve the right to make changes and to make the new Notice effective for all medical information we maintain. If we make a material change to the Notice, copies of the updated Notice are made available upon request and on our website, by the effective date of the material

Chapter 7. Your rights and responsibilities

change, and we send you the updated Notice, or information about the material change and how to obtain the revised Notice, in the next annual mailing.

The rest of this Notice will:

- Describe how we may use and disclose your medical information, including behavioral health information;
- Explain your rights with respect to your medical information, including behavioral health information; and
- Describe how and where you may file a privacy-related complaint.

If you have questions about the information in this Notice, please contact:

Commonwealth Care Alliance

Attention: Privacy and Security Officer

30 Winter Street

Boston, MA 02108

Toll Free: 1-866-610-2273

TTY: 711

SECTION 1

Uses and Disclosures of Your Medical Information Without Your Prior Authorization

This section of our Notice explains how we may use and disclose your medical information, including behavioral health, without your authorization in order to provide health care, obtain payment for that health care, and operate our business efficiently. This section also mentions several other circumstances in which we may use or disclose your medical information. For more information about any of these uses or disclosures, or about any of our privacy policies, procedures or practices, contact our Privacy and Security Officer at 1-866-610-2273.

Commonwealth Care Alliance's model of care requires working together with physicians and other care providers (including behavioral and mental health professionals, and Long Term Support Coordinators) to provide medical services to Commonwealth Care Alliance's members. Commonwealth Care Alliance professional staff, physicians and other care providers (referred to as "Care Team") have access to your Centralized Enrollee Record (where your medical information is stored and maintained) and share protected health information (PHI), including behavioral health information with each other as needed to perform treatment, payment, and health care operation activities as permitted by law.

Chapter 7. Your rights and responsibilities

For Treatment: We may use and disclose medical information, including behavioral health to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others.

Example: You are being discharged from a hospital. Our Nurse Practitioner may disclose your medical information, including behavioral health information, to a home health agency to make sure you get the services you need after discharge from the hospital.

For Payment: We may use and disclose your medical information, including behavioral health to obtain payment for health care services that you received.

Example: A claim for health care services may be sent to us by your doctor. The claim may contain information that identifies you, your diagnosis, and the treatment or supplies you received. We may use the medical information, including behavioral health information, to process the claim for payment and we may disclose the medical information, including behavioral health to Medicare or Medicaid when we seek payment for services that you received.

Exception: You may restrict disclosure of medical information relevant to a treatment for which you paid out of pocket and for which Commonwealth Care Alliance paid nothing for.

For Healthcare Operations: We may use and disclose your medical information, including behavioral health, to perform a variety of business activities that allow us to administer the benefits you are entitled to under your health plan with us. For instance, we may use or disclose your medical information, including behavioral health information in performing the following activities:

- Review and evaluate the skills, qualifications, and performance of health care providers treating you.
- Review and improve the quality, efficiency and cost of care that Commonwealth Care Alliance provides to you and our other members.
- Cooperating with other organizations that assess the quality of the care of others including government agencies and private organizations.
- Mail information containing your medical information to the address you have provided.

Example: We may use health information about you to manage your treatment, develop better services for you, or monitor the quality of care and making improvements where needed.

Required by Law:

- We will use and disclose your medical information, including behavioral health, and substance use disorder treatment records whenever we are required by law to do so.

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For example, Massachusetts law requires us to report suspected elder abuse. We will comply with any state and other applicable laws regarding these disclosures.

- We are required by law to notify you if your protected health information is affected by a privacy or security breach.
- Prohibited by law: Commonwealth Care Alliance does not engage in underwriting; but, if we did, we would be prohibited by law from using your genetic information for underwriting purposes.

Federal Government Uses and Disclosures: When permitted by law, we may use or disclose your medical information, including behavioral health and substance use disorder treatment records without your authorization for various activities by the federal government.

- **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. For example, we may use or disclose your medical information to help with a product recall or to report adverse reactions to medications.
- **Public health activities:** We may use or disclose your medical information, including de-identified substance use disorder treatment information for public health activities. Public health activities require the use of medical information as well as de-identified substance use disorder treatment information for various reasons, including, but not limited to, activities related to investigating diseases, reporting child abuse and neglect, monitoring drugs or devices regulated by the Food and Drug Administration, and monitoring work related illnesses or injuries. For example, if you have been exposed to a communicable disease, we may report it to the State and take other actions to prevent the spread of the disease.
- **Abuse, neglect or domestic violence:** We may disclose your medical information to a government authority if you are an adult and we believe that you may be a victim of abuse, neglect or domestic violence.
- **Health oversight activities:** We may disclose your medical information to a health oversight agency which is an agency responsible for overseeing the health care system or certain government programs.
- **Court proceedings:** We may disclose your medical, behavioral health or substance use disorder treatment information in response to a court order. Medical information may also be disclosed in response to a subpoena.
- **Law enforcement:** We may disclose your medical information to a law enforcement official for specific law enforcement purposes. For examples, we may disclose limited medical information about you to a police officer if the officer needs the information to help find or identify a missing person.
- **Coroners and others:** We may disclose your 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 your medical information in order to comply with workers' compensation laws.

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- **Research organizations:** We may use or disclose your medical information, including substance use disorder treatment records to research organizations if the organization has satisfied certain conditions about protecting the privacy of your 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.

Persons Involved in Your Care: We may disclose your medical information to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care.

We may also use or disclose your medical information to a relative, another person involved in your care or possibly a disaster relief organization (such as the Red Cross) in an emergency if we need to notify someone about your location or condition.

You may ask us at any time not to disclose your medical information to persons involved in your care. We will agree to your request and will not disclose the information except in certain limited circumstances such as emergencies.

Example: If you ask us to share your medical information with your spouse, we will disclose your medical information to him or her.

Massachusetts Immunization Information Systems

Vaccinations received during your visit are reported to the Massachusetts Immunization Information System (MIIS) as required by law. 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 health care 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 2**Other Uses and Disclosures Requiring Your Prior Authorization****Authorizations:**

Chapter 7. Your rights and responsibilities

Other than the uses and disclosures described above, we will not use or disclose your medical or behavioral health information without your or your personal representative's authorization (or signed permission). Substance Use Disorder (SUD) treatment records may be used and disclosed for treatment, payment or healthcare operations with written authorization from you or your personal representative. Authorization to use and disclose SUD treatment records is only required *once* and that will then authorize all such future uses or disclosures for purposes of treatment, payment, and health care operations until such time as the patient revokes such consent in writing. In some instances, we may wish to use or disclose your medical, behavioral health or substance use disorder treatment information and we may contact you to ask you to sign an authorization form. In other instances, you may contact us to disclose medical behavioral health or substance use disorder treatment records and we will ask you to sign an authorization form.

If you sign a written authorization asking us to disclose your medical, behavioral health or substance use disorder treatment information to a third party, you may later revoke (or cancel) your authorization. If you would like to revoke your authorization, you must do so in writing. If you revoke your authorization, we will follow your instructions except to the extent that we have already relied upon your authorization to disclose your medical information, or as required by law.

- **Use or disclosure for marketing purposes:** We may only use or disclose your medical information for marketing purposes if we have your explicit approval and authorization.
- **Sale of your protected health information:** Commonwealth Care Alliance does not sell your health information. If we did, we may only engage in the sale of your information to a third party if we have your authorization.
- **Marketing communications paid for by third party:** We will only send you communications on behalf of a third party for the purpose of marketing of products or services if we have your authorization.
- **Use and disclosure of psychotherapy notes:** We may only use or disclose your psychotherapy notes if we have your prior authorization or as required by law.

SECTION 3

You Have Rights with Respect to Your Medical Information

You have certain rights with respect to your medical information.

Right to choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices

Chapter 7. Your rights and responsibilities

about your medical information. We verify that this person has this authority and can act for you before we take any action.

Right to a Copy of this Notice: You have a right to have a paper copy of our Notice of Privacy Practices at any time, even if you agreed to receive the Notice electronically. If you would like to have a copy of our Notice, call 1-866-610-2273.

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 that Commonwealth Care Alliance maintains. If we maintain your medical records in an Electronic Health Record system, you may obtain an electronic copy of your medical records. You may also instruct us in writing to send an electronic copy of your medical records to a third party. If you would like to inspect or receive a paper or electronic copy of your medical information, you must provide us with a request in writing.

We may deny your request in certain circumstances. If we deny your request, we will explain the reason for doing so in writing. We will inform you in writing if you have the right to have the decision reviewed by another person.

If you would like a copy of your medical information, we may charge you a fee to cover the costs of the copy. The fees for electronic copies will be limited to the direct labor costs associated with fulfilling your request.

Right to Have Medical Information Amended: If you believe that we have information that is either inaccurate or incomplete, you have the right to request an amendment, correction or supplementation of your medical information that Commonwealth Care Alliance maintains. Your request must be in writing and include an explanation.

We may deny your request to amend, correct or supplement your medical information in certain circumstances. If we deny your request, we will explain our reason for doing so in writing, within sixty (60) days. You may send us a statement of disagreement. With any future disclosures, we will provide an accurate summary of the request and our denial.

Right to an Accounting of Disclosures We Have Made

You have the right to receive an accounting (which means a detailed listing) of disclosure other than for treatment, payment, and health care operations we have made for the previous six (6) years. If the information is contained in an electronic health record, the accounting is for the previous three (3) years. We'll provide one accounting a year for free but may charge a reasonable, cost-based fee if you ask for another one within 12 months. For substance use disorder treatment record disclosures in which patients have consented to disclose their patient identifying medical information using a general designation, upon request, patients must be provided a list of entities to which their information has been disclosed pursuant to the general designation. Accounting of disclosures for substance use disorder treatment record disclosures is

Chapter 7. Your rights and responsibilities

limited to disclosures made within the last 2 years. All requests for accounting of disclosures must be made in writing.

Right to Request Restrictions on Uses and Disclosures

You have the right to request that we limit the use and disclosure of your medical, behavioral health and substance use disorder treatment information for treatment, payment, and health care operations, but Commonwealth Care Alliance may not agree to the restriction. Under federal law, Commonwealth Care Alliance must agree to your request to restrict disclosures of medical information if:

- The disclosures are for purposes of payment or health care operations and are not otherwise required by law, and
- The medical information pertains solely to health care items or services for which you, or another person on your behalf (other than Commonwealth Care Alliance), has paid in full.

If we agree to your request, we must follow your restrictions, except if the information is necessary for emergency treatment. You may cancel the restrictions at any time by writing to us. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

The Right to Opt Out of Fundraising Communications

You have the right to request that we or our authorized agents do not contact you for fundraising activities.

Right to Request an Alternative Method of Contact

You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing.

SECTION 4

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 or with the federal government.

Commonwealth Care Alliance will not take any action against you or change the treatment of you in any way if you file a complaint.

To file a written complaint with or request more information from Commonwealth Care Alliance, contact:

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Commonwealth Care Alliance

Attention: Information Privacy and Security Officer
30 Winter Street
Boston, MA 02108
Toll Free: 1-866-610-2273
TTY: 711

To file a written complaint with the federal government, please use the following contact information:

U.S. Department of Health and Human Services Office for
Civil Rights
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Toll-Free Phone: (800) 368-1019
TDD Toll-Free: (800) 537-7697

Section 1.5 We must give you information about the plan, its network of providers, and your covered services

As a member of Senior Care Options Program, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Member Services (phone numbers are printed on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers including our network pharmacies.**
 - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
 - For a list of the providers and/or pharmacies in the plan's network, see the *Provider & Pharmacy Directory*.

Chapter 7. Your rights and responsibilities

- For more detailed information about our providers or pharmacies, you can call Member Services (phone numbers are printed on the back cover of this booklet) or visit our website at www.CommonwealthCareSCO.org.
- **Information about your coverage and the rules you must follow when using your coverage.**
 - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
 - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's *List of Covered Drugs (Formulary)*. These chapters, together with the *List of Covered Drugs (Formulary)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
 - If you have questions about the rules or restrictions, please call Member Services (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
 - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
 - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 8 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 8 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
 - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 6 of this booklet.

Section 1.6**We must support your right to make decisions about your care****You have the right to know your treatment options and participate in decisions about your health care**

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

Chapter 7. Your rights and responsibilities

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the 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 doctor 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 receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 8 of this booklet tells how to ask the plan for a coverage decision.

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 health care 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. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

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. Documents called “**living will**” and “**power of attorney for health care**” are examples of advance directives.

If you want to use an “advance directive” to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.

Chapter 7. Your rights and responsibilities

- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- If you are admitted to the hospital, they 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 your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with Massachusetts Department of Public Health, Division of Health Care Quality's Complaint Unit by calling 1-800-462-5540. To file a complaint against an individual doctor, please call the Board of Registration in Medicine at 781-876-8200.

Section 1.7	You have the right to make complaints and to ask us to reconsider decisions we have made
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If you have any problems or concerns about your covered services or care, Chapter 8 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. 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. Chapter 8 of this booklet 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 Chapter 2 of this booklet.

Chapter 7. Your rights and responsibilities

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.8	You have the right to make recommendations on our member rights and responsibilities policy
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If you have any recommendations on our member rights and responsibilities policy, you can call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.9	What can you do if you believe you are being treated unfairly or your rights are not being respected?
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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, 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** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **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 1.10	How to get more information about your rights
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There are several places where you can get more information about your rights:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.

Chapter 7. Your rights and responsibilities

- You can visit the Medicare website to read or download the publication “Your Medicare Rights & Protections.” (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
- Or, 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.

SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 What are 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 (phone numbers are printed on the back cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
 - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- **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 (phone numbers are printed on the back cover of this booklet).
 - We are required to follow rules set by Medicare and MassHealth (Medicaid) to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “**coordination of benefits**” because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership 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 your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.

Chapter 7. Your rights and responsibilities

- Make sure your doctors 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. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **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.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For most Senior Care Options Program members, MassHealth (Medicaid) pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium. If MassHealth (Medicaid) is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.
 - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
 - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 8 of this booklet for information about how to make an appeal.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are printed on the back cover of this booklet).
 - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area.
 - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
 - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Member Services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
 - Phone numbers and calling hours for Member Services are printed on the back cover of this booklet.
 - For more information on how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 8

*What to do if you have a problem
or complaint (coverage decisions,
appeals, complaints)*

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

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SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on

the type of problem you are having:

- For some types of problems, you need to use the **process for coverage decisions and appeals**.
- For other types of problems, you need to use the **process for making complaints**.

To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

This chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “integrated organization determination” or “coverage determination” or “at-risk determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. In Massachusetts, the SHIP is called SHINE (stands for Serving the Health Information Needs of Everyone). You will find phone numbers in Chapter 2, Section 3 of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- 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.
- You can visit the Medicare website (www.medicare.gov).

You can get help and information from MassHealth (Medicaid)

For more information and help in handling a problem, you can also contact MassHealth (Medicaid). Here are two ways to get information directly from MassHealth (Medicaid):

- You can call 1-800-841-2900, Monday through Friday, 8 a.m. to 5 p.m. TTY users should call: 1-800-497-4648.
- You can visit the MassHealth (Medicaid) website (www.mass.gov/mass.health).
- 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.

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

**SECTION 3 Understanding Medicare and MassHealth (Medicaid)
complaints and appeals in our plan**

You have Medicare and get assistance from MassHealth (Medicaid). Information in this chapter applies to **all** of your Medicare and MassHealth (Medicaid) benefits. This is sometimes called an “integrated process” because it combines, or integrates, Medicare and MassHealth (Medicaid) processes.

Sometimes the Medicare and MassHealth (Medicaid) processes are not combined. In those situations, you use a Medicare process for a benefit covered by Medicare and a MassHealth (Medicaid) process for a benefit covered by MassHealth (Medicaid). These situations are explained in **Section 6.4** of this chapter, “Step-by-step: How a Level 2 Appeal is done.”

PROBLEMS ABOUT YOUR BENEFITS

SECTION 4 Coverage decision and appeals

Section 4.1	Should you use the process for coverage decisions and appeals? Or do you want to make a complaint?
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If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The information below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare or MassHealth (Medicaid)**.

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

To figure out which part of this chapter will help with your problem or concern about your **Medicare or MassHealth (Medicaid)** benefits, use this chart:

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes. My problem is about benefits or coverage.

Go on to the next section of this chapter, **Section 5, “A guide to the basics of coverage decisions and appeals.”**

No. My problem is not about benefits or coverage.

Skip ahead to **Section 11** at the end of this chapter, **“How to make a complaint about quality of care, waiting times, customer service, or other concerns.”**

SECTION 5 A guide to the basics of coverage decisions and appeals

Section 5.1	Asking for coverage decisions and making appeals: the big picture
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The process for asking for coverage decisions and appeals deals with problems related to your benefits and coverage, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

In some cases, we might decide a service or drug is not covered or is no longer covered by Medicare or MassHealth (Medicaid) for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision.

When we have completed the review, we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or “fast coverage decision” or fast appeal of a coverage decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by Independent Review Organizations that are not connected to us.

- In some situations, your case will be automatically sent to the Independent Review Organization for a Level 2 Appeal.
- In other situations, you will need to ask for a Level 2 Appeal. MassHealth (Medicaid).
- See **Section 6.4** of this chapter for more information about Level 2 Appeals.

If you are not satisfied with the Level 2 Appeal decision, you may be able to continue through additional levels of appeal.

Section 5.2	How to get help when you are asking for a coverage decision or making an appeal
--------------------	--

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Member Services** (phone numbers are printed on the back cover of this booklet).
- You **can get free help** from your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor or other health care provider can make a request for you.**

Chapter 8. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- For medical care, your doctor or other health care provider can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is about a Medicare service and is denied at Level 1, it will be automatically forwarded to Level 2.
 - If your doctor or other health provider asks that a service or item that you are already getting be continued during your appeal, you **may** need to name your doctor or other prescriber as your representative to act on your behalf.
 - To request any appeal after Level 2, you **must** name your doctor as your representative to act on your behalf.
- For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, you must name your doctor or other prescriber as your representative.
- **You can ask someone to act on your behalf.** 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.
 - 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 health care provider, or other person to be your representative, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or on our website at www.CommonwealthCareSCO.org.) The form gives that person permission to act on your behalf. It must be signed by you and by the person you would like to act on your behalf. You must give us a copy of the signed form.
- **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.

Section 5.3	Which section of this chapter gives the details for your situation?
--------------------	--

There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 6** of this chapter, “Your medical care: How to ask for a coverage decision or make an appeal”

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(coverage decisions, appeals, complaints)**

- **Section 7** of this chapter, “Your Part D prescription drugs: How to ask for a coverage decision or make an appeal”
- **Section 8** of this chapter, “How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon”
- **Section 9** of this chapter, “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (This section applies to these services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you’re not sure which section you should be using, call Member Services (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

SECTION 6 Your medical care: How to ask for a coverage decision or make an appeal



Have you read Section 5 of this chapter, “A guide to the basics of coverage decisions and appeals?” If not, you may want to read it before you start this section.

Section 6.1	This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care
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This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Benefits Chart (what is covered)*. To keep things simple, we generally refer to “medical care coverage” or “medical care” in the rest of this section, instead of repeating “medical care or treatment or services” every time. The term “medical care” includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that our plan covers this care.
2. Our plan will not approve the medical care your doctor or other health care provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care that you believe our plan should be cover, but we have said we will not pay for this care.

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4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting (that we previously approved) will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
 - **NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:**
 - Section 8 of this chapter, "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon."
 - Section 9 of this chapter, "How to ask us to keep covering certain medical services if you think your coverage is ending too soon." This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
 - For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 6) as your guide for what to do.

Which of these situations are you in?

If you are in this situation:	This is what you can do:
To find out whether we will cover the medical care you want?	You can ask us to make a coverage decision for you. Go to the next section of this chapter, Section 6.2 .
If we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for.	You can make an appeal . (This means you are asking us to reconsider.) Skip ahead to Section 6.3 of this chapter.
If we told you, we will be stopping or reducing a medical service you are already getting.	You may be able to keep those services or items during your appeal. Skip ahead to Section 6.3 of this chapter.
If you want to ask us to pay you back for medical care you have already received and paid for.	You can send us the bill. Skip ahead to Section 6.5 of this chapter.

Chapter 8. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section 6.2	Step-by-step: How to ask for a coverage decision (How to ask our plan to authorize or provide the medical care coverage you want)
--------------------	--

Legal Terms

When a coverage decision involves your medical care, it is called an “integrated organization determination.”
--

Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a “fast coverage decision.”

Legal Terms

A “fast coverage decision” is called an “integrated expedited determination.”
--

How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called “How to contact us when you are asking for a coverage decision, about your medical care.”

Generally, we use the standard deadlines for giving you our decision

When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. **A standard coverage decision means we will give you an answer within 14 calendar days** after we receive your request **for a medical item or service**. If your request is for a **Medicare Part B prescription drug**, we will give you an **answer within 72 hours** after we receive your request.

- For a request **for a medical item or service**, we can take up to **14 more calendar days** if you ask for more time, or if we need information (such as medical records from out-of-network health care providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should **not** take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

information about the process for making complaints, including fast complaints, see **Section 11** of this chapter.)

If your health requires it, ask us to give you a “fast coverage decision”

- **A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.**
 - For a request **for a medical item or service, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network healthcare providers) or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should **not** take extra days, you can file a “fast complaint” about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see **Section 11** of this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
 - You can get a fast coverage decision **only** if you are asking for coverage for medical care **you have not yet received**. (You cannot ask for a fast coverage decision if your request is about payment for medical care you have already received.)
 - You can get a fast coverage decision **only** if using the standard deadlines could **cause serious harm to your health or hurt your ability to function**.
- **If your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision.
 - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
 - The letter will also tell you how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see **Section 11** of this chapter.)

Chapter 8. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a “fast” coverage decision

- Generally, for a fast coverage decision on a request for a medical item or service, we will give you our answer **within 72 hours**. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours**.
 - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should **not** take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
 - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), or within 24 hours if your request is for a Medicare Part B prescription drug, you have the right to appeal. Section 6.3 below tells how to make an appeal.
- **If our answer is no to part or all of what you requested**, we will send you a detailed written explanation as to why we said no.

Deadlines for a “standard” coverage decision

- Generally, for a standard coverage decision on a request for a medical item or service, we will give you our answer **within 14 calendar days of receiving your request**. If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** of receiving your request.
 - For a request for a medical item or service, we can take up to 14 more calendar days (“an extended time period”) under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should **not** take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
 - If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), or 72 hours if your request is

Chapter 8. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

for a Medicare Part B prescription drug, you have the right to appeal. Section 6.3 below tells how to make an appeal.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 6.3 below).

Section 6.3

Step-by-step: How to make a Level 1 Appeal (How to ask for a review of a medical care coverage decision made by our plan)

Legal Terms

An appeal to the plan about a medical care coverage decision is called a plan **“integrated reconsideration.”**

Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a **“fast appeal.”**

What to do

- **To start an appeal you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for the section called “How to contact us when you are asking for a coverage decision, making an appeal about your medical care.”
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1, “How to contact us when you are making an appeal about your medical care).”
 - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. If your doctor or other prescriber is asking that a service or item you are already getting be continued during your appeal, you may need to name your doctor or other prescriber as your representative to act on your behalf. (To get the form, call Member Services (phone numbers

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are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. It is also available on Medicare’s website at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf> or on our website at www.CommonwealthCareSCO.org. While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

- **If you are asking for a fast appeal, make your appeal in writing or call us at the phone number shown in Chapter 2, Section 1, “How to contact us when you are asking for a coverage decision, making an appeal about your medical care.”**
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a free copy of the information regarding your medical decision and add more information to support your appeal.**
 - You have the right to ask us for a free copy of the information regarding your appeal.
 - If you wish, you and your doctor may give us additional information to support your appeal in writing or in person.

If your health requires it, ask for a “fast appeal” (you can make a request by calling us)

Legal Terms
A “fast appeal” is also called an “integrated expedited reconsideration.”

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.”
- The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast coverage decision.” To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)

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(coverage decisions, appeals, complaints)**

- If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.

If we told you we were going to stop or reduce services or items that you were already getting, you may be able to keep those services or items during your appeal.

- If we decided to change or stop coverage for a service or item that you currently get, we will send you a notice before taking the proposed action.
- If you disagree with the action, you can file a Level 1 Appeal. We will continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the postmark date on our letter or by the intended effective date of the action, whichever is later.
- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 appeal is pending. You will also keep getting all other services or items (that are not the subject of your appeal) with no changes.

Step 2: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- The appeal reviewer is someone with appropriate clinical expertise who was not involved in the coverage decision. The appeal reviewer does not report to the coverage decision reviewer.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a “fast” appeal

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
 - 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 your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process where it will be reviewed by an Independent Review Organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.

**Chapter 8. What to do if you have a problem or complaint
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- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer on a request for a medical item or service **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
 - 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 your request is for a medical item or service. If we decide we need to take extra days to make the decision, we will tell you orally and in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should **not** take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see **Section 11** of this chapter.)
 - If we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process. Then an Independent Review Organization will review it. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If our plan says no to part or all of your appeal, you have additional appeal rights.

If we say no to part or all of what you asked for, we will send you a letter.

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

- If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Organization for a Level 2 Appeal. You must exhaust the Level 1 process before appealing to Level 2.
- If your problem is about coverage of a MassHealth (Medicaid) service or item, the letter will tell you how to file a Level 2 Appeal yourself.

Section 6.4	Step-by-step: How a Level 2 Appeal is done
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If we say no to part or all of your Level 1 Appeal, we will send you a letter. This letter will tell you if the service or item is usually covered by Medicare or MassHealth (Medicaid) or could be covered by both.

- If your problem is about a service or item that is usually **covered by Medicare**, we will automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that is usually **covered by MassHealth (Medicaid)**, you can file a Level 2 Appeal yourself. The letter will tell you how to do this. Information is also below.
- If your problem is about a service or item that could be **covered by both Medicare and MassHealth (Medicaid)**, you will automatically get a Level 2 Appeal with the Independent Review Organization. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Go to page for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service that is usually covered by Medicare only, your benefits for that service will not continue during the Level 2 appeals process with the Independent Review Organization.
- If your problem is about a service that is usually covered by MassHealth (Medicaid), your benefits for that service will continue if you submit a Level 2 Appeal within 10 calendar days after receiving the plan's decision letter.

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(coverage decisions, appeals, complaints)**

If your problem is about a service or item Medicare usually covers:**Step 1: The Independent Review Organization reviews your appeal.**

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a free copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

If you had a “fast” appeal at Level 1, you will also have a “fast” appeal at Level 2

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- If your request is for a medical item or service the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.** The Independent Review Organization can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.

If you had a “standard” appeal at Level 1, you will also have a “standard” appeal at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2.
- If your request is for a medical item or service, the review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.
- If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.** The Independent Review Organization can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of a request for a medical item or service, we must:**
 - authorize the medical care coverage **within 72 hours** or
 - provide the service within **14 calendar days** after we receive the Independent Review Organization's decision for **standard requests** or
 - provide the service **within 72 hours** from the date we receive the Independent Review Organization's decision for **expedited requests**.
- **If the Independent Review Organization says yes to part or all of a request for a Medicare Part B prescription drug, we must:**
 - authorize or provide the Medicare Part B prescription drug under dispute **within 72 hours** after we receive the Independent Review Organization's decision for **standard requests** or
 - **within 24 hours** from the date we receive the Independent Review Organization's decision for **expedited requests**.
- **If this organization says no to part or all of your appeal, it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")**
 - Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.
 - There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you get after your Level 2 Appeal.
 - The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** in this chapter tells more about the process for Level 3, 4, and 5 Appeals. See **Section 10** of this chapter for more information.

Chapter 8. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Legal Terms

The formal name for the “Independent Review Organization” that reviews Medicare cases is the “**Independent Review Entity.**” It is sometimes called the “IRE.”

If your problem is about a service or item MassHealth (Medicaid) usually covers:

Step 1: You can ask for a Fair Hearing with the state.

- Level 2 of the appeals process for services that are usually covered by MassHealth (Medicaid) is a Fair Hearing with the state. You must ask for a Fair Hearing in writing or over the phone **within 120 calendar days** of the date that we sent the decision letter on your Level 1 Appeal. The letter you get from us will tell you where to submit your hearing request.
- To pursue a MassHealth (Medicaid) 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 denial of appeal from Senior Care Options Program.
- The request along with a copy of the plan’s final denial notice must be sent to:

Executive Office of Health & Human Services — Office of Medicaid Board of Hearings

100 Hancock Street, 6th Floor Quincy, MA 02171

Or Fax to (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/eohhs/docs/masshealth/appforms/fair-hearing.pdf.
- 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 Senior Care Options Program’s 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 written appeal

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

denial notice to you, then the Board of Hearings will process your appeal using standard appeal times.

- 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 Senior Care Options Program. 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.

Step 2: The Fair Hearing office gives you their answer.

The Fair Hearing office will tell you their decision in writing and explain the reasons for it.

- **If the Fair Hearing office says yes to part or all of a request for a medical item or service**, we must authorize or provide the service or item within 72 hours after we receive the decision from the Fair Hearing office.
- **If the Fair Hearing office says no to part or all of your appeal**, they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision” or “turning down your appeal.”)

If the decision is no for all or part of what I asked for, can I make another appeal?

If the Independent Review Organization or Fair Hearing office decision is no for all or part of what you asked for, you have **additional appeal rights**.

If your Level 2 Appeal went to the **Independent Review Organization**, you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. **The letter you get from the Independent Review Organization will explain additional appeal rights you may have.**

The letter you get from the Fair Hearing office will describe this next appeal option.

See **Section 10** of this chapter for more information on your appeal rights after Level 2.

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)****Section 6.5 What if you are asking us to pay you back for a bill you have received for medical care?**

If you want to ask us for payment for medical care, start by reading Chapter 6 of this booklet, *Asking us to pay a bill you have received for covered medical services or drugs*. Chapter 6 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a health care provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 5.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4, *Benefits Chart (what is covered)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services and other covered services*).

Asking to be paid back for something you have already paid for:

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see **Section 5.1** of this chapter).

We can't reimburse you directly for a **MassHealth (Medicaid)** service or item. If you get a bill for MassHealth (Medicaid) covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the health care provider directly and take care of the problem. But if you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting services or item.

If you want us to reimburse you for a **Medicare** service or item or you are asking us to pay a health care provider for a MassHealth (Medicaid) service or item you paid for, you will ask us to make this coverage decision. We will check to see if the medical care you paid for is a covered service (see Chapter 4, *Benefits Chart (what is covered)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet, *Using the plan's coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for your medical care within 60 calendar days after we receive your request.

Chapter 8. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If the Medicare medical care you paid for is covered, we will send you the payment for your medical care within 60 calendar days after we receive your request.
 - If the MassHealth (Medicaid) care that you paid a health care provider for is covered and you think we should pay the health care provider instead, we will send your health care provider the payment for your medical care within 60 calendar days after we receive your request.
 - Then you will need to contact your health care provider to get them to pay you back. Or, if you haven't paid for the services, we will send the payment directly to the health care provider. When we send the payment, it's the same as saying yes to your request for a coverage decision.
- If the medical care is **not** covered, or you did **not** follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying no to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5.3 of this chapter. Go to this section for step-by-step instructions. When you are following these instructions, note:

- If you make an appeal for reimbursement, we must give you our answer within 30 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the health care provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the health care provider within 60 calendar days.

SECTION 7 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal



Have you read Section 5 of this chapter, “A guide to the basics of coverage decisions and appeals?” If not, you may want to read it before you start this section.

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)****Section 7.1 This section tells you what to do if you have problems getting
a Part D drug or you want us to pay you back for a Part D drug**

Your benefits as a member of our plan include coverage for many prescription drugs. Refer to our plan's *List of Covered Drugs (Formulary)*. (We call it the "Drug List" for short.)

To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3, for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the Drug List rules and restrictions on coverage, and cost information, see Chapter 5 (*Using our plan's coverage for your Part D prescription drugs*) and Chapter 6 (*Asking us to pay a bill you have received for covered medical services or drugs*).

Part D coverage decisions and appeals

As discussed in Section 5 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms

An initial coverage decision about your Part D drugs is called a "**coverage determination.**"

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
 - Asking us to cover a Part D drug that is not on the plan's Drug List
 - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
- You ask us whether a drug is covered for you and whether you meet the requirements for coverage. (For example, when your drug is on the plan's Drug List but we require you to get approval from us before we will cover it for you.)
 - **NOTE:** If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Chapter 8. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the following chart to help you determine which part has information for your situation:

Which of these situations are you in?

If you are in this situation:	This is what you can do:
If you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover.	You can ask us to make an exception. (This is a type of coverage decision.) Start with Section 7.2 of this chapter.
If you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need.	You can ask us for a coverage decision. Skip ahead to Section 7.4 of this chapter.
If you want to ask us to pay you back for a drug you have already received and paid for.	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to Section 7.4 of this chapter.
If we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for.	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to Section 7.5 of this chapter.

Section 7.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an “exception.” An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are examples of exceptions that you or your doctor or other prescriber can ask us to make:

Chapter 8. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

1. Covering a Part D drug for you that is not on our Drug List.

Legal Terms

Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **“formulary exception.”**

2. Removing a restriction on our coverage for a covered drug. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, go to Chapter 5, Section 4).

Legal Terms

Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **“formulary exception.”**

- The extra rules and restrictions on coverage for certain drugs include:
 - Being required to use the generic version of a drug instead of the brand name drug.
 - Getting plan approval in advance before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
 - Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
 - *Quantity limits.* For some drugs, there are restrictions on the amount of the drug you can have.

Section 7.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally **not** approve your request for an exception. If you ask us for a tiering exception, we will generally **not** approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won’t work as well for you or are likely to cause an adverse reaction or other harm.

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)****We can say yes or no to your request**

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. **Section 7.5** of this chapter tells how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 7.4	Step-by-step: How to ask for a coverage decision, including an exception
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Step 1: You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a “**urgent coverage decision.**” You cannot ask for an urgent coverage decision if you are asking us to pay you back for a drug you already bought.

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1, and look for the section called “How to contact us when you are asking for a coverage decision or about your Part D prescription drugs.” Or if you are asking us to pay you back for a drug, go to the section called *Where to send a request asking us to pay for the cost for medical care or a drug you have received.*
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. **Section 5.2** of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask us to pay you back for a drug,** start by reading Chapter 6 of this booklet: *Asking us to pay a bill you have received for covered medical services or drugs.* Chapter 6 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the “supporting statement.”** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the “supporting statement.”) Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See **Sections 7.2** and **Section 7.3** of this chapter for more information about exception requests.

Chapter 8. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form which is available on our website.

If your health requires it, ask us to give you a “fast coverage decision”

Legal Terms
A “fast coverage decision” is called an “expedited coverage determination.”

- When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “urgent” deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor’s statement. An urgent coverage decision means we will answer within 24 hours after we receive your doctor’s statement.
- **To get an urgent coverage decision, you must meet two requirements:**
 - You can get a fast coverage decision **only** if you are asking for a **drug you have not yet received**. (You cannot ask for an urgent coverage decision if you are asking us to pay you back for a drug you have already bought.)
 - You can get an urgent coverage decision **only** if using the standard deadlines could **cause serious harm to your health or hurt your ability to function**.
- **If your doctor or other prescriber tells us that your health requires an “urgent coverage decision,” we will automatically agree to give you an urgent coverage decision.**
- If you ask for an urgent coverage decision on your own (without your doctor’s or other prescriber’s support), we will decide whether your health requires that we give you a fast coverage decision.
 - If we decide that your medical condition does not meet the requirements for an urgent coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor or other prescriber asks for the urgent coverage decision, we will automatically give an urgent coverage decision.
 - The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the urgent coverage decision you requested. It tells how to file an “urgent” complaint, which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see **Section 11** of this chapter.)

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

Step 2: We consider your request and we give you our answer.***Deadlines for an “urgent” coverage decision***

- If we are using the urgent deadlines, we must give you our answer **within 24 hours**.
 - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. In **Section 7.6** of this chapter, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor’s statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a “standard” coverage decision about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours**.
 - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. In **Section 7.6** of this chapter, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**
 - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor’s statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Chapter 8. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Deadlines for a “standard” coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. In **Section 7.6** of this chapter, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 3: If we say no to your coverage request, you decide if you want to make an appeal.

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

**Section 7.5 Step-by-step: How to make a Level 1 Appeal
(How to ask for a review of a coverage decision made by our plan)**

Legal Terms

An appeal to the plan about a Part D drug coverage decision is called a plan “redetermination.”

Step 1: You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a “**fast appeal**.”

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
 - For details on how to reach us by phone, fax, or mail, or on our website for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called “How to contact us when you are making an appeal about your Part D prescription drugs.”
- **If you are asking for a standard appeal, make your appeal by submitting a written request.** You may also ask for an appeal by calling us at the phone

Chapter 8. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

number shown in Chapter 2, Section 1 “How to contact us when you are making an appeal about your Part D prescription drugs”

- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1 “How to contact us when you are making an appeal about your Part D prescription drugs.”**
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
 - You have the right to ask us for a copy of the information regarding your appeal.
 - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal”

Legal Terms
A “fast appeal” is also called an “expedited redetermination.”

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in **Section 7.4** of this chapter.

Step 2: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

Deadlines for a “fast” appeal

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
 - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. In **Section 7.6** of this chapter, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal for a drug you have not received yet. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for “fast” appeal.
 - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. In **Section 7.6** of this chapter, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
 - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
 - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.
- If you are requesting that we pay you back for a drug you have already bought, we must give you our answer **within 14 calendar days** after we receive your request.
 - If we do not give you a decision within 14 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. In **Section 7.6** of this

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chapter, we talk about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal our decision.

Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 7.6 Step-by-step: How to make a Level 2 Appeal

If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms

The formal name for the “Independent Review Organization” is the “**Independent Review Entity.**” It is sometimes called the “**IRE.**”

Step 1: To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for “fast” appeal at Level 2

- If your health requires it, ask the Independent Review Organization for a “fast appeal.”
- If the review organization agrees to give you a “fast appeal,” the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for “standard” appeal at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not received yet. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your level 2 appeal **within 14 calendar days** after it receives your request.
- **If the Independent Review Organization says yes to part or all of what you requested –**
 - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
 - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called “upholding the decision” or “turning down your appeal.”)

If the Independent Review Organization “upholds the decision,” you have the right to a Level 3 appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** of this chapter tells more about the process for Level 3, 4, and 5 Appeals.

SECTION 8 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Benefits Chart (what is covered)*.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your “**discharge date**.”
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Chapter 8. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section 8.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your covered hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted.

If you do not get the notice, ask any hospital employee for it. If you need help, call Member Services (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

1. Read this notice carefully and ask questions if you don't understand it. It tells you about your rights as a hospital patient, including:

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay and your right to know who will pay for it
- Where to report any concerns, you have about the quality of your hospital care
- Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon

Legal Terms

The written notice from Medicare tells you how you can **“request an immediate review.”** Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 8.2 below tells you how you can request an immediate review.)

2. You must sign the written notice to show that you received it and understand your rights.

- You or someone who is acting on your behalf will be asked to sign the notice. (Section 5.2 of this chapter tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows **only** that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

tell you your discharge date). Signing the notice **does not mean** you are agreeing on a discharge date.

3. **Keep your copy** of the notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
 - If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
 - To look at a copy of this notice in advance, you can call Member Services (phone numbers are printed on the back cover of this booklet) or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html

Section 8.2	Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date
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If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see **Section 2** of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

Step 1: Contact the Quality Improvement Organization for your state and ask for a “fast review” of your hospital discharge. You must act quickly.

A “fast review” is also called an “immediate review.”

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**. (Your “planned discharge date” is the date that has been set for you to leave the hospital.)
 - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date **without paying for it** while you wait to get the decision on your appeal from the Quality Improvement Organization.
 - If you do **not** meet this deadline, and you decide to stay in the hospital after your planned discharge date, **you may have to pay all of the costs** for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see **Section 8.4** of this chapter.

Ask for a “fast review”:

- You must ask the Quality Improvement Organization for a **“fast review”** of your discharge. Asking for a “fast review” means you are asking for the organization to use the “fast” deadlines for an appeal instead of using the standard deadlines.

Legal Terms
A “fast review” is also called an “immediate review” or an “expedited review.”

Step 2: The Quality Improvement Organization conducts an independent review of your case.***What happens during this review?***

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms

This written explanation is called the “**Detailed Notice of Discharge.**” You can get a sample of this notice by calling Member Services (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at:

www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says yes to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet.)

What happens if the answer is no?

- If the review organization says no to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day **after** the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)****Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.**

- If the Quality Improvement Organization has turned down your appeal **and** you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to “Level 2” of the appeals process.

Section 8.3	Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date
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If the Quality Improvement Organization has turned down your appeal **and** you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision it made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said no to your Level 1 Appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.***If the review organization says yes:***

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

Chapter 8. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- **Section 10** of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.4	What if you miss the deadline for making your Level 1 Appeal?
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You can appeal to us instead

As explained above in **Section 8.2**, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. (“Quickly” means before you leave the hospital and no later than your planned discharge date, whichever comes first.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, **the first two levels of appeal are different.**

Step-by-Step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms
A “fast” review (or “fast appeal”) is also called an “ expedited appeal. ”

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

Step 1: Contact us and ask for a “fast review.”

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called “How to contact us when you are making an appeal about your medical care.”
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

Step 2: We do a “fast” review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and we will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs, and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
 - If you stayed in the hospital **after** your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say no to your fast appeal, your case will automatically be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are **automatically** going on to Level 2 of the appeals process.

Chapter 8. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Step-by-Step: Level 2 Alternate Appeal Process

During the Level 2 Appeal, an **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the “Independent Review Organization” is the “ Independent Review Entity .” It is sometimes called the “ IRE .”

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. **Section 11** of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says yes to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan’s coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- **Section 10** of this chapter tells more about the process for Level 3, 4, and 5 Appeals.

SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 9.1	<i>This section is about three services only:</i> Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services
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This section is about the following types of care *only*:

- **Home health care services** you are getting
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a “skilled nursing facility,” see Chapter 11, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 11, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet, *Benefits Chart (what is covered)*.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, **we will stop paying** for your care.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Chapter 8. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section 9.2 We will tell you in advance when your coverage will be ending

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.
 - The written notice tells you the date when we will stop covering the care for you.
 - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care and keep covering it for a longer period of time.

Legal Terms

In telling you what you can do, the written notice is telling how you can request a **“fast-track appeal.”** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (**Section 9.3** below tells how you can request a fast-track appeal.)

The written notice is called the **“Notice of Medicare Non-Coverage.”**

2. **You will be asked to sign the written notice to show that you received it.**
 - You or someone who is acting on your behalf will be asked to sign the notice. (**Section 5.2** of this chapter tells how you can give written permission to someone else to act as your representative.)
 - Signing the notice shows **only** that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan that it's time to stop getting the care.

Section 9.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. **Section 11** of this chapter tells you how to file a complaint.)

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- **Ask for help if you need it.** If you have questions or need help at any time, call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see **Section 2** of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization for your state and ask for a review. You must act quickly.***What is the Quality Improvement Organization?***

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4 of this booklet.)

What should you ask for?

- Ask this organization for a “fast-track appeal” (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date on the Notice of Medicare Non-Coverage.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see **Section 9.5** of this chapter.

Step 2: The Quality Improvement Organization conducts an independent review of your case.***What happens during this review?***

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.

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- By the end of the day the reviewers informed us of your appeal, you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal Terms

This notice explanation is called the **“Detailed Explanation of Non-Coverage.”**

Step 3: Within one full day after they have all the information they need; the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?

- If the reviewers say yes to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say no to your appeal, then **your coverage will end on the date we have told you.** We will stop paying our share of the costs of this care on the date listed on the notice.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is “Level 1” of the appeals process. If reviewers say no to your Level 1 Appeal **and** you choose to continue getting care after your coverage for the care has ended, then you can make another appeal.
- Making another appeal means you are going on to “Level 2” of the appeals process.

Section 9.4

Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal **and** you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another

**Chapter 8. What to do if you have a problem or complaint
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look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** the date when we said your coverage would end.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said no to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.***What happens if the review organization says yes to your appeal?***

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to

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accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.

- **Section 10** of this chapter tells more about the process for Level 3, 4, and 5 Appeals.

Section 9.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in **Section 9.3**, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, **the first two levels of appeal are different.**

Step-by-Step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms

A “fast” review (or “fast appeal”) is also called an **“expedited appeal.”**

Step 1: Contact us and ask for a “fast review.”

- For details on how to contact us, go to Chapter 2, Section 1, and look for the section called “How to contact us when you are making an appeal about your medical care.”
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

Step 2: We do a “fast” review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan’s coverage for services you were receiving.
- We will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

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Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).

- **If we say yes to your fast appeal**, it means we have agreed with you that you need services longer, and we will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal**, then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are **automatically** going on to Level 2 of the appeals process.

Step-by-Step: Level 2 Alternate Appeal Process

During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the “Independent Review Organization” is the “ Independent Review Entity. ” It is sometimes called the “ IRE. ”

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. **Section 11** of this chapter tells how to make a complaint.)

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Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- **Section 10** of this chapter tells more about the process for Level 3, 4, and 5 Appeals.

SECTION 10 Taking your appeal to Level 3 and beyond

Section 10.1 Appeal Levels 3, 4, and 5 for Medical Service Requests
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This section may be appropriate for you if Medicare traditionally pays for the service and you have made a Level 1 Appeal and a Level 2 Appeal for a Medicare covered service, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written

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response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal A judge (called an **Administrative Law Judge**) or an **attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process may or may not be over.** We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
 - If we decide not to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
 - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal The Medicare **Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 Appeal decision, the appeals process may or may not be over -** We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you if the value of the item or medical service meets the required dollar value.
 - If we decide **not** to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.

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- If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process may or may not be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

Section 10.2 Additional MassHealth (Medicaid) appeals

You also have other appeal rights if your appeal is about services or items that MassHealth (Medicaid) usually covers. The letter you get from the Fair Hearing office will tell you what to do if you wish to continue the appeals process.

Section 10.3 Appeal Levels 3, 4 and 5 for Part D Drug Requests

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal A judge (called an **Administrative Law Judge**) or attorney adjudicator who works for the Federal government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was

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approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.

- **If the answer is no, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal The Medicare **Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

**SECTION 11 How to make a complaint about quality of care,
waiting times, customer service, or other concerns**



If your problem is about decisions related to benefits, coverage, or payment, then this section is not for you. Instead, you need to use the process for coverage decisions and appeals. Go to Section 5 of this chapter.

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**
Section 11.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can “make a complaint”

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none"> • Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	<ul style="list-style-type: none"> • Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor customer service, or other negative behaviors	<ul style="list-style-type: none"> • Has someone been rude or disrespectful to you? • Are you unhappy with how our Member Services has treated you? • Do you feel you are being encouraged to leave the plan?
Waiting times	<ul style="list-style-type: none"> • Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at the plan? <ul style="list-style-type: none"> ○ Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.
Cleanliness	<ul style="list-style-type: none"> • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor’s office?
Information you get from us	<ul style="list-style-type: none"> • Do you believe we have not given you a notice that we are required to give? • Do you think written information we have given you is hard to understand?

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Complaint	Example
Timeliness (These types of complaints are all related to the <i>timeliness</i> of our actions related to coverage decisions and appeals)	<p>The process of asking for a coverage decision and making appeals is explained in Sections 4 through 10 of this chapter. If you are asking for a coverage decision or making an appeal, you use that process, not the complaint process.</p> <p>However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"> • If you have asked us to give you a “fast coverage decision” or a “fast appeal,” and we have said we will not, you can make a complaint. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 11.2 **The formal name for “making a complaint” is “filing a grievance”**

Legal Terms

- What this section calls a “**complaint**” is also called a “**grievance.**”
- Another term for “**making a complaint**” is “**filing a grievance.**”
- Another way to say “**using the process for complaints**” is “**using the process for filing a grievance.**”

Chapter 8. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section 11.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. Call Member Services at 1-866-610-2273 (TTY 711). Calls to this number are free. 8 am to 8 pm, 7 days a week from October 1st through March 31st. From April 1st through September 30th, Member Services is available 8 a.m. to 8 p.m., Monday through Friday, and 8 a.m. to 6 p.m. on Saturday and Sunday.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
 -
- **Whether you call or write, you should contact Member Services right away.** You can make the complaint at any time after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast 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.**

Legal Terms

What this section calls a “fast complaint” is also called an “expedited grievance.”

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **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. If we decide to take extra days, we will tell you orally and in writing.
- **If we do not agree** with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)****Section 11.4 You can also make complaints about quality of care to the Quality Improvement Organization**

You can make your complaint about the quality of care you received by using the step-by-step process outlined above.

When your complaint is about **quality of care**, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (**without** making the complaint to us).
 - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
 - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4 of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 11.5 You can also tell Medicare and MassHealth (Medicaid) about your complaint

You can submit a complaint about Senior Care Options Program directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

Section 11.6 Complaints about Mental Health Parity

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

1. Senior Care Options Program must provide the same level of benefits for any mental health and substance abuse problems you may have as for other physical problems you may have;
2. Senior Care Options Program must have similar prior authorization requirements and

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

treatment limitations for mental health and substance abuse services as it does for physical health services;

3. Senior Care Options Program 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
4. Senior Care Options Program must also provide you within a reasonable time frame the reason for any denial of authorization for mental or substance abuse services.

If you think that Senior Care Options Program is not providing parity as explained above, you have the right to file a Grievance with Senior Care Options Program. For more information about Grievances and how to file them, please see Section 11.3 of this chapter of your *Evidence of Coverage*.

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 a.m. to 5 p.m.

For more information, please see 130 CMR 450.117(J).

PROBLEMS ABOUT YOUR MASSHEALTH (MEDICAID) BENEFITS

SECTION 12 Handling problems about your MassHealth (Medicaid) benefits

MassHealth (Medicaid) Level 2 Appeal Rights with the MassHealth Board of Hearings

As a plan member, you are covered by both Medicare and MassHealth (Medicaid). Therefore, if you are dissatisfied with any action or inaction taken by our plan (for example a denial of an appeal for service), you also have the right to appeal this to MassHealth (Medicaid). With every appeal decision we make, we will send you information in writing about your rights to appeal our decision to MassHealth (Medicaid) Board of Hearings.

Step 1: Contact MassHealth (Medicaid) Board of Hearings to ask for review of your appeal case

You may request a fair hearing through the MassHealth (Medicaid) Board of Hearing appeal process.

- To pursue a MassHealth (Medicaid) 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 denial of appeal from Senior Care Options Program.
- The request along with a copy of the plan's final denial notice must be sent to:

Executive Office of Health & Human Services — Office of Medicaid

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Board of Hearings
100 Hancock Street, 6th Floor
Quincy, MA 02171
Or Fax to (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/eohhs/docs/masshealth/appforms/fair-hearing.pdf.
- 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 Senior Care Options Program’s 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 written appeal denial notice to you, then the Board of Hearings will process your appeal using standard appeal times.
- 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 Senior Care Options Program. 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.

Step 2: The MassHealth (Medicaid) Board of Hearings Appeal reviews your case and gives you their answer

The Board of Hearings will review your appeal case and notify you about its decision.

- If the Board of Hearings says “yes” so 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.

Step 3: If the decision is “no” for all or part of what you asked for, you will have further appeal rights under MassHealth (Medicaid).

- If you do not agree with the fair hearing decision, you will have further appeal rights under MassHealth (Medicaid). You will be notified of those appeal rights if this happens.

You may contact Senior Care Options Program’s Member Services (phone numbers are printed on the back cover of this booklet) to ask for help with appeal process or for more information about

your appeal rights.

SECTION 13 Reporting Fraud, Waste or Abuse

If you think you might have seen fraud, waste, or abuse:

- **Call** the CCA Compliance Hotline at 1-800-826-6762
or
- **Email** CCA_Compliance@commonwealthcare.org

We are committed to work to prevent and/or address any fraud, waste, or abuse.

You, your family member, or your caregiver can make a report. Reports are be confidential. The report can be anonymous. It will not affect your services.

What are fraud, waste, and abuse?

These are all types of misuse of resources, money, or property of CCA or the federal or state government.

- **Fraud:** dishonest actions done on purpose and knowing that resources will go someone who was not approved for them
- **Waste:** too much of a resource is used. Waste is not on purpose.
- **Abuse:** actions that result in costs or payments for services that are not medically necessary or not the accepted standard of care

Examples:

- Billing for services not that were not provided
- Not being truthful when billing for services, such as:
 - Changing the type
 - Changing the charges
 - Changing the date
 - Changing the provider or the person who got the services
- Using someone else's ID card
- Delivery of equipment or supplies to a member when they did not need them

Tips to protect yourself from fraud

Offers of "free" medical help or treatments that come in ads, a telephone call, or to your front door **may be a scam.**

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

What to do:

- Be careful!
- Read your paperwork from CCA and make sure you got the treatments that are charged. Question anything that doesn't look right.
- Do not give out your Medicare, Social Security, bank account, or credit card information to someone on the telephone.
- If they come to your house, ask for their ID. No one from CCA can come into your home without your permission.

To learn more, go to <https://www.commonwealthcarealliance.org/report-fraud>.

CHAPTER 9

Ending your membership in the plan

Chapter 9. Ending your membership in the plan

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SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan
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Ending your membership in Senior Care Options Program may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
 - You can end your membership in the plan at any time. Section 2 tells you about the types of plans you can enroll in and when your enrollment in your new coverage will begin.
 - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

SECTION 2 When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the Medicare Advantage Open Enrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

Section 2.1 You may be able to end your membership because you have Medicare and MassHealth (Medicaid)
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Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you may be able to end your membership in our plan or switch to a different plan one time during each of the following Special Enrollment Periods:

- January to March
- April to June
- July to September

If you joined our plan during one of these periods, you'll have to wait for the next period to end your membership or switch to a different plan. You can't use this Special Enrollment Period to end your membership in our plan between October and December. However, all people with

Medicare can make changes from October 15 – December 7 during the Annual Enrollment Period. Section 2.2 tells you more about the Annual Enrollment Period.

If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

- **What type of plan can you switch to?** If you decide to change to a new plan, you can choose any of the following types of Medicare plans:
 - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
 - Original Medicare *with* a separate Medicare prescription drug plan.
 - 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.

Note: If you disenroll from Medicare prescription drug coverage and go without “creditable” prescription drug coverage for a continuous period of 63 days or more, you may need to pay a Part D late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.)

Contact your State Medicaid Office or MassOptions to learn about your MassHealth (Medicaid) plan options (telephone numbers are in Chapter 2, Section 6 of this booklet).

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.

Section 2.2	You can end your membership during the Annual Enrollment Period
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You can end your membership during the Annual Enrollment Period (also known as the “Annual Open Enrollment Period”). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.
- **What type of plan can you switch to during the Annual Enrollment Period?** You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
 - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)

- Original Medicare *with* a separate Medicare prescription drug plan
- *or* – Original Medicare *without* a separate Medicare prescription drug plan.

If you receive “Extra Help” from Medicare to pay for your prescription drugs: 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.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 1, Section 4 for more information about the late enrollment penalty.

- **When will your membership end?** Your membership will end when your new plan’s coverage begins on January 1.

Section 2.3	You can end your membership during the Medicare Advantage Open Enrollment Period
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You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **When is the annual Medicare Advantage Open Enrollment Period?** This happens every year from January 1 to March 31.
- **What type of plan can you switch to during the annual Medicare Advantage Open Enrollment Period?** During this time, you can:
 - Switch to another Medicare Advantage Plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
 - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you have until March 31 to join a separate Medicare prescription drug plan to add drug coverage.
- **When will your membership end?** Your membership will end on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.4	In certain situations, you can end your membership during a Special Enrollment Period
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In certain situations, you may be eligible to end your membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you may be eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):
 - Usually, when you have moved
 - If you have MassHealth (Medicaid)
 - If you are eligible for “Extra Help” with paying for your Medicare prescriptions
 - If we violate our contract with you
 - If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital
 - If you enroll in the Program of All-inclusive Care for the Elderly (PACE)
 - **Note:** If you’re in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

Note: Section 2.2 tells you more about the special enrollment period for people with (MassHealth) Medicaid.

- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
 - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
 - Original Medicare *with* a separate Medicare prescription drug plan
 - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.

If you receive “Extra Help” from Medicare to pay for your prescription drugs: 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.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 1, Section 4 for more information about the late enrollment penalty.

- **When will your membership end?** Your membership will usually end on the first day of the month after your request to change your plan is received.

Note: Sections 2.1 and 2.2 tell you more about the special enrollment period for people with Medicaid and Extra Help.

Chapter 9. Ending your membership in the plan

Section 2.5	Where can you get more information about when you can end your membership?
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If you have any questions or would like more information on when you can end your membership:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the *Medicare & You 2021* Handbook.
 - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
 - You can also download a copy from the Medicare website (www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **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 3	How do you end your membership in our plan?
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Section 3.1	Usually, you end your membership by enrolling in another plan
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Usually, to end your membership in our plan, you simply enroll in another Medicare plan. However, if you want to switch from our plan to Original Medicare but you have not selected a separate Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).
- --or-- You can contact 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.

Chapter 9. Ending your membership in the plan

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none"> • Another Medicare health plan 	<ul style="list-style-type: none"> • Enroll in the new Medicare health plan at any time. Your new coverage will begin on the first day of the following month. You will automatically be disenrolled from Senior Care Options Program when your new plan's coverage begins.
<ul style="list-style-type: none"> • Original Medicare <i>with</i> a separate Medicare prescription drug plan 	<ul style="list-style-type: none"> • Enroll in the new Medicare prescription drug plan at any time. Your new coverage will begin on the first day of the following month. You will automatically be disenrolled from Senior Care Options Program when your new plan's coverage begins.
<ul style="list-style-type: none"> • Original Medicare <i>without</i> a separate Medicare prescription drug plan <ul style="list-style-type: none"> ○ 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. ○ If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may have to pay a late enrollment penalty if you join a Medicare drug plan later. 	<ul style="list-style-type: none"> • Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). • You can also 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. • You will be disenrolled from Senior Care Options Program when your coverage in Original Medicare begins.

For questions about your Medicaid benefits, contact MassHealth at 1-800-841-2900 (TTY: 1-800-497-4648), Monday – Friday, 8:00 am – 5:00 pm. For more information about how to contact MassHealth (Medicaid), see Chapter 2, Section 6. Ask how joining another plan or returning to Original Medicare affects how you get your MassHealth (Medicaid) coverage.

SECTION 4 Until your membership ends, you must keep getting your medical services and drugs through our plan

Section 4.1 Until your membership ends, you are still a member of our plan
--

If you leave Senior Care Options Program, it may take time before your membership ends and your new Medicare and MassHealth (Medicaid) coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **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).

SECTION 5 Senior Care Options Program must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Senior Care Options Program **must end your membership in the plan if any of the following happen:**

- If you no longer have Medicare Part A and Part B. However, you may stay enrolled in our plan under MassHealth (Medicaid) as long as you are enrolled in MassHealth Standard.
- If you are no longer eligible for MassHealth (Medicaid). As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and MassHealth (Medicaid). You must be enrolled in MassHealth Standard to stay a member of our plan.
- If you move out of our service area
- If you are away from our service area for more than six 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 on the back cover of this booklet.)
- If you become incarcerated (go to prison)
- If you are not a United States citizen or lawfully present in the United States

Chapter 9. Ending your membership in the plan

- If you lie about or withhold information about other insurance you have that provides prescription drug coverage
- 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 Medicare 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 Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Member Services** for more information (phone numbers are printed on the back cover of this booklet).

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

Senior Care Options Program is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also look in Chapter 8, Section 11 for information about how to make a complaint.

CHAPTER 10

Legal notices

Chapter 10. Legal notices

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SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. All organizations that provide Medicare Advantage plans, like 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® complies with applicable Federal civil rights laws and does not discriminate on the basis of medical condition, health status, receipt of health services, claims experience, medical history, disability (including mental impairment), marital status, age, sex (including sex stereotypes and gender identity) sexual orientation, national origin, race, color, religion, creed, or public assistance. Commonwealth Care Alliance does not exclude people or treat them differently because of medical condition, health status, receipt of health services, claims experience, medical history, disability (including mental impairment), marital status, age, sex (including sex stereotypes and gender identity) sexual orientation, national origin, race, color, religion, creed, or public assistance.

Commonwealth Care Alliance:

- Provides free aid 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 Civil Rights Coordinator.

Chapter 10. Legal notices

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

Civil Rights Coordinator
30 Winter Street
Boston, MA 02108

Phone: 1-617-960-0474, ext. 3932, (TTY: 711)

Fax: 857-453-4517

E-mail: civilrightscordinator@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. 20211
1-800-368-1019, 800-537-7697 (TDD)

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

If you want more information or have concerns about discrimination or unfair treatment, please call the 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 (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Senior Care Options Program, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Who receives payment under this contract

Commonwealth Care Alliance Senior Care Options Program or its third party administrator will make payment for services provided and authorized by your care team under this contract directly to the plan provider. You cannot be required to pay anything that is owed by Commonwealth Care Alliance Senior Care Options Program.

SECTION 5 Notifications

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 your address. When you need to notify us, it should be mailed to Commonwealth Care Alliance, 30 Winter Street, Boston, MA 02108 or call us directly at 1-866-610-2273 (TTY: Call MassRelay at 711).

SECTION 6 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.

CHAPTER 11

Definitions of important words

Chapter 11. Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care 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. Chapter 8 explains appeals, including the process involved in making an appeal.

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

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 your PCP, a nurse practitioner, a registered nurse, a physician assistant, or/and a Geriatric Support Services Coordinator (GSSC) 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. See Chapter 3, Section 2.1 for information about care team.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Complaint — The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Chapter 11. Definitions of important words

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 8 explains how to ask us for a coverage decision.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The general term we use to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

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 is personal care that can be provided by people who don't have professional skills or training, such as 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. Medicare doesn't pay for custodial care.

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).

Dual Eligible Individual – A person who qualifies for Medicare and MassHealth (Medicaid) coverage.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: (1) rendered by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

Chapter 11. Definitions of important words

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision 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).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

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.

Integrated/Grievance – A type of complaint you make about us or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Health Outreach Worker – Health Outreach Worker (HOW) assists members managing their Social Determinants of Health (SDH) 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. SDH includes, but it is not limited to, housing, public assistance [SNAP, SSI Cash Assistance], Day Programs, fuel assistance, and MassHealth.

Home Health Aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Hospice – A member who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months

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before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive “Extra Help” from Medicare to pay your prescription drug plan costs, you will not pay a late enrollment penalty. If you ever lose your low income subsidy (“Extra Help”), you must maintain your Part D coverage, or you could be subject to a late enrollment penalty if you ever chose to enroll in Part D in the future.

List of Covered Drugs (Formulary or “Drug List”) – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

Low Income Subsidy (LIS) – See “Extra Help.”

MassHealth (Medicaid) (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. MassHealth (Medicaid) programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and MassHealth (Medicaid). 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. See Chapter 2, Section 6 for information about how to contact MassHealth (Medicaid) and MassOptions.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a PACE plan, or a Medicare Advantage Plan.

Medicare Advantage Open Enrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is from January 1 until March 31, and is also available for a 3-month period after an individual is first eligible for Medicare.

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Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Advantage health plan that is offered in their area.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Member (Member of our Plan, or “Plan Member”) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

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.

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them “network pharmacies” because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – “Provider” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “**network providers**” when they have an agreement with our plan to accept our payment as payment in full, and in some cases to

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coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as “plan providers.”

Integrated/ Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called “coverage decisions” in this booklet. Chapter 8 explains how to ask us for a coverage decision.

Original Medicare (“Traditional Medicare” or “Fee-for-service” Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn’t have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and MassHealth (Medicaid) benefits through the plan.

Part C – see “**Medicare Advantage (MA) Plan.**”

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

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Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive “Extra Help” from Medicare to pay your prescription drug plan costs, you will not pay a late enrollment penalty. If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage. Senior Care Options Program members do not have a premium.

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 health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Providers.

Prior Authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets “prior authorization” from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's

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also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

Serving the Health Information Needs of Everyone (SHINE – Massachusetts SHIP)

SHINE (Serving the Health Information Needs of Everyone) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	1-800-AGE-INFO (1-800-243-4636)
TTY	1-800-872-0166 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 SHINE program in your town or region.
WEBSITE	www.mass.gov/health-insurance-counseling

Senior Care Options Program Member Services

Method	Member Services – Contact Information
CALL	1-866-610-2273 Calls to this number are free. October 1 st through March 31 st : 8 a.m. to 8 p.m., 7 days a week. April 1 st through September 30 th : 8 a.m. to 8 p.m., Monday through Friday, and 8 a.m. to 6 p.m. on Saturday and Sunday. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. October 1 st through March 31 st : 8 a.m. to 8 p.m., 7 days a week. April 1 st through September 30 th : 8 a.m. to 8 p.m., Monday through Friday, and 8 a.m. to 6 p.m. on Saturday and Sunday.
FAX	617-426-1311
WRITE	30 Winter Street, Boston, MA 02108
WEBSITE	www.CommonwealthCareSCO.org

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